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**Comité permanent de la santé**

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⊕ (1535)

*[English]*

**The Vice-Chair (Mr. Stan Dromisky (Thunder Bay—Atikokan, Lib.)):** I'd like to call the meeting to order.

Before we proceed I'd like to thank all the representatives from the five different organizations for appearing, but not only for that purpose but for taking such an active participatory kind of role in our democratic society.

Democracy, as you know, is a relative thing. It all pertains to the amount of participation by each and every individual within our society. Thank goodness that we have people that represent organizations like yours who are doing their job in helping this country to develop policy and to find the right course for years to come.

Thank you very much for appearing.

We will follow an order, first of all we have two motions for the Standing Committee on Health received from Carol Skelton. You all have copies of the motions.

Yes.

[*Français*]

**Mme Yolande Thibeault (Saint-Lambert, Lib.):** Monsieur le président, je propose que la motion soit déposée.

[*English*]

**The Vice-Chair (Mr. Stan Dromisky):** Very good. The motion is to be tabled for a future meeting.

**Mrs. Carol Skelton (Saskatoon—Rosetown—Biggar, Canadian Alliance):** Why may I ask?

**The Vice-Chair (Mr. Stan Dromisky):** There's no debate on a motion of that nature.

All in favour for the first motion tabled to a future meeting.

**A voice:** Can we vote?

**The Vice-Chair (Mr. Stan Dromisky):** I wish you could because we have a heavy agenda today.

(Motion agree to)

**The Vice-Chair (Mr. Stan Dromisky):** The second motion by Carol Skelton, that this committee immediately convene hearings into the special health needs of northern remote communities especially those needs related to their unique funding requirements.

[*Français*]

**Mme Yolande Thibeault:**

[*English*]

**The Vice-Chair (Mr. Stan Dromisky):** Thank you.

(Motion agreed to)

**The Vice-Chair (Mr. Stan Dromisky):** We will continue by following the list that you have before you and we'll ask for some representative from the Canadian Union of Public Employees to make their presentation.

**Ms. Judy Darcy (President, Canadian Union of Public Employees):** We've actually switched the order around a little bit but I'm going to ask Maude Barlow to start if that's okay.

⊕ (1540)

**The Vice-Chair (Mr. Stan Dromisky):** All right, let me know what the order is.

Fine, Judy Darcy, you're number two.

**Ms. Judy Darcy:** Maude Barlow will say a couple of words and introduce Elaine Johnston from the Assembly of First Nations. Then we'll go back to Maude Barlow. Then we go to Mike McBane from the Canadian Health Coalition and then myself. Then Barb Byers, Canadian Labour of Congress.

**The Vice-Chair (Mr. Stan Dromisky):** I probably will forget that so you make sure that I follow that pattern.

**Ms. Judy Darcy:** Anything you want us to do, we're happy to take right over.

**The Vice-Chair (Mr. Stan Dromisky):** All right, very good.

Please proceed. Each organization has five minutes. After all the presentations are made there'll be questions and answers.

So let's start.

**Ms. Maude Barlow (Chairperson, Council of Canadians):** Thank you very much.

I'm Maude Barlow from the Council of Canadians and we're the representatives of the people who put on the People's Summit on Health Care this past weekend which was wonderful. We've chosen to start with Elaine Johnston from the Assembly of First Nations as a sign of our support for the first nations and their concerns about the First Minister's Meeting.

Elaine.

**Ms. Elaine Johnston (Director, Health Secretariat, Assembly of First Nations):**

Thank you.

I want to first of all acknowledge that we are on the traditional territory of the Algonquins and I'd like to thank you, honourable members, for listening to my presentation and to my colleagues for the honour of presenting first.

I'm Ojibway Pe-ta-waygamak from Serpent River First Nation. I'm a registered nurse by profession and the director of health at the Assembly of First Nations.

I've worked in various environments--hospital, community, air and water. I'm also a recipient of the health care system as a result of a serious fall last November.

I'm here to tell you that the Report of the Royal Commission on Aboriginal Peoples of 1996, Volume 3 on Health and Healing, echoed some of the recommendations from the Romanow Report.

We are disappointed that AFN was not invited to participate in the First Ministers' conference. This would have been an opportunity for mutual respect and the recognition of the immense responsibility of various governments to the plight of aboriginal peoples in this country.

Our health status is considered third world and the status quo is no longer acceptable. We were prepared to table how we could be full participants in looking for positive solutions for positive health outcomes and we were prepared to do that.

We were intrigued by the recommendations put forward by the Romanow Report for a framework agreement. Now that the unsigned accord mentions the Canada Health Council, we would urge governments to involve first nations.

The northern parts of the provinces have the same concerns that Nunavut, the Yukon and the Territories have. A flight from Fort Severn in Northern Ontario takes about three to four hours, depending on the destination. The closest hospital for specialty services is in Thunder Bay or Winnipeg.

In 2001, the average expenditure per Canadian was \$2,405. For aboriginal peoples it was \$3,307 for hospital care, medical care, prevention and other health services which the provinces provide. Why are the numbers higher? Poverty leads to poorer health and higher costs. The cost of health service delivery to remote areas is higher.

For First Nations and Inuit Health Branch it spends approximately \$1.3 billion with the majority of its funding in community health programs, and the remainder in non-insured health benefits, and about 2% on hospitals.

Without us being at the First Ministers' conference we have many concerns, questions, and again, decisions are being made for us. Corporatization of health care also concerns us greatly as our access to health services is already problematic.

We support the recognition of health care as a fundamental human right. I would urge the Standing Committee on Health to hear from members of our Chiefs Committee on Health.

Thank you, merci, and I look forward to a continued dialogue with you.

**The Vice-Chair (Mr. Stan Dromisky):** Thank you very much, Elaine.

Now, Elaine, you held up a report that you have there. Would you table a copy with the clerk so that we would all have a copy of it?

**Ms. Elaine Johnston:** I certainly will.

**The Vice-Chair (Mr. Stan Dromisky):** Thank you very much.

**Ms. Elaine Johnston:** So I'll hand it over now to Maude Barlow.

**The Vice-Chair (Mr. Stan Dromisky):** Maude.

**Ms. Maude Barlow:** Thank you very much. On behalf of the Council of Canadians, I want to express our concern about the first minister's meeting that took place last week. It's important to say I think that all of our groups collectively represent millions of Canadians, so we're here on behalf of a lot of members all of us together.

We felt that the Romanow commission was very clear in its presentation to the federal government and the people who presented to the Romanow commission were very clear in their position, and the polls are very clear. The Canadians don't want for-profit health care in our country, that we're in fact worried that we're losing Medicare by a death of 1,000 cuts. However, we're very disappointed that at the first minister's meeting last week, there was no discussion of for-profit health care, no mechanism put in place to either monitor it or control it in any kind of way; and rather than see an expansion of the public health care system, we're actually seeing quite a bit more money going into a system that's going to promote private health care.

We're also very concerned in all our organizations that under the rules of the current trade agreements like NAFTA and the national treatment provisions of NAFTA, the health care exemption is only good as long as we're delivering health care entirely in the public way and not for-profit way, and that as we move more into a commercial for-profit system, national treatment provisions of NAFTA currently say that we now have to start allowing American corporations that come into Canada not only set up a commercial presence but also demand equal funding to the domestic health care institutions in our country.

We're also very concerned about the expansion of health care under the general agreement on trade and services and the free trade area of the Americas which are services agreements or at least the FTAA has a new services agreement and the GATT is a services agreement. We've already put health insurance on the GATT's table, and we're deeply concerned that this was not addressed in the first minister's meeting.

We're also concerned that there was no discussion and no agreement that was come to around the reason that there's such a high price of prescription drugs in our country which is the patent monopoly rights given to the transnational drug corporation. So there's

money being put into catastrophic prescription drug care, but that's public money paying for and covering up the huge profits that are made by these transnational corporations.

So we're concerned about what was not in the accord, and are wanting very much for these issues to be raised when ministers come together again to hash out the details of this accord. And of course, we're very worried that the health council will therefore have no accountability if it's not able to deal with these issues. It's going after symptoms and not the problem.

I'll just finally say that we are collectively deeply concerned that by not dealing with these key issues, the first minister's meeting deepened the democracy deficit in Canada and highlighted the growing gap between the political elite of this country and the vast majority of Canadians who really don't want for-profit health care.

Thank you.

🕒 (1545)

**The Vice-Chair (Mr. Stan Dromisky):** Who follows? Michael McBane?

**Ms. Kathleen Connors (Chairperson, Canadian Health Coalition):** In fact, my name is Kathleen Connors, and I'm the chairperson of the Canadian Health Coalition and come to that position through my role as president of the Canadian Federation of Nurses Unions, and Mike McBane will do the brief intervention. But I think it's important that the committee know that today in this room I'm proud to have representatives of nurses from Prince Edward Island through to British Columbia. And we stand in solidarity with the other members sitting at this table around the issue of health care because it's where we live and work. And the perspective that maybe won't be address but just deserves attention is the whole issue of social determinance of health and that those issues cannot be ignored for the sake of health care provision. And so with that, hopefully you'll want to talk about that issue as well because housing and poverty and food safety and peace are all issues that are indirectly impacting on health of the Canadian population.

But Mike is going to speak to a more specific issue, and I would let him do so now.

**Mr. Michael McBane (National Co-ordinator, Canadian Health Coalition):**  
Thanks Kathleen.

I wanted to raise a couple of examples about why ownership and healthcare matters because we have the government saying, as long as it's publicly funded, including the Minister of Health, who cares who owns your health care facilities.

We have the Alliance party telling Canadians, delivery doesn't matter as long as you have this quality health care. So we need to look at the facts. Canadians were baffled that we are prepared to spend this much money and have no restrictions on it going to for profit and investor-owned health care.

I think one of the reasons why is the agreement between the government of Alberta and the Canadian government in 1996, which states two principles amongst 12. One of them says, we must ensure a strong role for the private sector in health care, both within and outside the publically funded systems.

The other, principle in this secret memorandum is that we will introduce measures to expand the opportunities for the private sector to deliver services within a single pair envelope. So perhaps this explains the silence in the agreement about restricting for profit delivery.

The second piece of evidence I want to point to is in the annual report to Parliament on the Canada Health Act. I photocopied this for members.

C'est disponible en anglais et francais.

Do members have a copy of this excerpt?

You will see that on the question of how much money is spend in for profit facilities, I gave you the province of Ontario. It's true for all provinces in the report. What is the answer? That the minister table before you, before Parliament, before Canadians representatives, not available. Every single category, every single province, not available.

That's a failure to perform legislative duty. If it's not available there should be no money going there. If we don't know how much profit taking and where this moneys going.

The third issue I want to raise around, why ownership matters is that it has higher death rates in for profit hospitals. This has been established by a team of Canadian medical researchers, published in the Medical Association Journal. This is irrefutable evidence about why it matters.

The fourth piece of evidence concerns the Alliance heal critic will relate to this, having worked on regional health authorities in Alberta. The example comes from the Calgary Regional Health Authority, where several members of the Regional Health Authority are running and owning for profit heal care facilities, for profit hospitals, for profit clinics, run by doctors who have senior leadership positions in the health authority.

Do you know what that's called? Conflict of interest. That's why we should matter who's delivering the care.

The fourth example I want to give very briefly is from Ontario. The request for proposals to build a private hospital in Ottawa. The contractor who got the bid was a major contributor to the election campaign of the Ontario minister and the Ontario premier. Some people would call that influence peddling.

The next example in Ontario, I have a letter-- which I haven't been able to distribute because it's not translated yet, but it's available--from an Alberta company that owns almost all the laboratory service clinics in Ontario and sent letters to eastern Ontario, Rockland, Cumberland, a number of local communities. This company said that unless you give us a 25% profit, we will close your x-ray clinic and if you want to keep it open, get your municipality to give us this subsidy.

They subsequently closed these clinics throughout eastern Ontario in communities that have no public transportation. The Ontario government calls this an innovative approach to health care. I call it extortion. If you look in the dictionary that's what they're doing.

So for any elected official to get up in the House o Commons and tell the people of Canada that ownership doesn't matter, I think of Suzuki's line, they're either stupid or they're lying.

I'll end there, we don't have a lot of time but I just want to say that on the Health Care Accord there will never be enough money if you allow the corporate scams that are currently in place and that the privatizing premiers have in store for this public financing. Thank you.

⊕ (1550)

**The Vice-Chair (Mr. Stan Dromisky):** Thank you very much Michael. Next.

**Ms. Judy Darcy (President, Canadian Union of Public Employees):** Thank you.

I'm Judy Darcy, National President of the Canadian Union of Public Employee which is Canada's largest union, with 527,000 members including 180,000 health care workers, several of whom are here today. We're in town for the People's Summit, and with me also is Claude Généreux, our National Secretary Treasurer who is the former president of CUPE's social affairs federation in Quebec, health care workers and an activist in the coalition solidarité santé. So if there are any questions that relate to how all of what we're saying today relates to Quebec, he would also be very happy to speak to that question.

When I was there the night of the first ministers' meeting and we were all frantically reading the document together with the media, the first thing that struck us was that there were three critical words that were in there, and three critical words that were missing.

I believe on page 2 of the document when it talked about the new innovative programs that this accord encompassed, it said "at their discretion", referring to the province's role in determining what this all was going to look like and how it was going to be delivered.

And three fundamental words that were not there were the words "not for profit", and to us that's extremely worrisome because we have seen as a result of major cuts from the federal government over the last decade as well as because of the ideological bent of several provinces in this country, we have seen privatization growing like wild fire across

the country and there is nothing, absolutely nothing, in that agreement, accord, deal, arrangement, whatever you want to call it, that is going to stem the tide towards further privatization and in fact we believe it is going to grow even more quickly as a result.

Already across the country almost every week there is a new P-3 Hospital that is announced, public-private partnerships. They are spreading like wild fire and the rhetoric that surrounds it says “It doesn't really matter who owns the hospital. What matters is the care services that are delivered”, that this debate is really all about bricks and mortar. Well, the fact is that in most of these public-private partnerships which are 25, 30, even 60-year long-term lease arrangements, they are about building, owning, operating, maintaining, etc., as well as financing by the private sector.

They're called experiments. They're called pilot projects, but the fact of the matter is there is already considerable evidence that exists in Canada and internationally that show that P-3 model for health care does hurt the quality of care.

There was a detailed study done by Louis Haurback who is the former director of Audit Operations for the auditor general that was prepared. We have copies of this for all of you, and we also have a copy of technical briefing papers that were prepared by our union for the Romanow commission on the issue of public-private partnerships.

But the bottom line with public-private partnerships with the experience in the U.K. is that because there are higher costs for borrowing for the private sector than the public sector, because you have to build in profit margins, because of huge overruns in construction costs, and on and on, the costs are higher and those costs then have to be taken from direct care and on average with PFI, private finance initiative hospitals in the U.K., known as P-3's in Canada, staff and bed costs, service cost, direct delivery, staff and beds, were cut by 25% to 30% and yet, several provincial governments, Alberta, Ontario, British Columbia--New Brunswick is musing about it--say, “this is the wave of the future” and the agreement that was made last week doesn't do a thing to stop it.

It has to be stopped. The federal government needs to act. It is also said by several of these same provincial governments that what matters is strictly is public funding, not public delivery, and in particular, it's said that it's only what are called “core services” that matter, not support services. The word “hotel services” is used, “hospitality services”, “auxiliary services” to describe the work that many of our members do. That work being in dietary services, in laundry, in cleaning, in housekeeping.

I want to also leave with you some major studies, a literature review on the relationship between cleaning and hospital-acquired infections and also a major study to comparisons between hospital workers and hospitality workers makes sense. In both cases the evidence will very clearly show, and we're happy to provide you more detailed information on it, the evidence will clearly show that it matters a whole lot to the quality of care, whether operating rooms are sterile.

It matters a whole lot that the people delivering laundry know that operating linens need to be separated from hospital room linens, from uniforms and so on, that there are very specific things that need to be checked for. They need to be cleaned in a certain way. There's a lot of study and evidence on this issue and that contracting this work out to the lowest bidder does not make sense, from the point of view of quality and safety and the quality of care and it certainly doesn't make sense from the point of view of creating a low-wage economy and doing decently paid women, hospital workers, out of jobs and replacing them with contingent casual part-time workers.

We also know that, with further privatization and delisting by provincial governments, that the issue of health insurance and health benefits is appearing on bargaining tables across the country. In the United States, the overwhelming majority of labour disputes and strikes happen over the issue of health insurance, and that trend is growing across this country and will grow even more marked if privatization is not tackled.

Fundamentally, what we want to say to you is that the first ministers failed Canadians. They failed Canadians because what they argued about, what they argued about once again was jurisdiction, what they argued about was money. And while money is absolutely critically important, the issue of not-for-profit and accountability, they were what was fundamental about Romanow, they should have been what was fundamental about what the first ministers agreed on, and they didn't.

So going back to what you said about democracy at the outset, sir, our members, together with other people who took part in the People's Summit, don't believe that the Government of Canada or the first ministers have really listened to Canadians. So you're going to see the beginning of even greater mobilization by the people across this country, including health care workers, as we're determined that we're going to have a health care system that really does do the job for Canadians, and that means a public, not-for-profit health care system.

🕒 (1600)

**The Vice-Chair (Mr. Stan Dromisky):** Thank you very much, Judy.

I think we have one more speaker.

**Ms. Barb Byers (Executive Vice President, Canadian Labour Congress):** Yes you do.

Good afternoon. My name is Barbara Byers. I'm an executive vice-president for the Canadian Labour Congress and we represent 2.5 million members across Canada and their families.

I'm a recent transplant to Ottawa. I come from the province of Saskatchewan. I come from the province that gave this great gift to Canada which is medicare. I was 11 during the doctors' strike so you can do your math from there, but suffice it to say that although

my family was not involved in politics in a partisan sense, very clearly we understood about what medicare meant to our family and to the families in our neighbourhood.

I believe that the people who came together in the 1960s, first of all in my province and then across Canada, had great vision and had great courage in terms of what needed to be done. They were prepared, as well, to take some risks for the health of the citizens of the country.

I don't believe that this has been recreated in 2003. The federal government had the opportunity last week to truly secure the future of medicare. It had the money. It had the support of the vast majority of the Canadian people and it had the strength of being the national government.

Unfortunately for Canadians the federal government lacked the political will to show the kind of leadership required by greatness, the greatness that we experienced in the 1960s. As a result we believe, as you've heard this afternoon, the integrity and the viability of medicare has been left at risk.

We, as has been pointed out, had a people's summit. When people first came there--and there were over 400 people from coast to coast to coast to coast--when we first arrived I think it's fair to say that a number of us were somewhat demoralized by the events of the week, that the first ministers' meeting had not turned out the way that we had hoped, that it hadn't endorsed the Romanow Report as we had hoped it would and so to quote Tommy Douglas, who liked to quote Robbie Burns, "we laid ourselves down for a little while and bled and then rose to fight again."

You opened your remarks talking about democracy and participation by individuals, well, I want to tell you that after about 24 hours of feeling sad, the participants at the conference decided that this wasn't going to get us very far, that we might as well be angry and take action. So I think you're going to see and experience lots of democracy across the country.

Our summit participants decided to rededicate themselves to that democracy, to rededicate themselves to medicare and to rededicate themselves and their organization to a full range of actions at the federal level, at the provincial level, at the municipal level and with employers. Quite clearly, we are going to take action with employers to make them clearly understand the economic advantage that they have because we have the kind of medicare system that we do.

You will see events as they unfold. They are still under discussion, but there is commitment from the national and provincial and local organizations to work together to achieve the things that we think need to be done.

We have rededicated ourselves as well to actions in support of aboriginal health and the health of excluded groups. We have rededicated ourselves to health accountability and transparency and that means taking on the for profit health providers and very clearly

showing what their profits are and what their benefits are and how that doesn't benefit people who need health care.

We have rededicated ourselves to health reform, to a national home care program. If you couldn't get as far as, even Roy said, on the home care and drug plan--and we know that there is talk, but there's no details--then quite frankly we'll go back to we needed far more than what was there, even in the Romanow Report.

We know with drug plans that there has to be, again, the political will to take on the patent drugs and to make sure, as has been pointed out, that people get the medication they need at the prices that they need and we've rededicated ourselves as well to primary health care.

As Maude has said we've rededicated ourselves to fighting trade deals which are undermining our health care system in this country and around the world and we've rededicated ourselves to democracy and to community actions.

Roy Romanow heard from Canadians time and time again. We believe that his report reflected that sentiment that came from Canadians and the things that they wanted and we want to assure the people in this room and the parties that you represent and the provincial politicians across this country that they are going to be hearing from Canadians in the coming days and weeks and months.

🕒 (1605)

Thank you.

**The Vice-Chair (Mr. Stan Dromisky):** Thank you very much, Barbara.

Now we will continue with our pattern of questions and answers. We normally start with the royal opposition. Who is going to be first?

Okay, Rob. You go right ahead. You have ten minutes. Now what does that really mean? If he has a long, long preamble that runs for six minutes, or seven minutes or eight minutes, that means that you have, anybody on that panel, only two minutes to respond, or three minutes or four minutes.

So please, members of the committee, keep your preambles as short as possible. It's more important for me to hear the kinds of responses that these people have to present than to listen to your preamble, okay? All right. Go right ahead.

**Mr. Rob Merrifield (Yellowhead, Canadian Alliance):** Okay. There's the deal. I'll keep my questions short if we can keep the answers short, and we can probably get through as many questions as we possibly can. That's what you're saying, right?

Let's start with the first ministers, not the first ministers, but the natives in the Northwest Territories. Elaine, I'm impressed that you're here. I'm really quite interested and intrigued by the response that they had to the accord last week because they're at least the ones who got up from the table, recognized it was a bad deal for them and refused to go along with it in any way.

I certainly appreciate your comments as far as recognizing the difference in the Territories and the uniqueness of providing health care to your peoples there. I'm just wondering what kind of a dollar figure, you must have an idea in the back of your mind as to what would be the appropriate number of dollars that the premiers from the territories would have agreed to. Where are we at with it? Is it just that it's not recognized, or is there an actual dollar figure that you've got in mind?

**Ms. Elaine Johnston:** I could tell you that for the First Nations and Inuit Health Branch, they already have, they spend \$1.3 billion, but what's happening....

**Mr. Rob Merrifield:** Excuse me, what was that?

**Ms. Elaine Johnston:** The First Nations and Inuit Health Branch, which covers the first nations and Inuit. They have \$1.3 billion. They estimate that they're going to have \$150 million deficit this year, \$285 million for the next fiscal year and \$350 million for the following year.

What they've also been doing is from the Speech from the Throne, moneys that have been targeted for children, they are taking some of those monies to cover off the deficit.

The problem that I see here is that unless we get sustainable funding, we're in the same situation as the provinces, if I can put it that way, in regard to sustainable funding, a base amount, and then we can start to help reform the system.

What we've been tasked with, even before Roy Romanow was commissioned to do his report and before Kirby was that we were tasked with health renewal. The problem that the department has been working with, Health Canada, has been the whole sustainability exercise. It has been "rob Peter to pay Paul" so to speak. That has been our challenge.

I know that there has been \$1.3 billion mentioned in the accord. There has been a lot of confusion about, what exactly does that mean because it says "aboriginal people"? We don't know whether that's sustainability money, whether that's targeted for programs. So there are a lot of unanswered questions in that regard to the \$1.3 billion.

If I was to give you a dollar amount, I would say that we would probably need to look at sustainability money to take care of the deficits that are already there. We need to look at health reform.

**Mr. Rob Merrifield:** How much for that?

**Ms. Elaine Johnston:** I would say \$750 million. Then we need to look at health reform moneys because there were moneys that were targeted for the provinces for health reform.

It's interesting in the accord, it says that aboriginal people will be taken care of in the health reform fund, but if you read further on in the accord, it says those moneys are targeted to the provinces. So I'm not exactly sure how that was going to happen.

**Mr. Rob Merrifield:** There was a lot of fuzziness in the numbers. Just give me your number for the reforms.

**Ms. Elaine Johnston:** For the reforms we were looking at roughly, I believe we were looking at close to \$1.5 billion on top of taking care of the sustainability.

🕒 (1610)

**Mr. Rob Merrifield:** Okay, \$1.5 billion. That's just for the territories.

**Ms. Elaine Johnston:** No, that's just for the first nations and Inuit.

**Mr. Rob Merrifield:** Oh, first nations, okay.

**Ms. Elaine Johnston:** Now as far as the territories, I can't speak for them as far as what they were looking for. When I had raised the issue that the northern parts of the provinces have the same issues as the territorial governments, the Yukon and Nunavut, is because in northwestern Ontario where I have worked, Fort Severn, which is northern Ontario, is the farthest community in northern Ontario, as I say they have the same problems of flights. They travel to Sioux Lookout to hospital. Then from there for the high specialty services they have to fly to Thunder Bay or Winnipeg.

**Mr. Rob Merrifield:** Yes, and we were quite surprised, they left the table and the things that you just said were not there, but we're not going to solve it here and hopefully we will be able to address that or the Prime Minister will address that in upcoming meetings.

I just want to get my head around where we're at with drugs with the panel here. We understand that a catastrophic drug plan that has come out of the court dealt with the difference in health delivery now because of the cost of some of the drug treatments, let's say, and therapies becoming very catastrophic, which are going to increase as we move forward. I don't think anyone has a bit of a problem with that, other than that some provinces are providing that now, some are limited, depending upon which province. However, 10% or 13% of Canadians have no drug plan at all. That was not addressed by Romanow. It was not addressed in the accord.

Your concerns, to me, or what you expressed in your panel was that we have to get cheaper drugs--that means challenging patent law. I imagine that's where your heads were

at with that--and to try to get easier access to drugs so that they become open for everybody.

One of the things that disturbs me about that--and I made this presentation to Mr. Romanow--is in Canada we have an alarming number of deaths because of the misuse not of illicit drugs but prescription medications. I hope you would champion that cause as much as the others so that the people who are dying because of prescription medication would also be addressed. There are two sides of the coin here that we absolutely have to get hold of when we have 30% of our seniors addicted to prescription medication and 20% of our general population.

Actually, Kathleen mentioned that we have to look more broadly than just crisis managements in health care. I want your perspective on that. It wasn't mentioned here in your presentation, but have you thought of the other side of that coin?

**Ms. Kathleen Connors:** In response, I would suggest that you might want to take a look at the brief that the coalition presented to Mr. Romanow because, in fact, the brief does address many of the issues--the issues with respect to prescribing practices and, to date, it's physicians who prescribe most of the pharmaceuticals in this country with a limited prescribing practice for some nurse practitioners so that the issue of prescribing practices, and even the drug detailing that happens around why positions are hoodwinked quite often into prescribing newly patented, more expensive drugs when a non-patented older drug has the same therapeutic effect. There is reference around that and around education of people about the medications that they take, around practitioners, about interrelationships in the medication protocols that you have because one drug may cause a side effect and impact on how an other drug will interface with how you will come out in the treatment.

The issues of the use of drugs, patent protection, of looking at referenced based pricing and an examination by the Canadian governments, federally and provincially, of drug programs that are available in Australia and New Zealand need to be considered because there are countries that have wrapped their heads, much more successfully than this country has, around how to be cost effective in the provision of pharmaceutical products to the people. Then the other piece is having the political courage, such as Brazil and India have had in the world, in saying no to the extensive 20-year patent protection, under obligations of trade, that moderates. There are many issues.

The Canadian Health Coalition and certainly CUPE, the Canadian Labour Congress, CNFU, in our presentations raised many of these issues and we have provided--

🕒 (1615)

**Mr. Rob Merrifield:** It's just that my time is limited and I don't know how much I have left.

**The Vice-Chair (Mr. Stan Dromisky):** You have one minute.

**Mr. Rob Merrifield:** All I would do is just leave it at that. I think we made the point that there's the two sides to it. I would hope that when you go out and challenge the better access for drugs and the cheaper drugs, that you'd also challenge the abuse of drugs that are presently taking place because it's two-sided. If we open it up and we don't touch the other, we will cause a tremendous amount of problems, even more acute than we have right now, with regard to the abuse of prescription medication. So I hear what you're saying and all I'm doing is challenging you with that.

I would suggest that what you're all saying is that you agree with Romanow, and that you champion Romanow's report. There have been a number of reports. In fact, this government has spent \$243 million just studying health care in the last decade, so we don't really need more reports. Nonetheless, this was a very important report. Kirby had a report as well, and others.

If we--

**The Vice-Chair (Mr. Stan Dromisky):** Thank you very much.

Now we will jump over to Mr. Ménard.

**Mr. Rob Merrifield:** (Inaud.) going to answer it anyway.

**The Vice-Chair (Mr. Stan Dromisky):** No, but you're making a statement. You weren't asking a question.

**Mr. Rob Merrifield:** I was about to ask one.

[*Français*]

**M. Réal Ménard:** Moi, je crois beaucoup à l'importance d'un système public et universel. Je pense que dans ma propre province, même si je ne qualifie jamais le Québec comme province mais pour qu'on se comprenne bien, il y a des choses extrêmement intéressantes qui se sont faites. Ce qui m'intéresse le plus dans les prochains mois c'est toute la question du coût des médicaments.

Mercredi je vais déposer une motion à mes collègues. Quand on vient du Québec ce n'est pas une question facile parce qu'évidemment il y a toute l'industrie du médicament d'origine, mais je ne partage pas le point de vue selon lequel l'analyse de ce dossier ne peut pas se faire en remettant en cause la propriété intellectuelle. Le Canada, vous le savez, est membre de l'OMC. Il a signé l'accord sur l'ABPIC. Pour moi il ne faut pas aborder ce volet en disant «on va remettre en cause le 20 ans», parce que c'est donner un coup d'épée dans l'eau. Cela ne pourra pas se faire. Par contre il y a des choses à regarder.

On peut regarder, et c'est là-dessus que je voudrais connaître votre point de vue, le rôle du Conseil d'examen du prix des médicaments brevetés. Est-ce qu'on fait la comparaison avec les bons pays? Il y a des gens qui disent qu'on devrait se comparer avec l'Australie.

Vous avez donné l'exemple de la Nouvelle-Zélande. Cela, il y a quelque chose qu'on peut faire. Moi, je crois que le fond du problème c'est que Santé Canada ne fait pas son travail. Ce n'est pas normal que l'on donne des autorisations de recherche et que l'on permette d'introduire sur le marché des médicaments qui n'ont pas de nouvelles valeurs thérapeutiques. C'est cela le problème.

Vous savez, pour la première fois cette année au Canada, le coût des médicaments est supérieur à la rémunération totale de tous les médecins. Je crois que Santé Canada a une responsabilité. Je comprends que si on investit 700 millions pour faire de la recherche, on ne va pas le récupérer en deux ans. Mais je m'attends à ce que Santé Canada, lorsqu'on autorise les médicaments et lorsqu'on les met sur le marché, je m'attends à ce que ce soit des médicaments nouveaux. Et les études que j'ai lues, cela fait deux ans que je lis là-dessus, me donne à penser que ce n'est pas le cas.

Je souhaite donc que ce comité, c'est un travail qui doit se faire collégialement, s'engage dans toute la question du coût des médicaments. On ne pourra le faire sous l'angle de la remise en question de la propriété intellectuelle parce qu'il y a une affaire qui s'appelle le droit, et une affaire qui s'appelle les conventions internationales. Puis au Québec, de toute façon, cela ne passera jamais. Mais s'il y a des façons originales, novatrices d'atteindre les résultats qui sont que les médicaments soient plus facilement disponibles qu'ils ne le sont présentement et à meilleurs coûts, je pense qu'on peut se rejoindre.

Deuxièmement, et je termine là-dessus, votre adhésion au rapport Romanow, je peux la comprendre mais jamais le Bloc pourra souscrire à un rapport qui donne plus de pouvoir au gouvernement central dans un domaine de responsabilité qui n'est pas le sien. Et cela, on va avoir toujours présent à l'esprit ces considérations. Moi, qu'il y ait au Canada anglais un régime d'assurance-médicaments, je suis très d'accord avec cela. Au Québec cela s'est fait, et cela s'est fait vous le savez en 1996. Alors cela a quand même une certaine antériorité.

Donc, c'est ce que je voulais partager avec vous. Est-ce que vous pensez que ce que j'avance sont de bonnes pistes de solution pour remettre en cause ou pour avancer en tout cas un débat intelligent sur le coût des médicaments?

🕒 (1620)

**Claude Généreux:** Il y a plusieurs aspects à la question en fait et il n'y a pas beaucoup de temps.

**M. Réal Ménard:** Mais le président est très généreux.

**Claude Généreux:** Mais je vais quand même essayer d'y répondre, aller droit au but.

**Le vice-président (M. Réal Ménard):**

**Claude Généreux:** On vous a mentionné effectivement dans nos présentations, qu'il y a plusieurs régimes qui existent à l'extérieur du Canada et bien sûr vous avez fait la mention que le gouvernement québécois s'est doté d'un tel régime, qui n'est pas parfait, mais il s'est doté d'un régime. Vous avez émis comme déclaration qu'on ne peut pas s'en prendre, on ne peut pas toucher à la propriété intellectuelle. Au Québec, ça ne passerait pas. Je vous dirais respectueusement que nous sommes en désaccord.

**Le vice-président (M. Réal Ménard):** Pourquoi?

**Claude Généreux:** Il faut s'y adresser de la même façon dont M. Luis, au nom de l'ONU, l'Organisation nationale des Nations unies, tente de faire des percées majeures en Afrique. Non seulement en Afrique du Sud, mais dans tout le continent africain. De la même façon que la Chine impose une négociation où différentes compagnies, qui ont breveté et qui ont la propriété tant intellectuelle que commerciale de ces médicaments-là, qui ont été brevetés bien sûr selon des conventions.

**Le vice-président (M. Réal Ménard):** La Chine n'a pas signé l'ABPIC?

**Claude Généreux:** Ce que je voulais dire par là, c'est que tant en Chine que sur le continent africain, il y a moyen de s'asseoir si on le veut, s'il y a une volonté politique et sociale de faire face aux problèmes. Pour la propriété intellectuelle effectivement ça nous attire un coût qui est énorme, qui est excessif et le problème est inaccessible financièrement non pas parce qu'il y a un problème de consommation individuelle, tel qu'il a été suggéré tantôt, non pas en question, mais en déclaration par l'honorable député qui vous a précédé. On n'est pas des *dope addicts* au Canada. On n'est pas des drogués qui consomment trop.

Il y a un problème de prescriptions, ce n'est nous individuellement, comme citoyens et citoyennes, qui se prescrivent les médicaments. Il y a une éducation des médecins et des compagnies--j'essaie de courir à la réponse, mais il y a tellement de sous-questions dans vos questions--Il est possible de remettre en question--si je me renonce--le régime actuel de propriété intellectuelle. Non pas de le renier, mais de le revoir, de le corriger, pas que ça soit moins chers. Oui, nous sommes d'accord qu'il y ait des médicaments, qui n'ont pas fait leurs preuves cliniquement, thérapeutiquement, mais qui sont mis en marché. Non seulement qui nous coûtent chers, mais qui procurent aussi un effet adverse à la santé. Il y a de nombreuses études américaines et canadiennes à ce sujet qui ont entraîné d'ailleurs des fatalités.

Le *New England Journal of Medicine* dernièrement avait une étude assez extensive sur le sujet. Il y aurait lieu effectivement, comme une bête sauvage, de les dompter, parce que ce sont des bêtes sauvages. Elles ne sont pas en cages, elles n'ont pas été domptées du tout, ce consortium-là de compagnies. Il y a lieu qu'il y ait une volonté gouvernementale de s'asseoir et de légiférer, de réglementer plus spécifiquement et mieux que ça ne l'est présentement le régime de médicaments. Nous ne doutons pas qu'au Québec, il y a un régime de médicaments, mais là aussi il y a beaucoup d'améliorations à amener.

[English]

**The Vice-Chair (Mr. Stan Dromisky):** Thank you very much, Claude. There are other people who would like to respond to some of the areas of concern that Réal has introduced.

What we will do, we're going to stick to schedule for the first round diligently and then we will, on the second round, be much more flexible than we are in the first round. In all fairness to all members of the committee we must stick to the first round as stated in our regulations.

So we will now jump to a Liberal. Is there someone from the Liberal side who would like to raise a question?

Dr. Castonguay.

[Français]

**M. Jeannot Castonguay (Madawaska—Restigouche, Lib.):** Merci, monsieur le président.

On sait que dans l'entente, il y a beaucoup de détails qui seront à venir finalement, mais on sait qu'on a parlé, entre autres, de cibler certaines sommes d'argent plus spécifiquement sur les soins de premières lignes, les soins à domiciles et également de couvertures de coûts catastrophiques. Évidemment, il y a eu des objections à ça, mais finalement il semble que les gens se sont entendus. Personnellement, je crois que c'est un pas dans la bonne direction et j'aimerais avoir votre opinion là-dessus.

Maintenant, lorsqu'on s'en va dans ce sens-là, est-ce que vous croyez qu'on devrait avoir finalement des règles qui parfois seraient pancanadiennes ou est-ce qu'on doit quand même respecter les différentes juridictions provinciales et avoir des programmes qui sont équivalents? On a entendu les deux sons de cloches. À un moment donné, les gens nous ont dit : « Écoutez, il faudrait que ça soit un programme qui soit égal pour tous les Canadiens. » Évidemment, lorsqu'on parle aux provinces, on leur dit : « Écoutez, vous devez respecter les juridictions provinciales. On peut avoir des programmes équivalents. » Quelle est votre réflexion à la suite de votre fin de semaine là-dessus? Vous avez sûrement, j'imagine, discuté de ces différents aspects-là, les différents et j'aimerais que vous partagiez vos opinions avec le comité ou ce que vous avez conclu à la fin de vos rencontres.

🕒 (1625)

[English]

**Ms. Judy Darcy:**

If I could just deal with the home care part, other people may want to speak to other parts of it.

Roy Romanow recommended that there should be a national public not-for-profit home care program and that the Canada Health Act should be amended to include it. The arrangement, agreement, accord, deal--whatever you want to call it--says the home care program will be at the provinces' discretion.

Now, we believe that it should be a more comprehensive home care program and not deal strictly with palliative care and post-acute care release, which is almost exclusively what it deals with because other support services allow seniors to stay in their homes much longer, to be independent. It's better for their quality of life, their mental health and it costs the system less, frankly, than them having to go into long-term care.

So there are many things that are missing in the definition of what will be funded but the fundamental problem is that it should be a public not-for-profit home care program and if it's not, we've already seen that there are enormous problems.

The Ontario government...there has been a patchwork of programs in some communities in Ontario over a number of years and some have worked better than others but with the model that the Ontario government has introduced and has insisted on, you have a competitive bidding model for home care in the province, it's co-ordinated through what are called CCAC's, Continuing Care Access Centres, and they're clearly directed by provincial government policy that they need to regularly flip contracts...go to the lowest cost bidders, which generally means profit delivery, but it doesn't mean better quality care, and you have experiences that have been well-documented and publicized.

In Windsor, Ontario, for instance, the Victorian Order of Nurses for years was providing high quality home care to residents there, to seniors, and then because the contract has to be flipped, because someone says they can do it at a lower cost, people who have been there providing care to a senior citizen for years are yanked, because they can find another agency that can do it cheaper. Not better...not better for that senior, not cheaper in the long run either. That's what a for profit model leads to, and it means growing privatization in the health care system because people are being released from hospital sicker and quicker. More people therefore have demand for home care and you're seeing growing privatization in the system.

It matters if it's public or whether it's profit.

[*Français*]

**M. Jeannot Castonguay:** Sur ce point-là, j'ai très bien compris. Vous le faites pour une deuxième fois aujourd'hui.

Maintenant, j'aimerais quand même savoir, lorsqu'on parle avec les provinces qui nous disent, écoutez, ne vous inquiétez pas, envoyez-nous l'argent, on va s'occuper de gérer les

soins de santé dans nos provinces respectives... Puis, ce que je voulais savoir finalement, c'est si vous croyez qu'on devrait avoir un programme qui est le même dans tous... Si on prend les soins à domicile, par exemple, est-ce que ça devrait être un programme qui est le même dans toutes les provinces ou à la grandeur du pays, ou est-ce qu'il y a une place pour chacune des provinces d'avoir un programme équivalent? Parce que ça fait partie quand même du débat. On ne peut pas se fermer les yeux et dire: Écoutez, les provinces, vous n'avez plus . Il y a quand même une juridiction qu'il faut respecter, je crois, et c'est pour cela que dans vos discussions... Qu'est-ce que vous avez conclu là-dessus?

*[English]*

**Mr. Michael McBane:** If I could just intervene on that issue, I think Canadians are sick and tired of the issue of jurisdiction stepping in the way of access to care that's right now being denied. Under the constitution of our great country, Canada, our constitution says there's a federal spending power. That is constitutional and you don't use the federal spending power unless you're establishing a national standard. That's constitutional.

So please, governments in other provinces that claim it's a jurisdictional intrusion to establish national standards with federal spending are actually not correct. The federal spending power is constitutional and you don't use it if you don't have national standards as your objective, and clearly our organizations want national standards in home care. We need national standards in long-term care. We need national standards in all aspects.

That doesn't mean you're dictating to a province how to deliver but all provinces, including Quebec, share the same values, the same principles, and they're sick and tired of the Quebec government playing jurisdictional games as well. Civil society like the values of Romanow, they like the notion of national standards and that's what Canadians want.

So let's get on, work together at all levels, and not play a football over jurisdiction.

*[Français]*

**M. Jeannot Castonguay:** Alors, si je comprends bien...

*[English]*

**The Vice-Chair (Mr. Stan Dromisky):** Keep it for later.

All right, we will now...this side of the room. It's the NDP. Svend Robinson.

**Mr. Svend Robinson (Burnaby—Douglas, NDP):** Thank you. Thanks very much, Mr. Chair.

It's my first meeting as the new health critic and I'm delighted to be here at the committee. I have a very steep learning curve and I look forward to participating as a member of the committee.

🕒 (1630)

My question is for one of the witnesses who has focused particularly on the issue of private for-profit care.

One of the concerns I think many of us have is that we still aren't able to get access to the information to know just to what extent this is already a reality, to what extent this is already weakening the public not-for-profit health care system. I wonder if perhaps the witnesses could talk a little bit about some of the existing difficulties, compounded by the fact that the accord or the arrangement or whatever we want to call it, as I understand it, is totally silent with respect to this issue.

So, it's failed on accountability totally unless I maybe missed something in the agreement. I didn't see anything in there at all about access to information, about Canadians having the right to know where that money is going and how much of that money in fact is going to the private for-profit sector.

We heard today in the House of Commons in response to my question to the Prime Minister, the Prime Minister saying well, you know, we're respecting the five principles of the Canada Health Act, so what have you to complain about? How do you respond to that and specifically, how do you respond to the concern about access to information about private for-profit money?

**Ms. Kathleen Connors:** Really quickly, looking at the indicators that are appended to the agreement accord, whatever it is, there is nothing in the proposed indicators that the provinces are going to have to report on, that even require the provinces to report what those public dollars are being spent on. That could easily have been inserted. That's one thing that wasn't there. That's one thing this group is going to insist that the indicators include.

Mike made earlier reference to the lack of not available, not available for the requirements of the annual report on the Canada Health Act. There is a legislative responsibility for that information to be provided, so we're calling on the federal government to exercise that legislative authority to provide that information, to demand that kind of accounting be made available so that we're making decisions based on evidence, on knowledge, on what gives us the best bang for our buck.

[*Français*]

**M. Jeannot Castonguay:** Ce point-là je l'ai très bien compris, vous le faites pour une deuxième fois aujourd'hui. Maintenant j'aimerais quand même savoir, lorsqu'on parle avec les provinces qui nous disent: « écoutez, ne vous inquiétez pas, envoyez-nous

l'argent, on va s'occuper de gérer les soins de santé dans nos provinces respectives ». Ce que je voulais savoir finalement c'est si vous croyez qu'on devrait avoir un programme qui est le même dans tout. Si on prend les soins à domicile, par exemple, est-ce que ça devrait être un programme qui est le même à la grandeur du pays ou s'il y a une place pour chacune des provinces d'avoir un programme équivalent? Parce que ça fait quand même partie du débat. Pourquoi se fermer les yeux et dire: « écoutez, les provinces, vous n'avez plus de câble ». Il y a quand même une juridiction qu'il faut respecter, je crois, et c'est pour ça que dans vos discussions, qu'avez-vous conclu là-dessus?

[*English*]

**Mr. Michael McBane:** To follow up on Kathleen's point is that when you sign a contract as a public health authority with a private investor owned corporation, those contracts are secret, so you don't know how much money's changing hands; those books are not open. Canadians want accountability and transparency. The last place you're going to get it is if you sign a contract with a private corporation. They're not obliged by law to open their books and so we don't know what's happening in these private contracts in Alberta.

We don't know about these private MRI clinics, what the deals are with the doctors, it's all secret. So we're losing control over the medical standards and we're also losing public accountability. There's no auditing with these private investor owned facilities. It's opening ourselves up to incredible corporate fraud.

**A Voice:** And I agree with him.

[*Français*]

**M. Jeannot Castonguay:** Alors, si je comprends bien...

[*English*]

**Mr. Svend Robinson:** I had one other question if--

**Anil Naidoo (Campaigner, Council of Canadians):** Thank you, chair.

Thank you for the question. I'm with the Council of Canadians. I just want to add to comments by our fellow panellists here in that there is a veil of secrecy around corporate information as we've all seen. That runs into the drug industry, as well, certainly. There is no true peer review of drugs. That's what's getting us in a lot of trouble around the whole drug issue and new effectiveness of drugs.

I think with P3 hospitals as Mike brought up, that's another issue. I think we're setting ourselves up for Enron style funny accounting to influence our health care industry. We saw it with King's Health Centre in Toronto a few years back. I think the amount of

evidence is legion on the side that we need true transparency and that means public accountability and that's not in this accord.

🕒 (1635)

**Mr. Svend Robinson:** I just had one other question, Mr. Chairman, if I might.

**The Vice-Chair (Mr. Stan Dromisky):** on the Liberal side?

**An hon. member:** Yolande had an answer as well.

**The Vice-Chair (Mr. Stan Dromisky):** She could add on this round as we're coming up. You'll have the opportunity. All the panelists will have--

**Mr. Svend Robinson:** Is it 10 minutes, Mr. Chairman?

**The Vice-Chair (Mr. Stan Dromisky):** Pardon?

**Mr. Svend Robinson:** Is it 10 minutes on the first round?

**The Vice-Chair (Mr. Stan Dromisky):** Only five.

**Mr. Svend Robinson:** Oh, it's only five.

**The Vice-Chair (Mr. Stan Dromisky):** Yes. Sorry about that. The royal opposition gets 10. Yes, the Liberal side...

Madame Thibeault.

**Mr. Svend Robinson:** On a point of order, Mr. Chairman.

I appreciate that I am new to the committee, but I've sat on many parliamentary committees, and this is the first committee I've ever sat on in 24 years in which there's been a different length of time for a member, as opposed to other members.

**The Vice-Chair (Mr. Stan Dromisky):** Diversity is an enrichment of life.

**Mr. Svend Robinson:** Has this been adopted as a formal motion by the committee, this difference of time?

**The Vice-Chair (Mr. Stan Dromisky):** We could discuss this at a further point.

**Mr. Svend Robinson:** Well, Mr. Chairman, there should be equality of access to the witnesses.

**The Vice-Chair (Mr. Stan Dromisky):** I think we have established a pattern here, and we're following the pattern. It has been in practice for quite some time, so we will continue now.

Madame Thibeault, five minutes.

[*Français*]

**Mme Yolande Thibeault:** Merci, monsieur le président.

Bonjour messieurs et mesdames.

Monsieur McBane, j'aimerais relever quelque chose que vous avez dit, en passant, dans votre présentation. Vous avez parlé d'une étude qui démontrerait que dans les institutions privées, il y aurait un taux de mortalité plus élevé que dans les institutions publiques. Est-ce que l'étude identifie des raisons pour une telle situation?

**M. Michael McBane:** Oui, il y a plusieurs raisons qui sont très fondamentales et très claires. Ces hôpitaux dépendent moins sur les professionnels qui y travaillent, c'est-à-dire que les patients ne reçoivent pas assez de soins.

[*English*]

The fundamental reason for the higher mortality rate in for-profit hospitals in the United States is that the investors are cutting back on the budget that pays for high-cost labour, which is doctors and nurses and other technicians. It's been documented that the for-profit hospitals have inadequate staffing which jeopardizes peoples' lives.

**Ms. Maude Barlow:** It should be added, that wasn't just a study, it was a Meda Analysis of all of the studies done on the difference in the death rate in for-profit versus not-for-profit hospitals. So it's more than just one study, it's an actual scientifically grounded Meda Analysis.

**Ms. Judy Darcy:** We can certainly provide you copies of it.

[*Français*]

**Mme Yolande Thibeault:** C'est ce que j'avais demandé, si vous pourriez nous donner le titre de l'étude pour qu'on puisse la lire nous-mêmes.

Alors, ce que vous nous dites, monsieur McBane, finalement, c'est que dans les cliniques privées, il y aurait moins de personnel hospitalier que dans une institution de l'État. C'est ce que vous nous dites.

[*English*]

**Mr. Michael McBane:** Yes. The study is available on our website at medicare.ca. The lead doctor is P.J. Devereaux.

Another reason besides cutting back on staff, in dialysis, higher mortality rates in dialysis for for-profit clinics. They're not changing the filters as often, and they're not transferring patients for transplant quick enough, because they're making more money treating dialysis than they are putting people in for transplants. This is also a documented result of higher mortality in not just for-profit hospitals, but for-profit clinics. Both these studies are on our website.

**Ms. Judy Darcy:** Just further on that same issue, I spoke earlier about the connection between the cuts in cleaning and infection control staff, and mortality rates. There are also studies available on that, that in the United States, you've seen a 25% cut in hospital housekeeping, cleaning, infection control staff, and a direct relationship between that and higher rates of death as a direct result. This is especially with superbugs and all those things we read about all the time in the media, bugs that are immune to a whole lot of drugs that are on the market. We've seen a rapid increase in those, and when you don't have the people to take care of cleaning and infection control, the rate of infection goes up and the number of deaths also goes up.

🕒 (1640)

[*Français*]

**Mme Yolande Thibeault:** Est-ce que vous nous dites que ce phénomène-là n'est pas rendu chez nous encore?

[*English*]

**Ms. Judy Darcy:** I'm saying that the major studies on it are in the United States because that's where you see a predominance of for-profit hospitals where we're in a position to do a comparison. It's also where we've already seen a significant cut of staffing that are responsible for things like infection control. So the results are already in there. We're saying, we shouldn't be experimenting because there's evidence. We don't need the proof, the proof will be in lives, let's not go there.

[*Français*]

**Mme Yolande Thibeault:** Merci beaucoup. J'ai bien hâte de voir l'étude dont M. McBane parle.

Merci.

[*English*]

**The Vice-Chair (Mr. Stan Dromisky):** Thank you very much.

Now we will start our next cycle and I believe, Madame Skelton, you have a question.

**Mrs. Carol Skelton:** Thank you very much. I do come from Saskatchewan and I'm very proud of it. When the doctor strike was on my aunt was expecting twins so I can remember it very well.

I too have great concern about our nurses and our staffs at our hospitals and I know at home even we're having problems getting nurses or getting quality people. Our nurses are played out, they're tired, they're having a hard time. Had there not been any studies done on what's happening? Why wasn't this discussed, health care professionals, health care workers, why wasn't this discussed in the accord? Have you got any ways to help us look at that whole situation?

**Ms. Kathleen Connors:** I'd be very pleased to tell you that from a nursing perspective in 2001 to 2002 there was a year long study done by the Canadian Nursing Advisory Committee that consisted of representations from federal and provincial governments, employers, nurses unions, nursing education centres and from nurse executives. As a result of that year long study there was a report called the *Canadian Nursing Advisory Committee Report* that tabled an extensive report with some 51 recommendations to deal with issues related to the retention and recruitment of new nurses.

Now the health ministers when they met federal-provincial-territorial, there was some words but no reference to that report and we were very, very disappointed as health care providers that there was no reference to the implementing recommendations of the CNAC report in the most recent accord.

The words in the accord around health human resources, and it's more than nurses, it's positions, it's the technicians, the technologists, it's having adequate numbers of prepared people to do the dietary and the laundry and the maintenance that needs to be done. This is an area of delivery of care that involves people's lives. It's incumbent to have the best and the brightest practitioners.

So we have, in addition to the Advisory Committee report, there are actually some Health Canada-HRDC joint labour sector studies happening for the physicians, for the nurses, and it involves licensed practical nurses, registered psychiatric nurses and registered nurses. There is a sector study looking at, I believe, an interest in technicians and technologists. There's a number looking at the health care centre. So there is work being done.

The fact that there's no reference being made to this work and talking about ideas that have been put forward to address this and no targeted funding, no strings attached, that is a dire concern. I have to say the accord talks about primary health care reform. How are we going to have true primary health care reform where you have a multi-disciplinary team of providers providing care if you don't have sufficient numbers of practitioners there? You still need to have those people working in the hospitals because we can not eliminate the hospitals of this country.

🕒 (1645)

**Mrs. Carol Skelton:** Why don't you think it was included?

**Ms. Kathleen Connors:** It wasn't included because the issue of targeting dollars for things ... . We have looked at issues like having employment insurance dollars, where there's a huge surplus, we have proposed--the Canadian Labour Congress has actually proposed--a pilot project for health care where EI dollars could be used to assist individuals to get the educational preparation to become nurses, to become health care providers. That seems to be going nowhere, but we proposed it. Why isn't there a pick-up on that? Why are these recommendations around keeping nurses and other providers in the system by, for example, adopting what is happening in New Brunswick ? There, nurses who are approaching their retirement, in the collective agreement it's been negotiated that they can work part-time, the employer and the nurse will make full-time pension contributions rather than lose that nurse entirely to the system, they're going to be kept and their pension will accrue so that they will retire with sufficient income to retire with dignity. Why are those measures not being adopted? It's lack of political will and commitment to the people who work in the system, I would suggest.

**Mrs. Carol Skelton:** Thank you.

Do I have more time?

**The Vice-Chair (Mr. Stan Dromisky):** In the next round.

We'll jump over to Réal.

[*Français*]

**M. Réal Ménard:** Je vais devoir partir à 17 h 00 parce que j'ai un discours à la Chambre.

En tout respect, M. McBane, l'Assemblée nationale a voté une résolution et jamais on acceptera qu'il y ait des normes nationales dans le domaine de la santé. Qu'il y ait de l'imputabilité et vous savez qu'il y a, à l'Assemblée nationale, différents mécanismes d'imputabilité, ça on est tout à fait d'accord avec ça.

Je veux revenir sur la question des débats sur l'industrie pharmaceutique.

Moi, je vous mets en garde. Ce débat-là, il doit se faire et moi je suis prêt à le faire pour le Bloc. Je vais prendre mes distances face au commentaire de M. Robinson quant aux sources de financement. Ce qui est certain, c'est que ce n'est pas un film de cow-boy. Il n'y a pas les méchantes industries pharmaceutiques face aux consommateurs. Ça prend aussi des médicaments et il y a un arrimage à faire entre les deux. Il y a un discours critique à développer, il y a des façon originales de vivre ce débat-là, mais ce n'est pas un film de cow-boy. Il faut faire attention parce que des fois, quand on veut positionner le

débat pour ne pas y mettre les nuances, on perd de la crédibilité dans le débat. Je suis sûr que ce n'est pas évidemment ce que vous voulez faire. Le discours centralisateur à la NPD, ça fait 8 p. 100 des intentions de vote. Ce n'est pas à ça que nous on veut s'associer. On veut s'associer à des façons renouvelées de tenir le discours et je suis sûr que chacun d'entre vous pouvez avoir un contribution à cet égard-là. Je pense que quand on regarde le rôle du conseil d'examen du prix des médicaments brevetés, le rôle de Santé-Canada, l'expertise de différentes fédérations professionnelles, il y a moyen de faire ce débat-là. Ce n'est pas vrai qu'on va pouvoir faire complètement abstraction des traités ou de ce qui existe au niveau de la législation de la propriété intellectuelle. Ce n'est pas vrai cela. Le cas de l'Afrique du Sud est différent. On peut être membre de l'OMC sans avoir signé l'ATPIC, mais quand on a signé l'ATPIC, ça crée un certain nombre d'obligations et ce n'est pas vrai qu'on peut faire abstraction de cela.

**Claude Généreux:** C'est un sujet fort intéressant, mais il manque de temps. Alors, je n'en parlerai pas.

Nous ne nions pas la propriété. Effectivement, pour que ce soit clair, c'est ce que le Sommet populaire pense des relations entre le Québec et le reste du Canada. Le Sommet représente l'ensemble de la population sur le territoire du Canada et donc, la population québécoise aussi.

Au Sommet, nous avons un apanage très représentatif de la population québécoise, des organismes représentant des bénévoles dans tous le réseau de la santé et des services sociaux, des organismes représentant toute sorte d'organismes sans but lucratif, des organismes représentant les bénéficiaires des différents services de santé et de services sociaux, enfin, ceux qui livrent les services de santé et de services sociaux, toutes les centrales syndicales.

Nous parlons avec l'ensemble et le reste de la Coalition, avec une seule voix et nous disons, oui il y a de la place pour que le Québec puisse vivre autrement ses aspirations et pour qu'il puisse les gérer autrement. Il n'y a aucun doute que, historiquement et même conjoncturellement, la population québécoise, comme dans le reste du Canada, a les mêmes aspirations pour avoir un régime qui soit géré publiquement, qu'il n'y ait pas juste de l'argent, mais que ce soit sous contrôle public. Là, on voudrait être clair et on ne niera pas ce droit au Québec, à travers le Sommet et la Coalition que nous sommes.

La meilleure façon--et je dis cela d'une façon non partisane--pour le gouvernement québécois, s'il veut établir sa compétence, il faut aussi qu'il l'exerce. La Coalition à ce sujet suggérerait, bien respectueusement, au gouvernement québécois et à toute autre personne, si au Québec on veut exercer cette juridiction-là, qu'on enchâsse dans une loi québécoise, qui ressemble à la loi canadienne, si on veut l'élargir, la moderniser pour intégrer non seulement le Régime d'assurance-maladie qui existe déjà, et même l'améliorer, les questions qui ont été posées, tout à l'heure, sur le Régime de soins de longue durée, on pourrait instituer un tel régime.

Alors, ce n'est pas en contradiction du tout avec notre vue, mais il faut exercer ce champ-là. La population québécoise, dans un sondage récent, quand je disais conjoncturellement, il y a deux semaines, un sondage Polara disait qu'au Québec, nous voulons revigorer un système de santé public.

🕒 (1650)

**Le vice-président (M. Réal Ménard):** Mais ce ne sont pas des normes nationales, on s'entend.

**Claude Généreux:** Quand on parle des aspirations, on parle de standards. Est-ce que c'est la même chose? Non. Quand on parle d'équivalences, équivalences ne veut pas dire la même chose. Des équivalences, il faut que ça se ressemble. Il faut que ce soit transférable. Si je suis malade, aujourd'hui, à Ottawa, et que j'ai ma carte d'assurance-maladie du Québec, je devrais être en mesure de pouvoir transférer ma possibilité d'être soigné gratuitement ici même à Ottawa en Ontario. Il faut qu'il y ait des standards qui se ressemblent, qui puissent se mesurer, qui soient équivalents. Mais que le gouvernement québécois puisse exercer son champ de compétences, le Sommet n'a aucun problème avec ça. À ce jour, il y a des déclarations de principes, mais pas de lois québécoises qui ressemblent de près ou de loin à une loi canadienne, qui enchâssent le fait qu'il y ait un financement, mais aussi une livraison de services publics, une propriété publique pour le bénéfice de la population.

[*English*]

**The Vice-Chair (Mr. Stan Dromisky):** Thank you very much.

Dr. Bennett.

**Ms. Carolyn Bennett (St. Paul's, Lib.):** I just had a couple of very specific questions on the idea of drugs and privatization in that I guess I always wonder why generic drugs are viewed to be not private companies and why we are happy to not look at their books. I have a sneaking suspicion they're making lots of money and I guess last week we were pretty upset when we realized the issue around pork and beef insulin. There seems to be lots of drugs with expired patents which have never been genericized. So I just wondered if you had any...I've heard numbers up to 90% of drugs with expired patents have never been genericized. It's better to early work the patent on a potential blockbuster than it is to actually just genericize a drug that's for a small boutique drug for a small condition.

So I guess I think in terms of these next steps if sunlight is indeed the greatest disinfectant, how can we begin to make sure that all of the public dollars that we're spending on health care that they'd go to private companies, that we'd get to see what's happening in those companies. I don't care whether it's a private home care provider.

One of the deals of making a deal with governments is that your books have to be open and so that we can actually see where the profits are. I understand that some of the

generic companies sell the drugs for a lot less in the states because there's competition down there than they do up here. I'm always interested in why some have black hats and some have white hats and I think for-profit is for profit and we should actually figure out what's happening with our public dollars.

In those sort of rumours that I've heard, do you have any numbers on any of this?

**Mr. Michael McBane:** Dr. Bennett, we agree that all companies should be treated the same. That they have a for-profit obligation to their shareholders and it's not to serve the public health interest.

**Ms. Carolyn Bennett:** But they don't have any shareholders, they're private companies. So they don't actually have to have an annual report that you look at.

**Mr. Michael McBane:** Right. Nobody in our position, when we argue for the availability of generic products, are arguing there should be special arrangements with generic companies in terms of evading transparency or allowing them to be irresponsible in pricing or in any other safety cutting making unsafe drugs available.

The issue on the generics is that they should be more available and purchased in a bulk fashion. Because a lot of medications as you know have generic equivalents. A lot of the new medications, in fact most of the new medications according to the government agency the Patent Medicine Prices Review Board, up to I believe 92% have no therapeutic advancement, zero. Therefore you should be using more generics because you're in fact getting no value for higher prices from the brand name companies.

The people who have the facts on this, like Dr. Arnold Relman just recently wrote an article in the *American Prospect* December 2002, and there are good and bad people in this story. The brand name companies are not innovating; there is practically no new chemical entities in the pipeline according to the experts; and the people who are innovating, they're doing it on the backs of public research dollars. And what do they get for all this? Thirty percent return on investment. That is plunder.

🕒 (1655)

**Ms. Carolyn Bennett:** But is not the biggest problem in drug costs in this country the fact that physicians are prescribing the most expensive anti-hypertensive instead of a mild diuretic or giving macrolides for strep throat. So in terms of spiraling drug costs, there's a lot in terms of prescribing we need to do.

I guess that's why I had hoped that if we could move into some sort of actual health council, that we could start to really have a look at what public administration would mean and look like if we could actually see where the drugs were going, how many people are on uppers and downers at the same time, how many people we're killing doing this stuff. I guess that's--my real thing is that if we only look at evergreening or the things

that have been raised, we aren't going to get to this big problem of what could be treated without a drug, what is a better way of treating certain conditions.

**Ms. Elaine Johnston:** Can I respond?

The federal government provides non-insured health benefits to first nations and Inuit. It's interesting you should say that the doctors provide the most expensive drug.

What Health Canada does is it won't allow those most expensive drugs and goes to the generic drug. But it's not necessarily whether it's most effective, it's what's going to cost us the most. And you talk about efficiencies, that's what they're looking at. That's our concern is what is the best drug for the client from the point of view of safety and what is best for them in regard to their health condition.

So you have two dichotomies here. When you're talking about what accountability mechanism, when you talk about the health council and the accord, my concern is what kind of accountability is this health council going to have? Because if you look at the accord and the wording that's in the accord, it doesn't really have any meat, it doesn't have any substance. So it needs to have more in the health council to look at the whole accountability issue that you're raising.

**Ms. Maude Barlow:** I don't think anyone on this side of the room would disagree that a profit is profit and that all the books need to be open. Two points I'd make though, one is that, that doesn't negate our argument that we have to do away with the power of these patent drug because they are holding on and as you know all the ways they have including they're allowed to keep the generic's' in court for two years while their drugs go stale, even if they know they're going to lose because their 20 year patent is up and they can spend all the money they want on lawyers because it's worth it for them. That's holding the Canadian people ransom.

But I also think and I just want to go back to them--I'm sorry that our Bloc friend is not here--and that is this notion that we can't open up the TRIPS Agreement, of the Trade Related Intellectual Property Agreement of the trade agreement. That is one of the most divisive issues coming up at the World Trade Organization meeting in Cancun Mexico this fall.

All of the African countries, increasingly most of the Latin-American countries, a number of Asian countries are asking that that TRIPS agreement be reopened to deal with this 20 year patent right. Not just for the AIDS drugs and so on to be able to, in catastrophic situations but actually to break the back of it.

I just got back from Brazil, we've got a new prime minister or president there, who isn't going to willingly go into a TRIPS agreement in the free-trade area of the America's and we would very much like to see Canada playing a different kind of role and always taking the most extreme pro-drug company, pro-American, frankly position at these trade agreements, at these trade negotiations.

So the notion that those can't be opened up ever, I'd just like to put on the record that that's not true, there's a lot of push to renegotiate the TRIPS agreement.

🕒 (1700)

**The Vice-Chair (Mr. Stan Dromisky):** Thank you. Svend Robinson.

**Mr. Svend Robinson:** Thanks very much Mr. Chair.

On the pharmaceutical drug issue. I'm very glad that Maude Barlow made the point about the TRIPS agreement because I was in Doha, as she was and she'll recall that this was an item of huge controversy and real concern.

I mean frankly, it was shameful that as some of the poorest countries had to beg and plead with the wealthy countries just to have the principle that public health should come ahead of corporate profits in pharmaceuticals. I mean it was just unbelievable.

I guess and this is a subject for bigger debate but for the life of me I don't understand why the summit and progressive folks in the country aren't even moving beyond this notion that we have to kind of reopen TRIPS and so on. If ever there was a sector in which the public sector should be actively involved as pharmaceuticals and I believe that we've got to start looking at that very seriously, at the role for the public sector in which we ask some of the finest scientists and others in this field to come together to work on the creation of a publicly owned pharmaceutical company that is not based on how much money can we make globally and I think it's long overdue.

When you look at the obscene levels of profits of the multi-national pharmaceutical companies, when you look at the amount of money they spend on marketing, when you look at the amount of money they waste on drugs which have marginal, if any impact, when you look on the fact that the multi-nationals refuse to, in many cases fund research for drugs that only help poor people and the sleeping sickness in Africa was the classic example of that.

I just want to respectfully suggest to the groups that are represented here today that, you go a bit further and say look, this is a sector in which in fact the people of Canada have a right to have ownership and take profit right out of it.

But in terms of my question, because we've only got five minutes, I wonder if you could just elaborate on the issue of diagnostic services because this is one in which, once again, you've got the private for profit sector, they're just waiting to move in, in many cases are already there.

Romanow clearly recommended that there should be an amendment, as I understand it to the Canada Health Act, to include a diagnostic services within the framework of the Canada Health Act so that then there could be at least, theoretically enforcement, although with this government we don't see enough enforcement under the existing

provisions. But could one of the witnesses just comment on the importance of actually broadening the scope of the Canada Health Act to include diagnostic services.

**Ms. Judy Darcy:** Well, I'll start.

It is the single biggest travesty of that agreement by the first ministers that it threw out the fundamental tenet of Romanow's report which was that not for profit delivery was the way to go. He didn't say it for ideological reasons. We all know Mr. Romanow. We know that he was a very pragmatic man and he insisted that all of his findings be based on evidence and he said over and over again that the issue of public versus private delivery was fundamentally important and all the first ministers talked about was public funding. They didn't deal with the issue of public delivery.

When he said public delivery that meant that these new programs, the expansion of our home care program which would modernize it, like diagnostic services, like a national home care program, like a national pharmacare program, even the limited catastrophic drugs, that they should be part of the Canada Health Act which would mean that they would be covered by the principles of the Canada Health Act and that was so that they would be public, not for profit.

*The Globe and Mail* was absolutely right. On the eve of the first ministers' conference, the morning, they ran a headline that said "Not for Profit is Off the Table" and there has been a conspiracy of silence amongst the first ministers and the media in this country on that issue. Nobody is talking about it. We raised our voices loud and clear at the first ministers' meeting and to the media afterwards and barely a word was spoken of that issue. That's where they failed Canadians.

Canadians are absolutely clear on it. We did some polling in CUPE that was released about two weeks ago just before the premiers' meeting. Ninety-five per cent of Canadians said that there needed to be far better accounting for how health care dollars were spent. Ninety-two per cent said every penny of federal and provincial health care dollars, that government should have to account for it, and 77% of Canadians said that not a penny should go for profit. That has been ignored by all of the first ministers in those statements.

**Mr. Michael McBane:** If I could just make a comment about the diagnostic sector because we know that the Ontario government has plans to open up 25 private CAT scan, CT and MRI clinics. The problem, of course, is they are going to go around and take the radiologists out of the public hospitals to come and work in those private clinics. After two and a half years they'll be profiting \$1 million per clinic.

There's an Alberta entrepreneur who is going around recruiting the doctors out of our public system and he's been told by the Ontario health minister "don't worry, I have the contracts in my back pocket for you" and now they're gloating that the feds are giving them the green light.

This is going to sabotage public health care with our money and so we cannot accept federal politicians saying “this doesn't matter” because that is in fact going to cannibalize the public MRI system public diagnosis which Romanow said “if you take public money and put it in the private instead of the public, you will cannibalize Canada's public health care system” and that's what Ontario plans to do.

Thank you.

🕒 (1705)

**The Vice-Chair (Mr. Stan Dromisky):** Thank you very much.

Mrs. Scherrer.

[*Français*]

**Mme Hélène Scherrer (Louis-Hébert, Lib.):** Merci, monsieur le président. Moi, je voudrais aborder un sujet qui est tout à fait différent de celui qu'on a abordé jusqu'à maintenant.

À la conférence des premiers ministres, ce que j'ai surtout entendu, c'était des premiers ministres qui venaient un peu effectivement demander des sous pour combler des besoins déjà existants, des besoins en équipement, des besoins en ressources humaines, mais je n'ai pas entendu des premiers ministre parler, entre autres, du profil des Canadiens et de notre jeunesse canadienne au niveau de la prévention. Les statistiques nous démontrent actuellement que nos jeunes Canadiens et Canadiennes sont très obèses, très sédentaires, ont des problèmes à peu près à tous les niveaux et j'aurais beaucoup aimé entendre qu'on investissait de façon très importante en prévention quand on sait que la prévention, finalement, si on faisait beaucoup plus de prévention, je pense que ce serait un des moyens très importants de réduire les coûts.

Il y a effectivement un volet qui est sorti où on investissait de façon un peu plus importante au niveau de la prévention. Je n'ai pas entendu parler beaucoup d'investissements au niveau de la nutrition. Je n'ai pas entendu parler beaucoup de programmes d'activités physiques. Mais j'aimerais savoir où vous vous situez, vous, comme sommet, par exemple, pour pousser ce volet-là de façon beaucoup plus importante, parce qu'on parle actuellement de maladies, mais on ne parle pas de santé. Puis, je pense que si on n'investit pas là-dedans et qu'on ne le fait pas de façon très importante et très musclée, j'ai l'impression qu'on va manquer notre coup dans les années à venir. Les besoins qu'on a actuellement vont croître sans arrêt, les besoins réclamés par la maladie, mais si on ne se fait pas un programme actuellement et que des gens comme vous ne se lèvent pas pour dire, à partir de maintenant, on va investir absolument dans la prévention au niveau de notre jeunesse, je pense qu'on est en train de manquer notre coup et jamais on va réussir à réduire ou contrôler les coûts de la santé.

[*English*]

**Ms. Elaine Johnston:** I can say that it was a discussion about, number one, that health promotion and prevention was lacking and the determinants of health. It's very critical with regards to trying to reform the health care system.

I know that the Assembly of First Nations, when we presented to Roy Romanow, we talked about a wellness model. Now, he only put two recommendations in his report which talked about partnerships and a framework agreement. He didn't really talk about what we had presented with regards to a wellness model, which talks about health promotion and prevention as you mentioned.

My concern with what has come out of the accord is that it is focused on these key areas, which is really not health reform. It's more talking about money and investing in certain targeted programs, or areas. I don't even want to call them programs. I know that this was a discussion because we did have the Canadian Public Health Association there at the forum this weekend. The concern is that there is no focus on promotion and prevention, and how do we get that? The premiers did talk about money and they talked about specific areas, so that is a concern, very much so, and we feel that this certainly needs to be addressed.

**Ms. Barb Byers:** I want to add to that as well.

I think the summit this weekend definitely took on the issues, as Elaine has said, but also issues around poverty, around clean water, around homelessness.

One of the things we probably could have discussed more was the question of health and safety because it's a preventative program. If you're dealing with preventing injuries at work, that's dealing with the system as well. The amount of money that's spent on Workers' Compensation ... Again, here's a system where guess what, the Workers' Comp systems across this country are the biggest users of the for-profit systems. They're paying to make sure that their people can jump the queue. It might seem contradictory for a labour leader to say that we don't think that workers should go to the front of the queue, but we don't because we think that there should be a queue that is there for everybody. There should be, again, equal access to quality care. Workers' Comp systems are in fact again undermining that, so they're all combined.

🕒 (1710)

**Ms. Kathleen Connors:** On the issue, I said as we were having a meeting earlier today, the issue of social determinance of health and the issue of health care spending, governments have the choice. You spend it on the front end and keep people well and healthy and without requiring hospitals, or physicians, or nursing, or technicians' services, or you spend it on the system. So spending on homes, adequate housing, clean water, a peaceful environment, all those things, money spent there will save the acute-care system millions and billions of dollars. Then we would have the money so that we could keep seniors in their homes with the provision of home care that includes somebody maybe going and getting some groceries, shovelling the walk, and providing

the supportive services so that these people don't have to be institutionalized. We just have to get the politicians to get the issues right and put the priorities where they need to be.

**Mr. James Lunney (Nanaimo—Alberni, Canadian Alliance):**

Thank you, Mr. Chairman.

I just want to expand the dialogue maybe a little further than where it's been, although we've touched on some of the issues I want to raise. The issue is genuine health care reform. I want to make sure Canadians get true value for their health care dollars.

It came up earlier--I think Kathleen mentioned about effectiveness or cost effectiveness with pharmaceuticals--that perhaps there are other models that we might look at for delivering value to Canadians in that regard.

Shouldn't Canadians have access to all, and perhaps best, options? On this front, there's great concern that much of our health care delivery system has developed without demands to demonstrate either effectiveness or cost effectiveness. A lot of procedures that are done today have very dismal results, and we've had some great disappointments.

Someone else here mentioned about the secrecy regarding drugs, for example, and effectiveness, and because of proprietary information and patenting and so on, the issue of peer of review. Great disappointments, for example, are hormone replacement therapy, which was recommended for years. Women bought into that. Lots of dollars were spent on it with actually very poor outcomes, in fact the reverse of what they might have been expecting. And anti-arrhythmia drugs, for example, have just been turfed out as basically not doing what they're supposed to.

What if there are other ways of doing procedures that might be more effective? What about wellness and prevention? What measures might be taken in that area? What if vitamins and nutrients might be more cost effective than medications for many conditions? What about, for example, intravenous chelation therapy, which has a potential to save millions and millions of dollars for people with heart conditions? What about chiropractic treatment of low back pain? Mr. Romanow touched briefly on that, but had no room for discussing it.

If we're talking about primary care reform, what about practitioners that, for example, like chiropractic, in treating neuro-muscular skeletal disorders? If we stick to just low back pain, the health care economists suggest it could save up to \$2 billion a year, by simply redirecting how the care is delivered.

There's a shortage of manpower. But what if there are other professionals who have been kind of shut out of the current system who, actually, could deliver very effective care if they were given a chance? How does this fit in with a primary health care debate?

I just throw that out for consideration. It's a little different direction than where we've been. I wonder if panel members would have something to contribute to that dialogue.

**Mr. Michael McBane:** I think you've asked some really good questions. I would suggest that one of the reasons is, and there was another question about why not more focus on prevention, in our society the economic values are running roughshod over other social objectives. There's a perverse economic incentive at work where the drug industries and the food industries and the chemical industries are making a lot of money off disease management. There's no money in health promotion.

If your objective is to make money, you're not going to concentrate on preventing people from getting sick in the first place. That's why I'm concerned. For example, the Minister of Health has just announced there's going to be a wellness summit in the next month or so. I predict she will have the food industry there and the drug industry there, whose job is to sell products that are making our children sick in terms of the additives in the food, etc.

We have to get our priorities right. Are we interested in people's health, or are we interested in selling chemicals? The corporate powers behind these products are what's blocking a lot more effective treatments, a lot safer treatments, and a lot more holistic medicine.

🕒 (1715)

**Claude Généreux:** Mr. McBane, we don't have a problem. Quite the opposite, we'd welcome, for example, midwives to be acknowledged and to be integrated into part of the overall system. It's not a problem, but it doesn't mean the door is open-ended.

We had a chance to compare, for example when you alluded to effectiveness, what was going on with eye surgery, between Edmonton and Calgary, for example, in Alberta, cataract surgery. It was way more effective and efficient in terms of when it was publicly delivered, in terms of the waiting time for beneficiaries. The actual net outcome was way better when it was performed in Edmonton where it was public rather than in Calgary where it was private. We have traces there to see what works better. In this case, it was clearly public.

Again, it's not a problem to look at the summit. The coalition certainly doesn't have a problem with possibly chiropractors for some very specific acts, midwives, as I had mentioned, and others. We didn't want to go there because of time constraints. If we can continue the discussion, of course we'd like to say there's more to that.

**Ms. Barb Byers:** Elaine has a comment, and then I have a brief comment as well.

**Ms. Elaine Johnston:** I mentioned earlier that the first nations have been in this health reform before Romanow and before Kirby were announced. The question that was posed to us was, "Well, tell us how to do business better?"

We always found there were stumbling blocks in front of us and I think that this accord has now had...we're finding the same thing. We knew it before. It is that money keeps becoming the issue, okay?

What stalled us out in regards to our health reform discussions was, "Well, how much money does first nations and Inuit health branch need to sustain the programs they already have?" The provinces are having that same discussion. So I guess the question we have is, how do you get back into real health reform discussions? That for the first nations has always been the issue. We don't have enough health care workers. That's the reality. For many, many years we've had community health representatives because we couldn't get nurses. We don't have enough physicians. So how do we take care of that?

You've asked a question that we've been asking ourselves for many years. The problem is that we're always in crisis mode in regards to trying to respond to the problems. So how do we get back on track of talking about real health reform? I think you're asking a very important question. We've been asking that as well.

**Ms. Barb Byers:** I just want to give the people here a bit of an example of a real preventative program that actually worked that unfortunately isn't around any more because the profit motive took over. It's something we haven't talked about here. That is the dental plan for children. Ms. Skelton will remember this from Saskatchewan.

We had a dental plan that was offered through the private system with dental nurses going into schools and parents had the option of their children seeing the dental nurses there. From the ages of 5 to 16 the kids were covered under that plan. From 16 to 18 they could go to private dentists and the plan would cover their care there. We had the plan from probably, what, the early seventies until early eighties.

The private dentists lobbied the Devine government to get rid of the children's dental plan because not only were they missing out on the work of working on kids' teeth during the ages of 5 to 16, the problem was that when the children then went into the private system, their teeth were in too good shape and so we have a problem here: You can't make money on kids who don't have cavities and other needs. That's the reality.

So there was a huge outcry when that program was done away with by the Devine government and it was purely, as Michael has said, economics and not about the prevention that was needed. It was a huge hit to farm families because parents who didn't have to worry about that before ended up having to leave their farms and go get their kids at school and take them off to the dentists and so on. It was very difficult. It was a real prevention program.

And you know what? I had forgotten about it until Carolyn raised the whole question of dental health earlier today. It's the reality that we have very good prevention programs when we look for them and they can do the job for us, but we can't let the economics take over.

🕒 (1720)

**The Vice-Chair (Mr. Stan Dromisky):** Mr. Robinson.

**Mr. Svend Robinson:** I just wanted to get some clarification from the committee with respect to a notice of motion, as a new member of the committee, what the rules are with respect to it, because I wanted to give notice of a motion that I intend to move at the earliest possible opportunity with respect to...that this committee urge the government to support the creation of a northern health fund as called for by the three territorial premiers to be funded at the level requested by the premiers. I think it was Mr. Merrifield who asked earlier what that might be. It's approximately between \$60 million and \$70 million. It's peanuts in the overall scheme. It's 0.5% of the promised new federal dollars in the first ministers' health accord. So I wanted to give notice of this motion now. I'm not sure at what point I might actually move it. Would it be 48 hours?

**The Vice-Chair (Mr. Stan Dromisky):** Yes, we need 48 hours for it.

**Mr. Svend Robinson:** Fine. Well, I've given notice of the motion. I'll give it to the clerk.

**The Vice-Chair (Mr. Stan Dromisky):** Okay, give it to the clerk.

Are there any questions from the Liberal side? Do you have a small one?

**Ms. Carolyn Bennett:** No, it's huge and really long.

Say we could get to a federal-provincial situation where there were national standards and where there was a health council and where people came together collaboratively and the feds showed up with their problems on aboriginals and the military and corrections and veterans...how do you actually see enforcement? The Canada Health Act has been pretty difficult to enforce because nobody really wants to take money away from a poor province for flunking. Are we really going to claw back provinces in the future?

**Ms. Barb Byers:** We have to. Yes.

**Ms. Carolyn Bennett:** For any other law in the country, would you say: well, do we really want to enforce that law?

Obviously, we need sticks and carrots. I do think we have to keep the sticks or we threaten and hope you never have to use it--and, obviously, if you don't use it too often, people think you'll never use it, I think is what I'm hearing you say. But is there a way we could move to a reward system where provinces, who had neat new ways of doing things, got extra money for having the dental program or a way of measuring outcomes or waiting lists or all that, where you actually gave rewards, and a conference once a year and--this was obviously my big fantasy--we would bring best practices together at the

time of the first ministers meeting so that people could be celebrated if they were doing good stuff?

**Ms. Judy Darcy:** Well, certainly, if the federal government believed that we should have a national public home care program, they could have said certainly to Manitoba, that has had a public not-for-profit home care program in place for a number of years, “Yes, we want to give specific support to encourage this”. They could encourage models or pilot projects, absolutely, but they also have to penalize the provinces that are breaking the law.

It's outrageous in this country that one province after another, after another, has set up more private hospitals, more private clinics, more delisting of services and the federal government has sat on their butts and done nothing. The attitude has been “Hear no evil, see no evil, speak no evil” and they just sit and do nothing. It's like fiddling while Rome burns.

The federal government has it's fiscal authority--

**The Vice-Chair (Mr. Stan Dromisky):** The meeting has come to an end.

Now, before we dismiss our guests, I would like to say to the members of the committee that we meet on Wednesday from 3:30 p.m. to 5 p.m. to deal with Bill C-260, and then from 5 p.m. to 5:30 p.m., we hope that we will be successful in determining, without any hassle, what our agenda will be for the next year or two or three. All right? So please be here.

Now, the witnesses, thank you very much. Believe it or not, you will have had an impact on these people here. You have go-getters on this committee and I think most of them, in fact I would say all of them, are very, very sensitive with the issues that you have presented. Thank you very much for coming.

The meeting adjourned to the call of the chair.