



CANADA

# Standing Committee on Health

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⊕ (1545)

[*English*]

**The Chair (Ms. Bonnie Brown (Oakville, Lib.)):** Good afternoon, ladies and gentlemen. It's my pleasure to welcome you to this meeting of the Standing Committee on Health. On your behalf, to welcome our key witness, Roy Romanow, the former Commissioner on the Future of Health Care in Canada. He has with him Dr. Gregory Marchildon and Michel Amar.

So with these three witnesses we will welcome them and congratulate Mr. Romanow on his report, which the whole country welcomes, I think I can say, certainly this committee did. It's a few months ago now so we would invite you to begin to update us on where you think the results have led us and where you would like to see us go.

Mr. Romanow.

**Mr. Roy Romanow (Former Commissioner, Commission on the Future of Health Care in Canada):** Merci beaucoup. Thank you very much, Madam Chair. I'm not sure that I'm going to be able to enlighten very much, maybe the committee members will be able to enlighten not only me, but the Canadian public on this very important subject matter even though we're living in very trying times at the present time.

I want to thank you for introducing my two colleagues. I'd like to just very briefly repeat, I have seated to my left Dr. Greg Marchildon who is the Chief Executive Officer for the Royal Commission and lead pen for

the report. To my right here is Michel Amar who is the Commission's Director of Consultations and I would argue as well, the architect of our strategy for engaging Canadians in this process.

With your permission, Madam Chair and the permission of the committee members, if I run into any rough spots for questioning, my rule is I answer all the easy ones and these two guys answer all the tough ones.

*[Français]*

Madame la présidente, c'est un honneur et un privilège de comparaître à nouveau devant le comité permanent. Je sais que je suis ici pour répondre à vos questions, donc mes remarques préliminaires seront brèves.

*[English]*

Over four months ago the final report was submitted--it just seems like yesterday when you're having fun--and just over two months since Canada's First Ministers came together to achieve an important 2003 Health Accord.

The Health Accord is a major first step in my judgment in fixing medicare for a number of reasons. If I may on the positive just briefly outline the positive reasons.

First,

*[Français]*

En premier lieu, selon le cas, les premiers ministres ont réitéré publiquement leur engagement vis-à-vis les cinq principes de la Loi canadienne sur la santé.

*[English]*

They reaffirmed their commitments in the five principles of the Canada Health Act.

Second, they recognized that reform and new public investments are required to meet Canadians desire for a sustainable health care system that provides timely access to quality health services.

Third, they took a solid first step, in my judgement, toward reform by not only reaching consensus on a number of targets and objectives for improving health care, but they also agreed to report publicly on their individual and collective progress in meeting them.

Fourth, the first ministers accepted the imperative to improve transparency and accountability of Canada's health care system.

Fifth, they recognized the urgent need to better monitor population health, and to address health disparities by directing Canada's health ministers to, in their words, "continue to work on healthy living strategies and other initiatives to reduce disparities in health status".

By the way, the FPT symposium on healthy living scheduled for the end of April in Toronto is yet one example of the new spirit of collaboration on health care, and I think this will serve Canadians very well indeed.

And last, and perhaps most significantly, the first ministers agreed to work together with each other, and with the health care providers, and with Canadians, the public at large, in shaping the system's future by agreeing to the creation of a health council of Canada. I'll have more to say, with your permission, very briefly on this issue of the health council of Canada toward the end of my remarks.

Now these are very notable achievements, and first ministers, I would argue again, deserve credit for their efforts, for their flexibility, and for their leadership, and Canadians I would also argue, Madam Chair, should be very pleased that the first ministers agreed to embrace a reform agenda that goes beyond a simple focus on hospitals and physician services.

The ambitious and explicit targets that have been established by ensuring 24/7 access by Canadians to front-line primary health care is another important and positive development. We should also welcome the collective commitment by first ministers to set certain national objectives in regard to home care, especially for community mental health services, which I have described as one of the orphaned children of health care. This is a praiseworthy step forward, as is I would argue the recognition by the first ministers of the need for action to provide catastrophic prescription drug coverage for Canadians, and the decision to allocate \$1.3 billion for first nations health.

At this point also, Madam Chair, I want to congratulate Minister Anne McLellan and her provincial counterparts for their excellent work on establishing criteria and public reporting mechanisms that will apply to the \$1.5 billion medical equipment fund, I believe just announced twenty-four or forty-eight hours ago. This is, in my view, a very positive evolution from the general open-ended approach that characterized, and I think, marked the failure of previous accords like the September 2000 accord, maybe failure is overstating it, but at least the less than satisfactory September 2000 accord.

Finally, the agreement to replace the old CHST, or the current CHST, the Canada Health and Social Transfer with a dedicated CHT, a Canada Health Transfer, I think is a very important accomplishment. It will improve transparency and accountability in regard to what each level of government is contributing to the health care system.

Now, those are the positive things amongst others, and that having been said I also have some observations and questions, however, about the adequacy of the dollars on the table and where and how they will be spent to improve and strengthen the health care system for Canada and Canadians.

Let's make no mistake about it, there is a lot of taxpayer money on the table in this current accord, a lot of money, and depending upon the assumptions used, and I think it doesn't help us very much to get drawn into sterile debates about whether it's new or old money, the fact is there is somewhere between \$30 billion to \$35 billion approximately at stake over the next several years, \$30 billion to \$35 billion--that is a lot of money.

But I do have four major concerns with the dollars issues, or the moneys issues. What are they? First, there is less money than what the Senate committee report on health suggested was necessary, less money than what our own commission recommended, and most importantly less money in the immediate term in any event than is needed for Ottawa to contribute its historical federal share of the medicare bargain.

⊕ (1550)

The second concern, while first ministers accepted allocating some \$16 billion over the next five years to a health reform fund, there are still too few details available to know what the health reform fund will actually achieve, what conditions if any will apply or what criteria will be used to evaluate its effectiveness. This is a lot of work yet to be done.

I have similar concerns about the immediate \$2.5 billion top up that has been agreed to ostensibly for assisting provinces to address urgent immediate priorities like attacking the wait list problem and improving timely access to care. If the \$2.5 billion is spent wisely and here's the important part in my view and according to a coherent plan, it can make a very real positive difference.

However so far the only real guarantee that the additional \$2.5 billion will in fact be devoted to health care in this area really will be an effective and transparent accountability framework which allows Canadians to see exactly how their governments are using this money. That's good. We want the accountability and the transparency but there also needs to be a coherent plan.

Third, much of the money available within the health reform fund will be back loaded toward the end of the term of the 2003 accord. And this may end up delaying needed reforms in a number of areas. Under the health reform fund, less than \$1 billion will be available in year one for transforming the system and funding increases will rise only gradually thereafter what I mean by back loading. Change will still occur. Let's give the government and the first ministers credit. There's no doubt about that. But change will occur but it should be understood it'll occur more slowly than should be the pace ideally, the desirable pace that I think Canadians and the system demands.

And as I will explain shortly, the lack of stable and predictable transfers will hamper our ability to support longer term planning while encouraging federal provincial bickering in the short to medium term.

Those are the four concerns I have about the money issues.

Now Madam Chair and members of the committee, I do not want my comments to be construed as critical or as damning the accord with faint praise. As a former premier, I can personally attest, boy how I can attest to that, on how difficult and politically fraught the federal provincial arena can be. The health accord is, I repeat a first major step and we should acknowledge that. It provides a strong foundation for revitalizing our system. It will allow us to take the further steps necessary in the coming years to build the most effective public health care system in the world or division statement to make Canadians the healthiest people in the world.

And this committee, as it knows better than most, knows that there is no shortage of areas in our health care system where we can and must do better. For example, first we need to better coordinate and support the expansion and alignment of health care professionals and of our health infrastructure making sure that plans in all jurisdictions can keep in step with patient needs and expectations.

Second, timely access to quality care, a reality, it's got to be made a reality. Third, we need to focus more on preventing chronic diseases, investing more in population health and wellness initiatives that make the system more sustainable and that promote self reliance and our own responsibilities for health care.

Fourth, we need to upgrade our national capacity in health research especially as it applies to population health and as it applies to health informatics. Fifth, we need more collaborative initiatives like the common drug review process that came on stream earlier this year to help us get a handle on containing ever increasing rises in drug costs and they'll continue to go up.

⊕ (1555)

And we need to ensure that we have a regulatory system that is more responsive to public policy imperatives in this area for safety; affordability; security of supply; ethical standards; and competitiveness. However, I believe that only limited progress can be made in tackling these problems anywhere in this country in the absence, again, of a coherent and coordinated--I come back to this theme--national plan of

action. This presupposes that the conditions exist for the federal and provincial governments to move forward together.

Well, Madam Chair, I say we're getting much closer, but we are not there yet. To make headway on this problem I believe we must continue to make progress in three key areas.

[*Français*]

D'abord, je crois qu'il faut modifier la façon de financer notre système de santé, non seulement afin de sa stabilité ainsi que sa prévisibilité, mais aussi afin de réduire la tension entre le fédéral et les provinces.

[*English*]

Second, I believe we need to modernize the Canada Health Act statutorily to reflect the reality of how health care is delivered in Canada, today. And last, we need to establish an effective Health Council of Canada to make the system more accountable to taxpayers and to give patients and providers a stronger voice and a greater say in shaping their future directions in health.

Let me just summarize my views in this regard before I close. In my final report, talking about the health system and the CHA, I recommended that by 2005-06, Ottawa cover a minimum of 25% of provincial health spending for CHA, Canada Health Act, expenditures and that this be provided in the form of a dedicated cash-only transfer. I also proposed an escalator clause within the transfer to allow the federal share of health spending to track inflation and adapt to changing patterns of provincial health care spending.

Taking account of tax points that were permanently transferred to the provinces way back in 1977, the 25% cash transfer, taking that plus the tax points, would restore Ottawa's share of CHA-covered health spending to historic levels.

What would this new funding mechanism have achieved? For one thing, it would remove an ongoing irritant, which I fear exists and is still there, from the already volatile intergovernmental relations mix, while simultaneously improving transparency and accountability. The federal and provincial governments would be working together from the same numbers and they would not be continually negotiating the size of the federal transfer or the growth of the federal transfer, or both. In short, the result would be a more positive federal-provincial dynamic and adequate stable and predictable funding for the system. That stability, that tranquility in the federal-provincial wars over health care is desperately need.

I also linked the 25% federal funding floor by 2005-06 to targeted funding, on the argument that the funding should buy change in a number of specific areas over the next two fiscal years. The targeted funding was to focus on addressing key short-term priorities of Canadians, such as timely access to care, advanced diagnostic services--I've talked about that earlier--it was also intended to kick-start the revitalization of medicare by providing federal funding to support home care, prescription drug treatment as integral components of a modern-day health care system in Canada.

To entrench these changes, the report recommended the Canada Health Act be amended by statute to include priority--note the word "priority"--home care services, and, over time, prescription drug coverage. In my view, this would acknowledge that health care today is more than just about doctors and hospitals, which is all the Canada Health Act, as important an act as it is, currently covers.

Keeping in mind that prescription drug coverage and home care are the fastest growth areas--the fastest growth areas--of health care spending, this would also ensure that Ottawa was financially responsible for paying its share of the system's expansion and bring into the basket of services under the CHA.

Now, as this committee knows--and this is the last major point that I want to make. Sorry, for being a little bit long-winded--one of the real barriers to improved co-operation and coordination in our health care system is that the different levels of government--I've said this before--and sometimes different provincial governments, begin from very different starting points on simple issues of fact. Thus, the report suggested the creation of a Health Council of Canada, whose membership would be broadly reflective of the various interests at play in health care: patients, providers and the officials. It would promote collaboration amongst the governments and it would also make sure that they would be reporting to those who utilize and own the system, namely ordinary Canadians.

🕒 (1600)

The Health Council would incorporate the following features: it would bring together under a single roof a number of existing federal and provincial advisory structures and agencies, and provide an objective and neutral forum whose expertise governments and the public could draw upon as required for support.

Second, it would give patients and providers a more direct say in how the system operates and the means to monitor its performance.

If there's any message I got from the Royal Commission hearings, it was those two for sure.

Thirdly, it would serve as a focal point for gathering health information for setting common health data and informatic standards, something to which we've made some progress with CHII, but frankly in my judgment, there's a long way to go. Then once we get the common health data and standards for interpreting and reporting to Canadians how we're making out in achieving those standards, namely the outcomes.

And fourthly, in time, as trust is gradually built, the council would become a trusted source of advice for governments on how best to discharge their individual and collective responsibilities for the system and assist in fact finding and in resolving disputes over the interpretation of the Canada Health Act.

Now I note that the 2003 Health Accord commits governments to establish the Health Council of Canada, right around the corner, by May 5, 2003. Obviously the council's eventual terms of reference and governing structure, the autonomy, the quality of those selected to serve on it will determine its effectiveness.

I remain hopeful that first, ministers will create an effective and inclusive and independent health council that will do more than just focus narrowly on the implementation of the accord. Properly structured, it will mean less bureaucracy, not more.

May I just repeat that, Madam Chair, because I think there's been a lot of misinterpretation. This is not an extra bureaucracy. It means or should mean less bureaucracy and streamlining it and not more. And it should, I say, it will speed up the pace of innovation and reform, not slow it down.

Madam Chair and members of the committee, whether or not we as Canadians and governments of Canada succeed in establishing an effective Health Council of Canada will prove to be, in my judgment, a litmiss test as to whether or not the governments of this great nation of ours have listened to Canadians as they told me they wanted the accomplishments of the council during the Royal Commission hearings.

I would therefore also like to draw attention to the standing committees' consideration. On March 21, 2003, a workshop in Toronto that was organized by Professor Colleen Flood with the University of Toronto, funded with the support of the Atkinson Foundation of Toronto. The workshop brought together some of the foremost health policy minds in the country who have been active and vocal advocates for a national entity that would have roles and functions similar to those which I have just outlined. The stature and the calibre of

the participants is eloquent testimony to the interest in the Health Council and the interest that has been generated in the Health Council, and the proprietary sense that flows with that for ordinary Canadians about accountability and transparency.

I repeat again, in my judgment, Canadians will be watching extremely carefully, this being probably after the budget and the accord, the first major act to determine whether or not the council is set up, has the appropriate mandate, the appropriate resources, independence and leadership that are required to make a real and positive difference to influence the future direction of health care in Canada. With respect, we cannot fail Canadians.

In closing, let me say that the past 18 months or so that I spent as commissioner were among the most exciting and challenging, and I might add, most rewarding in my public life. The process renewed my faith in Canadians in their maturity, in their capacity to understand and to make tough choices, in their faith in the democratic system that politicians and governments will listen and still can listen, in their capacity to understand and to make the tough choices and also in the common values that unite us as a united country.

🕒 (1605)

I absolutely believe that we can make our health care system the very best in the world--and it's very good now--if we're prepared to heed the advice of Canadians and to respect their wishes, and I believe that the health accord is a very important first step to getting there, but there's much work yet ahead of us.

Merci beaucoup. Thank you very much.

**The Chair:** Thank you very much, Mr. Romanow.

We'll move to the question and answer session, and we'll begin with Mr. Merrifield representing the Alliance Party.

**Mr. Rob Merrifield (Yellowhead, Canadian Alliance):** Thank you.

I appreciate you coming in again, Roy. You were here last time and I challenged you, I think, when I chatted with you about your commission. I certainly applaud the work that you've done in the sense that I think you've given it your best. But of course what I said to you back then was that the report will be either a success or a failure, not determined on how good or how bad the report is, but how much is actually accepted and complied with and implemented, as you have recommended.

You obviously have seen the health accord and what has come out of that. Some you could say is perhaps a step towards some of the things you recommended and other things are not.

I have a number of questions. I know I'm not going to get at them all. So what I'm really wrestling with is which ones I should ask first.

🕒 (1610)

**Mr. Roy Romanow:** The easiest ones.

**Mr. Rob Merrifield:** Yes, the easiest ones.

When it comes to the money, what was frustrating to I think many Canadians is the dollars coming out of the accord. If you didn't like the numbers, you just read a different paper that morning and you got a

different rate of numbers. It seemed like there was very much confusion, and I think there is still a little confusion as to the number of dollars because some of them, as you have said, have been previously announced and which were actually new dollars and which were not.

Never the less, let's forget about the numbers because we could get into a long debate about that and it's not worth it. The reality is that the provinces stepped away from that table and agreed to the arrangements of taking the money that was on the table and so did the federal government.

So I guess my challenge to both the provinces and the federal government is to stop the squabbling and start performing as far as moving ahead on health care reforms is concerned.

My first question to you is on the strings attached to that money. You had recommended some fairly stiff strings to those dollars. I believe that was the approach going into the accord of the federal government. Nonetheless, provinces held on and said that a lot of this was their jurisdiction.

You being a premier of a province, if you were to, let's say, take home care and have been provided, like in New Brunswick, a very comprehensive home care program, and if there were strong strings attached to that money, would you forego having that money or would you want the flexibility that the provinces have achieved through the accord? Are you pleased with that or you not pleased with that?

**Mr. Roy Romanow:** Well, Mr. Merrifield, if I may say so, as usual, a very tough question to answer, but an important one.

To be very succinct, I believe that the accord improved in a way on the commission's recommendations by putting into the medical reform fund three of the five specialized funds, which I advocated, and in doing so provided some flexibility for the provincial governments to use those sources within that medical reform fund, which were applicable to their individual jurisdictions.

New Brunswick has a pretty good, if I may say so, home care plan and their priority may be in another area. I think in that regard there is some improvement, as I say, with respect to the accord.

The key question however still remains for me that the devil, as we know, resides in the details. That is to say how one accesses the medical reform fund, under what terms and conditions, the coherent plan, the degree of flexibility that is going to be involved are yet to be determined, or at least they're being worked on and need to be determined. I think that the issue is one which I don't dismiss as an improvement. I think it is an improvement, but I think more time needs to be worked out before the health reform fund...before I can even comment particularly on that.

**Mr. Rob Merrifield:**

So what I'm hearing you say is that you're okay with the flexibility under the fund and I would agree with that and concur with that.

The other problem that I have and I would agree with your other comment with regard to the rest of the health reform fund in the sense of, let's say, the catastrophic drug plan, it's supposed to be worked out over a two year period. I know you're recommending the provinces anti up 50:50 on that fund. That is yet to be worked out and it really will be interesting to see how that's worked out. And I don't know if there's any point in commenting about that necessarily, but it is going to be interesting.

My other question is, when it comes to the strings attached, would it not have been wiser and less confrontational to have challenged the provinces--and as you being a premier or an ex-premier--to have

come up with the ideas of where you would apply the money to retain the values that Canadians hold so dear in their Medicare system under a single payer? Would it be not a better way to have them come forward with their recommendations of where they would apply the money and then hold them accountable for the goal posts of where those dollars to be able to achieve the goals? Would that not have been a much less confrontational approach and yet respected their jurisdictional provision of health care under their constitution and their authority?

And I'm just a little confused as to why that wouldn't have taken place and then have their electorate hold them accountable, make sure they either be rewarded or not rewarded as to success in it.

**Mr. Roy Romanow:** I'm not saying that you're saying this, Mr. Merrifield, but I'm not sure that the recommendations which we set out had a confrontational element to it. I'm not arguing that you are saying so, but my answer to you is simply this: I think that if we're having a national system, and I mean by national, one which recognizes that health care is not an exclusive provincial jurisdiction, although there would be an argument given to me perhaps by members of the committee, it is a shared responsibility, it's a primary responsibility of the provinces, but it also involves the federal government. How else can one conclude that it involves the federal government because under what authority would the federal government get into an exclusive provincial field of activity? It gets into it because of the federal spending power, which is a constitutional authority--and I don't want to get constitutional, but--that Ottawa has.

So we have to decide as Canadians whether we come to this cooperatively. The primary delivery of the health care system and other powers reside provincially; the federal spending power, with its sources of money contributing to that, and I argue that it's got to be done cooperatively.

Now the strings that are attached, that you submit, really are the result, Mr. Merrifield, of what I felt was an accurate assessment or conclusion of what Canadians told me they wanted by way of transformational change in the areas which were important to them, keeping in mind that we heard from every provincial government. I heard from every provincial government, either a premier or a minister of health, in every territory as well, during the course of the public hearings, setting out their shopping lists, if I can describe it that way. And there were some common themes and they boiled down to the five specific fundamental categories.

I'll finish off.

We need to have a flexibility because one size does not fit all. But we also need to compromise that flexibility with having a platform which is common to our Canadian citizenship and is common to what needs of Canadians across the country are.

🕒 (1615)

**Mr. Rob Merrifield:** Isn't it very easy as a premier or as a province to just come to the federal government and say we need more money, as we have seen the history of the provinces doing it? I mean, that's what they've said and I tend to agree with them because I think there was a renegeing of the original agreement and I think you concur with that. But isn't that letting them off the hook somewhat by not suggesting to them that the federal government is there to accomplish and to make sure that national values remain from coast to coast to coast in this country in health care? And to force them to come up with some of where they would apply these new dollars to achieve the values and the goals for efficiency and sustainability of our health care system into the 21st century? And I just would suggest that that would be much more difficult for them to approach in a confrontation way as they might from Big Brother down, saying "I want you to put it here, here and here..." and in specific dollars.

**The Chair:** Mr. Merrifield, there's only one minute left if you wish Mr. Romanow to answer.

**Mr. Rob Merrifield:** Well I think he's answered that. Unless you want to add some more to it?

The other quick one is on the drugs. You had recommended a national drug safety agency. We haven't seen that in the accord. In fact, it was rather mute as to what would happen in that area and it's an area that we're very concerned about. And, as a committee, we're about to go into a major study on the prescription medications. And I wonder what your comment is on that?

**Mr. Roy Romanow:** Before I do, Mr. Merrifield, I'm not advocating a big brother or a big sister approach from Ottawa. I repeat again the only way this country can work in my judgment is through collaboration and cooperation. One can disagree whether this commission report captured the areas where I think the vast consensus of Canadians think some form of collaborative, conditionalized--that's a bad word to use perhaps in some minds--action and program should be undertaken, but I do not view that it should be top down. I simply think the health care needs in Saskatchewan are different than they are in Nunavut and they're different in B.C. So it's collaborative, but I think we don't in very substantive terms disagree, maybe in nuance.

On the drugs the question you'd asked is...again, if you could just repeat it very briefly for me.

**The Chair:** I think it's actually too late. Mr. Merrifield is well over his time and it's now time for Mr. Ménard to have the floor, Mr. Romanow.

[*Français*]

**Le vice-président (M. Réal Ménard (Hochelaga—Maisonneuve, BQ)):** Merci, madame la présidente.

Mon premier commentaire sur votre rapport, c'est un peu à l'image de votre carrière politique, c'est-à-dire qu'il y a des éléments très attachants et des éléments très détestables. Vous savez que le gouvernement du Québec a rejeté le rapport Romanow. Il me semble qu'il y a deux billets qui sont assez faux dans l'ensemble de votre philosophie d'intervention.

L'idée c'est de penser qu'il n'existe pas déjà dans les provinces des mécanismes d'imputabilité, comme s'il n'y avait pas de périodes de questions, comme s'il n'y avait pas de régies régionales, comme s'il n'y avait pas différentes façons pour les provinces d'expliquer à leurs concitoyens comment ils utilisent les fonds.

Deuxièmement, le billet le plus grave de votre rapport, c'est de vouloir utiliser la santé pour faire du notion building. Alors, que le gouvernement fédéral est celui qui a le moins d'expertise en santé et quand on regarde sa performance concernant les Forces armées et les autochtones, où même pour le faire, cela ne nous invite pas à lui confier un rôle accru.

Ceci est mon premier commentaire. Je vais maintenant y aller avec une question précise, si vous me le permettez, sur le coût des médicaments. Pour la première fois, dans l'histoire du Canada, le coût pour les médicaments d'ordonnance est supérieur à l'ensemble de la rémunération des médecins. Je partage absolument l'analyse du moment que c'est la principale cause d'indexation ou de progression du coût des systèmes de santé, mais vous êtes demeuré évasif sur comment on peut limiter le coût des médicaments.

En effet, lorsqu'on lit votre rapport, vous ne faites pas de corrélation entre la protection de breveté que le Canada accorde pour 20 ans et le coût des médicaments. Est-ce que je lis bien votre rapport en pensant que vous n'avez pas fait cette corrélation et comment pensez-vous qu'on puisse, au-delà des structures--l'agence pour moi, c'est une structure--mais comment pensez-vous qu'on puisse limiter le coût des médicaments?

Nous avons des propositions pour le comité. J'ai déposé un mandat sur lequel on pourrait échanger, mais j'aurais souhaité que vous soyez plus explicite.

🕒 (1620)

**M. Roy Romanow:** Merci beaucoup, monsieur Ménard, pour votre question.

[English]

May I just make a quick response in English about the two preliminary points that you make with respect to accountability. I understand the argument that you advance. In my province we have regional health boards, and provincial governments, I suspect I even did so myself as premier, argue that there's accountability through the department of health provincially and through regional health boards and the like.

The issue here, however, is \$30 billion to \$35 billion of federal funds to buy change, to guarantee that the money which is advanced--this has nothing to do with any particular province, I'll use it as an example--isn't used to buy--and overuse the example--lawnmowers as opposed to putting it into medical equipment. That's why I gave credit to Ms. McLellan in her announcement of a few days ago. That is the context of accountability, but it's more than that. It is, I think, that Canadians generally and with the greatest of respect from what I even heard in Quebec in two large meetings in Quebec City and Montreal was the desire of the vast majority of the people in Canada.

[Français]

**Le vice-président (M. Réal Ménard):** Est-ce que vous comprenez qu'il y a déjà des mécanismes? Votre raisonnement est dangereux, c'est un paroxysme, mais c'est un peu votre carrière politique. On déchire la Constitution canadienne. Le gouvernement fédéral est mandataire pour la santé pour les autochtones, pour les Forces armées, pour la quarantaine, les épidémies et les brevets, sa juridiction. De quel droit est-ce qu'un gouvernement comme le gouvernement du Canada viendrait dire à des gens, qui offrent des services au quotidien, dans le domaine de la santé, vous allez être imputables? Est-ce que vous avez des exemples pour le Québec? Je connais la question du Québec où les fonds dédiés n'ont pas été utilisés pour ce qu'ils devaient être.

[English]

**Mr. Roy Romanow:** Well, first, I think we just have to agree to disagree, Monsieur Ménard, about whether it is exclusive provincial jurisdiction for health care or whether it is a shared jurisdiction.

**Mr. Réal Ménard:** You are still my friend.

**Mr. Roy Romanow:** Well you're my friend too, but I think it's a shared jurisdiction. We have to disagree if I can not convince you of that point of view.

May I also say, Monsieur Ménard, that the government of Canada is the sixth largest provider of health care services on the front lines, which is not insubstantial when you consider the other provinces and the territories. Again, if you'd like to respond, but I want to say on the key question of patents and the question of drugs, I haven't seen your proposal I'm sorry. I look forward to looking at it and studying it.

The issue of drugs and their increasing costs is a complicated one. There are some arguments which say that the cost factor of pharmaceutical prescription drugs is due to prescriptions. We have 10.1 prescriptions for every many, woman and child in Canada, which is surely either the right amount, or a hugely over-

prescribed amount. There is a question of whether or not generic drugs are any kind of a relief here because if my memory serves me correctly on the report, Monsieur Ménard, on generic drugs, Canada now has a ranking of third highest of the OECD, which could arguably be said that they're pushing the price right up at the top.

Then the question of the patents raise the issue of a recommendation which I made in the report which is that we should look at, at least two aspects of patents, something called evergreening, namely the extension of 20 years to 20 years by changing and the issue of notice of compliances allowing generics once a patent runs out to move into this area.

Finally, may I say, Mr. Ménard, very briefly--I'm sorry for being long-winded--the recommendation which we had in the report said, you almost need another Royal Commission to examine the detail of these very complex issues. What we also said was, in the meantime let's decide that over a certain dollar value. If you require drugs you're in a catastrophic category, \$1,500 or more. It is the single pair, the principle of value, solidarity, the business of equity as well that kicks in at that stage of the game and we couple that idea with what we call a prescription management program, namely using drugs in an appropriate way to take a look at this 10.1 figure that I described.

🕒 (1625)

**The Chair:** Thank you very much, Mr. Ménard.

The next person is Ms. Bennett.

**Ms. Carolyn Bennett (St. Paul's, Lib.):** Thank you, Madame Chair.

In your remarks, obviously you think the accord has been an important first step. You've also called upon Canadians to be vigilant in terms of keeping up the momentum, in terms of what they said they wanted to see. What would you say Canadians should be watching for in terms of the next steps? In that, there were some pretty tight time lines in your report, what would you be looking for next in terms of Canadians feeling confident that things were moving along?

I guess we're all curious in terms of your role in terms of the Atkinson Fellowship and whether you'll be helping coach Canadians on what to be watching for.

**Mr. Roy Romanow:** Well, Dr. Bennett, I think that the next immediate first step is the one that I made in the opening remarks and that is the Health Council of Canada. I know that you particularly have been doing a lot of work in this area and thinking about it, which I think is very valuable and it's part of that Colleen Flood Study that I mentioned on March 21. I think that's the first important litmus test.

If this is not achieved, without repeating myself at length but just to make the point, I do think it'll have an extremely negative impact, not only on health care reform. Again, I don't want to be too gloomy about it, but it could have a very negative impact about whether or not the political system listens. I think that's the next first step.

We have to start our reforms now on primary health care. We have to start our reforms now on wait lists and timely access to health care. All of these will take some immediate attention that will take some time for actual implementation. I would put those priorities as the top priorities.

With respect to myself, I'm on the lam in kind of looking for a job, so thanks for inviting me and allowing me to put forward my views. I think at this stage of the game it's in the hands of parliamentarians and I think

parliamentarians will not take offence when I say, as a former politician, it's really in the hands of the public to push all of us along to make these reforms. That's how I'd see it.

**Ms. Carolyn Bennett:** In terms of the council being a trusted body and earning the trust of the players, obviously, some of us were pretty concerned after the December 6 health ministers meeting, some of them came out, went to the mike and said, "We don't need a council". How will we know on May 5, when the council's announced, or when would Canadians know whether this is a real council or not a real council and whether it has the heft that you'd hoped for in your report?

**Mr. Roy Romanow:** That is a very tough question. I think some tests will be the personnel appointed, making sure they are of integrity and ability and enjoy the confidence of Canadians. I think the mandate, although the accord says the mandate is the accord, itself, which, frankly, may not be the end of the world because the accord is certainly porous enough in its wording that might allow, over a period of time, confidence-building.

I think over a little longer time will be trust, which has to be earned by the members of the health council. I think almost immediately is the spirit, coupled by the words and actions, in which governments accept the health council. If this is a grudging acceptance, or if it's something which is imposed--talking about Big Brother--then, I think we have ourselves another dimension to the federal-provincial squabbling, which would not be very helpful.

However, if we make the proper appointments, with the proper mandate, and gradually grow over time--I don't know what that means, that will be defined by Canadians--that would probably be a modest, but pretty good start.

🕒 (1630)

**Ms. Carolyn Bennett:** And the money?

**Mr. Roy Romanow:** Well, the money, I can only repeat what I said in my opening statement. I think the certainty of money, the floor, needs to be achieved for all the reasons that I articulated: it avoids ongoing battles and it avoids the kind of statements which we saw at the last first ministers' meeting.

I'm coming back to see you a year from now. Everybody has to be in this together: the caregivers have to know how much money is available, because they're going to be making demands, the managers have to know how much money is available, the provinces, the federal government. I think the way to do that is to do it in historical terms, that's 25% portion of the insured, provincial-delivered CHA services, when you take into account the tax points transferred. The sooner the better.

**The Chair:** Thank you, Ms. Bennett.

Ms. Wasylycia-Leis.

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

I'm certainly glad that our new health critic couldn't be here today, so I could come and at least complete a chapter in my life around the Romanow Commission.

I wanted to just publicly take the opportunity to say thank you, to you, Mr. Romanow, and all the staff, for your great contribution to the whole question of the future of health care and to say, I think, for most Canadians, you reflected their values and you backed up your recommendations with solid research.

I think the disappointment by Canadian now, though, is that they feel that it has been sort of sidelined by the federal government and there has been no sort of outright acceptance by the federal government for the adoption of the Romanow blueprint. Although there's some progress on different fronts, that failure has been noticed by Canadians and I think they're counting on your to continue the fight for the recommendations that you've give to us.

I have three quick questions. I'm going to start by dealing with the question of the whole issue of privatization and for-profit delivery. In your report, you indicated, for constitutional reasons, that you couldn't recommend an outright prohibition against for-profit delivery. However, your recommendations throughout clearly seemed to be grounded and based on the evidence that for-profit delivery could, in fact, harm medicare.

So my first question to you is: given that the Health Minister, the Alliance and others have said it really doesn't matter who owns the institutions and how the services are delivered, what would you say, in response, based on the evidence you gathered and in light of the trade implications noted in your report?

**Mr. Roy Romanow:** That's a very difficult question. I would say by way of preliminary, I see the accord, the product of federal, provincial and territorial governments and again I do not want to deviate from my opening statement, these are not easy agreements to arrive at.

I want to repeat again, I think it was a pretty important first big step, the accord and cannot be and should not be classified as a failure. It's got to be classified as a good stepping stone to move forward and all governments are involved in coming to that accord and I commend them for it.

On the issue of privatization and private for profit, I simply would say to you that the evidence has not yet been contradicted that I know of by comparable studies to show that it is either more cost-efficient in terms of dollars or more efficient in terms of health outcomes to have anything but for core services, note words I use "core services" a single pair publicly administered system.

The public administration rubric as being some sort of a banker only and I'll write the cheques does not speak to the problem. The fact of the matter is, if you look at the American models, people say oh well why are you concentrating on the American models, look elsewhere where's there's been experimentation the evidence is quite clear.

It is cost-effective and the outcomes are very very much better. The report documents this. There are two researchers from Harvard, many, I cite two of them Will Handler and Himelstein, Americans. What they did was they in 1991, in the report they studied the...just the administration costs and the overhead costs of the American system compared to the Canadian system.

It was audited by the GAO, the General Accounting Office of Congress and approved their numbers. They did an audit 10 years later, it's about to be published if not published already, Greg, same numbers. What does it amount to? In America \$1,150.00 U.S. overhead and administration costs in Canada \$325.00 U.S. per person, per year.

One of the irony's of it all is, that 60% in one way or another of the American health care system is financed by American taxpayers. Medicare, medicate and tax breaks which they don't account for, for individual people to buy in a private insurance and tax breaks for private, private for profit insurance companies to get me insured.

The net result is, nearly 100 million people are either uninsured or under insured and the result is that in 26 categories of the OECD, their heath outcomes in at least 24, if not all 26 are significantly worse than

Canada. What am I saying? I'm saying that if you look at the evidence and open, even at this late stage unfinished to see any study which disputes that.

So to me, the federal government has no power to pass a law, the delivery is a provincial responsibility. The constitutional hook for the federal government to get into this is the publically administration hook, that's why it's principle number one of the Canada Health Act and why I recommended it should not be changed. That is their hook and the federal spending power, that's the Canada Health Act.

I think if the evidence is there it only makes sense. Ideology aside for all governments, provincially, federally and territorially, to give the costs dollar and health dollar outcomes which work.

🕒 (1635)

**The Chair:** Thank you Miss Wasylycia-Leis. Mr. Castonguay.

[Français]

**M. Jeannot Castonguay (Madawaska—Restigouche, Lib.):** Merci, madame la présidente. Merci, monsieur Romanow d'être là et merci pour l'excellent rapport.

Vous savez, j'ai passé plus de 25 ans à travailler comme médecin dans la province du Nouveau-Brunswick et très souvent je disais, lors de mes discussions, qu'il fallait dépolitiser le système de santé, parce que c'était l'une des difficultés qu'on avait. C'était des gens qui se pointaient du doigt, qui s'accusaient l'un et l'autre, du *buffering* comme vous l'avez mentionné. Je pense que si on veut avancer, il va falloir sortir de là maintenant.

Lorsque je vois ce que vous suggérez, le *health council*, ma perception--corrigez-moi si ce n'est pas correct--est que je crois que c'est un outil qui probablement pourrait nous aider à aller de l'avant pour dépolitiser un peu le débat. Ça fait deux ans que je suis ici, que je vois encore la politisation dans la santé et ça m'écoeure. C'est aussi simple que ça.

Je sais que vous avez parcouru les provinces, vous avez parcouru le pays, pouvez-vous nous donner votre *feedback*? Comment est-ce que le *health council* semble être reçu par les différents gouvernements provinciaux d'une part? Quel est le pouls à ce niveau-là? Vous avez mentionné également que ceci représenterait moins de bureaucratie plutôt que plus, alors qu'on entend des commentaires parfois que ça va encore rajouter de la bureaucratie dans le système. Est-ce que vous pourriez élaborer sur ce sujet-là?

[English]

**Mr. Roy Romanow:** On the ...

[Français]

Merci, docteur Castonguay.

[English]

On the latter part and when I say this about our commission report, I want to stress while I support everything that's in here obviously, maybe somebody can come up with a better idea. And when I make a defence, it's not because I'm saying it's this or nothing, not the case at all. But in our report, we said bring in CIHI, the Canadian Institute of Health Information, bring in COTA the technology assessment agency,

currently existing bureaucracies and put it under a health council of Canada, of eminent Canadians involving caregivers like yourself, the public, specialists in the field and government people and streamline the bureaucracy.

One of the things which astounded me was that there were five I think federal, provincial, territorial committees of health each one of which had six task forces underneath them, 30. Nobody knows what these studies are all about. I'm sure that, Judy as a former minister of health in Manitoba will know that's the case. You have to streamline and prioritize that. So there's where the argument is about no bureaucracy.

On the issue of what the reaction is, the province's reaction I think is well covered in the newspapers. Some think as we heard Monsieur Menard speak that it's invasion of provincial jurisdiction. I must remind the committee that when the Social Union Framework Agreement was written in 1999, there was a specific paragraph headlined called accountability and transparency related to health care and future health care programs and reforms to which all of the premiers and the Prime Minister signed on. To be fair, with the exception of Monsieur Bouchard who was then the Prime Minister of Quebec. This is not new. So the provinces vary. I don't understand why it was acceptable in 1999 but not acceptable today.

As for the public, I'm sure there are some who don't agree with it but I can tell you that very early in the public hearings and even before that, in the consultation and in the citizen participation, in the decision making, two different concepts but related, overwhelming support for accountability. Canadians are simply seeking it, they're demanding it to be blunt about it. That's my assessment of it. Why? Because they want to know, they want it depoliticized, it'll always have an element of politics to it, but depoliticized and they want to make judgments based on solid facts and data.

🕒 (1640)

[Français]

**M. Jeannot Castonguay:** Est-ce que vous iriez jusqu'à dire que si on avait eu si peu à mettre en place ce *health council* on va avoir encore de la difficulté à dépolitiser le débat sur la santé?

[English]

**Mr. Roy Romanow:** If the health council does not see the light of day, I think, mixing metaphors, the heart and soul of health care reform which has been so well started by the first ministers will have been removed. This is all a package. A health council monitoring how much money is spent, for what purposes to buy change, not more, more, more money. That hasn't worked. When I was premier, I was there, we picked up \$24 billion in 2000 and one year later the Prime Minister set up a royal commission and here we are after the royal commission with \$35 billion, they gave us \$30 to \$35 billion I think is the range. That's the amount of money.

**Dr. Gregory Marchildon (Former Executive Director, Professor and Canada Research Chair in Public Policy and Economic History, Faculty of Administration, University of Regina, Commission on the Future of Health Care in Canada):** Not for health.

**Mr. Roy Romanow:** Not for health, oh the overall. If it just goes into straight circumstances without any conditional changes, it isn't going to work. So I think that the answer for me is obvious.

**The Chair:** Thank you, Mr. Castonguay.

Mr. Thompson.

**Mr. Greg Thompson (New Brunswick Southwest):** Thank you, Madam Chair. Mr. Romanow, it's nice to have you with us and I think we've all read Romanow cover to cover I would say by the questions that are being asked. But one of the questions I do have for you in regards to your report, your royal commission versus senate committee report, Mr. Kirby, was the fact that Kirby recommended a national insurance premium. I guess he called it a variable premium and now hidden within the bowels of your report, there's a very slight reference to that.

In fact, I don't have the report with me but I think if my memory serves me correctly, you said something that might be considered in the future but basically something we probably wouldn't need at this point but suggesting that maybe we'll have to go down that route at some point. And I do know that you took the opportunity to examine some of the European models that have successfully used premiums over the years. So if you could comment on that, sir and then I don't want to get away from Mr. Menard's point on drugs, catastrophic drugs.

I guess the question I have to you, the catastrophic drug costs for individuals, it's something that I've personally experienced. But at what point do these drugs, these catastrophic drug prices become catastrophic for the state, that is the ability of the government to pay. In some cases, up to \$10, 000 for a month's supply and some even more outrageous than that. So those two points, sir, if you could ...

**Mr. Roy Romanow:** Mr. Thompson, first of all, speaking to the Senate report, which is a very good report, as I recall there were a number of options set out for financing it.

Premiums was one that was raised by Senator Kirby. But on the issue of premiums, they exist as we know in Alberta and in British Columbia, and they've existed in a number of jurisdictions, including my home province of Saskatchewan. The problem with the premiums as I see it basically are two-fold, two problems, at least two-fold.

One, you need a very high premium in order to get real money to finance the health care system, thus you'll see in Alberta and B.C., a rather, in my judgment--I don't want to get involved in political fights with my former colleague Ralph Klein and Premier Campbell--fairly substantial increases in the premiums.

I know that governments which have not had premiums have looked at them and they've decided that the big barrier was, you would have to put something in the neighbourhood of \$1,200 for a family of four, which on top of drug costs, which I'll say a word about momentarily, is pretty expensive.

The second argument is one of principle. Is it a fair tax? Because that's all it is, it's a tax. Some people in Alberta, my friends say "It's not a tax, it's a premium". It's a tax. If you're making \$100,000 a year and you're paying \$1,200 for a premium that's one kettle of fish. If you're making \$45,000 a year and you're paying \$1,200 a premium that's an entirely different kettle of fish. It's not geared to ability to pay. As much as we may have reservations about paying taxes, I think the only fair method is based on ability.

So I think those are two show-stoppers on premiums. The best method of financing still is on the ability to pay income tax, progressive income tax system, in my view.

Your point on drug coverage I think is excellent. That is why in our report, we recommended entering into this very cautiously. Namely catastrophic to begin with, and limiting that by tying it to what we call "prescription management" into certain diseases. Roughly 5% of Canadians consume 40% of the drugs. The average cost per family is \$1,200 a year, annually. We need to make sure that the combination of prescriptions and the kinds of drugs, and the kind of diseases to which they're addressed.... There are five categories that account for about 60% of the drugs for the illnesses; 60% or so, or five categories--psychotropic, heart disease, cardio-vascular, high blood pressure, various drugs underneath them. These are

the bulk. You have to manage that very carefully. You cannot overnight move into a universally covered drug care plan.

I want to see that as an eventual goal, but only after there is fine calibration, including prescription policies, including the actions of everybody from the pharmacist, the doctors to the patients and their demands. Calibration. In the meantime, what I think is important is to save catastrophic costs.

Sorry again for being longwinded.

I heard case after case of people coming to me and saying, if I'm right on this, for rheumatoid arthritis: "You know, I have to pay \$20,000 on Remicade a year". Or if you have CF, cystic fibrosis, it's incredible. This can't work in a country as ours. So we have to start with some catastrophic care and then very delicately move into the question of possible universal expansion, but only after we get the data to mix and match the prescription with the need.

🕒 (1645)

**The Chair:** Thank you, Mr. Thompson.

Madame Scherrer.

[*Français*]

**Mme Hélène Scherrer (Louis-Hébert, Lib.):** Merci, madame la présidente.

Merci beaucoup d'être ici, monsieur Romanov, aujourd'hui. J'ai effectivement survolé votre rapport, je ne peux pas vous dire que je l'ai lu effectivement d'un couvert à l'autre, mais suffisamment pour m'apercevoir que finalement votre rapport fait une évaluation et un bon profil de la situation du système de santé au Canada et je pense que vous identifiez très bien les faiblesses et les manques du système actuel et vos recommandations portent surtout pour répondre aux besoins, mais j'avais l'impression que les recommandations allaient plus dans le sens de répondre aux besoins actuels et dans un relativement court terme au niveau des manques et des faiblesses majeurs que le système connaissait. Vous identifiez très bien des facteurs qui font que la croissance des coûts monte de façon pratiquement exponentielle et quand on parle par exemple du coût des médicaments--dont on parle régulièrement--on parle du coût des équipements, on parle des ressources humaines, des coûts des ressources humaines qui coûtent très cher aussi, mais dans mon esprit à moi, même si ce n'est pas facile, chacun de ces facteurs-là peut peut-être se contrôler par un signe de piastre à l'autre bout, c'est-à-dire un investissement financier.

Je reviens toujours sur la même chose parce que pour moi c'est important également. Je ne retrouvais pas de façon très musclée dans votre rapport un investissement au niveau de la prévention et pour moi la prévention demeure une façon de diminuer les coûts à beaucoup plus long terme et quand je parle de prévention, je parle d'intervention directe auprès des habitudes de vie des Canadiens.

Quand on regarde les dernières statistiques, et je suis toujours apeurée de voir les dernières statistiques où on voit que le taux d'obésité devient pratiquement effarant, le tabagisme devient un facteur très important chez les jeunes, la sédentarité aussi. Et quand on regarde souvent les crédits et les budgets qui sont accordés dans chacun des budgets de santé tant au niveau provincial qu'au niveau fédéral, le budget qui est accordé vraiment à l'investissement au niveau de la promotion de la santé et au niveau de la prévention est pratiquement ridicule. Est-ce que c'est parce que, politiquement, ce n'est pas vendable? Parce que, en tant que politicien, vous savez que ce n'est pas facile de prévoir des investissements qui vont rapporter uniquement dans 10 ans, dans 15 ans ou dans 20 ans ou si c'est sur le terrain quelque chose dont les gens ne

vous parlaient pas du tout ou si vous personnellement vous n'avez pas l'impression que c'est une façon très importante de réduire les coûts de santé à très long terme?

🕒 (1650)

[*English*]

**Mr. Roy Romanow:**

You're right, Mr. Thompson, it looks like everybody has read the report. I hope you haven't fallen asleep in the middle of the night in doing so.

Let me, again without any defensiveness--I'm here to try to help the committee and provide the best advice and knowledge and experience that I've garnered--when I say that, with respect, I don't agree with you on the contention that we don't talk about the role of prevention.

One could argue maybe we should have devoted more pages to it, but without getting into too much detail, at page 128 straight through to 134--under "Primary Health Care and Prevention", that chapter--we stress the need for prevention in population health, but as a part of primary health care.

I think one of the problems of medicine, so doctors and others tell me, is the stovepiping. You know, there is the primary, there is the acute, there is tertiary, there is the wellness, and it's got to be into an integrated approach.

Secondly, so much good work has been done in this area by people like Marc Lalonde and Mr. Jake Epp, others who have studied wellness, we could only add to it by way of some modern additional information as I did by noting, for example, the Federal and Provincial/Territorial Ministers on Sport, Recreation and Fitness.

So we recommended the need to really pump money into prevention and population health, going so far as to recommend a national immunization strategy for children which I think everybody says makes absolute good common health sense and costs money down the road.

And the need to deal with obesity, which is identified at page 129. Smoking, we say, costs more than \$16 billion a year to our economy, including \$2.4 billion in health care costs. It's \$13.6 billion in... Well, you and I agree on these figures. And on it goes.

So I would argue that we did try to focus in on it but we did not want to put it into an isolated category because I think the best way to do it is to make this as the primary health care model. When I go to my doctor, at first point of entry, he or she is going to say to me, what is my lifestyle? What is my intake of food, my physical exercise? Do I smoke? Do I drink, etc., and how do you manage this? Then some analysis and try to reorient me in this regard. I didn't think that it deserved--it deserved, in a way--but I didn't think that it would do anything but stovepipe the demarcation. We don't need that.

I heard it at every stop. People were saying to me at every stop, "Prevention and population health". In fact, Dr. Bennett was talking about the Atkinson Foundation and this is one of the areas I'm going to at least be trying to look at to further augment the report.

I don't say that defensively. I just simply say that it's there.

🕒 (1655)

[Français]

**Mme Hélène Scherrer:** Je veux simplement mentionner que souvent on regarde autant le budget au niveau provincial que le budget au niveau fédéral et on s'aperçoit qu'effectivement c'est un voeu pieux, que tout le monde ont d'excellentes intentions. Mais quand on arrive pour traduire un investissement financier ou un montant comme tel, ça se traduit tout le temps par un montant qui est pratiquement minime versus l'ensemble du volet complet, qu'on parle d'activités physiques, d'un programme ou d'un autre ou de prévention, on s'aperçoit finalement que ce n'est pas un montant important.

Alors, je suis contente de le voir et je trouve qu'on devrait effectivement le recommander de façon beaucoup plus importante, que ça se traduise par des montants d'argent.

[English]

**Mr. Roy Romanow:** I don't disagree with you about focusing more and more, but I do disagree with you about us not focusing on it. Because under chapter 5, Primary Health Care and Prevention is the title of the chapter, and you've read this.

“To”--very quickly, Madame Chair, with your permission--“integrate prevention and promotion initiatives as a central focus”--promotion, prevention--“of primary health care targeted initially at reducing tobacco use and obesity and increasing physical activity in Canada, implement a new national health immunization strategy”. Then we enveloped the primary health care fund with a \$2.5 billion targeted, you've got to make the change to achieve these. Now, I agree with you, we need more, but I think that it's in there.

**The Chair:** Thank you, Madame Scherrer.

Mr. Lunney.

**Mr. James Lunney (Nanaimo—Alberni, Canadian Alliance):** Madame Chair, I believe Ms. Skelton had her hand up ahead of me, actually.

**The Chair:** No, first round, if Ms. Skelton wishes to go, that's fine, but she did not indicate, so it will be Mr. Lunney.

**Mr. James Lunney:** Thank you, Madame Chair.

On the same vein, Mr. Romanow, when you concluded your remarks to us you expressed your hope that this agreement will help to restore the health care system in Canada to the best system, and alternatively, Canadians to the healthiest people. Similar to my colleague here, you went on to express there that Canadians expect the government to invest more in wellness and prevention and to promote self-reliance.

I'm just trying to clarify something here, because Madame Chair here just brought up the prevention issue, but there is an inverse relationship between remediation and prevention equation and the disease management system that we have in Canada. Largely, our medical model is one of disease management.

Many of these remedial interventions are on the side that is outside the public investment domain, that is your chiropractors of which there are about 7,000 in the country, your naturopaths of which you have about 1,200 in the country and Canadians are paying out of their pocket to access these services.

You seem to understand this, but our governments are so strapped with the disease management side of trying to manage sickness that the more we invest or put money into the disease management the less money provincial governments have to invest on the remedial management side.

That's certainly true in British Columbia where they just cut the \$50 million that they had and were investing in chiropractic, for example, which I'm sure the commissioner knows of the studies here in and so on, the health care economists have shown that chiropractors alone could save up to \$2 billion in managing low back pain. But you mention that in chapter 4, you seem to understand that we talk about allied health professionals, and I had it marked here, moved my page a little bit....

There it is, in recommendation 15 where you talk about the need to improve the supply and distribution of health care providers, encourage changes to their scopes and patters of practice and ensure that the best use of this is made in the mix of skills of different health care providers. You mention that also, in the earlier page you talk about specifically, beyond the focus on nurses and doctors are numerous issues that affect other health care providers as well.

My concern is your report, although is mentioned to this lip service, the reason the Health Care does absolutely nothing to tip that equation in terms of remediation and prevention.

**Mr. Roy Romanow:** Well, Mr. Lunney, with some modification to your comments, in my view, I say that the primary health care model and the special targeted \$2.5 billion, which now is part of the reform fund, does not prohibit the inclusion of people who are in naturopathic work or chiropractic work. In my province of Saskatchewan, long before this Royal Commission was set up, we in fact covered a lot of the chiropractic work. It's a question of primary care of primary care teams. It's up to the provinces to take up the money and say, this is where the appropriate inter-disciplinary mix of professions will work or not work.

If you argue that I did not say, therefore we should be putting money into naturopaths, etc., you're right. I'm not writing prescriptively what should be the one size fits all for every province or for every jurisdiction. It may be entirely something different say, in Nunavut. I believe it can be totally different in Nunavut. They need to develop their primary care and their wellness models in an entirely different basis.

In Nunavut, just to give you an example, their biggest problems are dealing with mental illness, alcoholism, suicides, housing, which is in the realm of health care and maybe not in the realm of health care. They have to get primary health care needs to deal with those problems. I'm not going to say to them, you need to have a naturopath. Maybe in B.C. or in Saskatchewan. Nothing prevents the provinces from picking up on it if they want to.

🕒 (1700)

**Mr. James Lunney:** Given the inverse proportion relationship between money spent on remediation reduces the burden on the disease management side, I think it's becoming better understood, it's certainly been obvious for years. Roughly, you've got over 8,000 practitioners out there who are qualified and who could take quite a bit of the burden off the disease management side if their services were better accessed. What would you recommend can be done to encourage provincial governments to take seriously the benefits of remediation and prevention in distributing that \$2.5 billion or accessing it?

**Mr. Roy Romanow:** I think that it's there in the report. Clearly, I know you don't share and I respect your point of view quite sincerely, but I think it's in the report in the sense of flexible wording and options which permit the provincial governments and the provinces to tailor their programs according to their needs; the Nunavut example that I gave you.

For example, I say team work, inter-disciplinary collaboration. When I say, inter-disciplinary collaboration, I'm not talking doctors and nurses, I'm talking inter-disciplinary. There are people who will go to chiropractors, we all know that, or naturopaths and use them. It is from all health care providers and to devise a 24-7 program to see that it's achieved.

My point being, that may not be specific enough and it may not be motivational enough. If that's your point, I certainly get that very, very clearly, but it was my intention to say, I'm not going to cross every T and dot every I for a province. I'm going to simply say to you, you've got the right and that fund is going to be targeted for you to be motivated to use this kind of inter-disciplinary collaboration.

**Mr. James Lunney:** I have one last very small question and I appreciate that comment, we need to see more of an emphasis I think in that direction.

The last one has to do with catastrophic drug costs. We touched on that, catastrophic drug costs. I was at a function recently where the Health Minister attended and she was asked, how would this be implemented? How would the dollars be accessed and how would this \$1.5 billion for catastrophic drug costs be administered? Frankly she didn't really have any idea.

I think we touched on that just earlier about where do you draw the line. I guess my colleague here raised the issue. What parameters are there? Are you aware of any parameters that are being discussed on catastrophic drug management at this present time or other models across the country?

**Mr. Roy Romanow:** I don't know what the federal government's approach or what their studies show, but we based our recommendation on the evidence and the research which we uncovered. May I mention the sources? The Manitoba health centre was our primary research area, but we also tried it out on two or other provincial drug plans.

Manitoba taught us, as I cited here earlier, that the average cost a year for drugs is \$1,200. So we assumed, that being the current cost that we all carry ourselves unless we're covered through a private insurance plan, an employer plan of some nature, we would leave it there. But anything over that, namely, \$1,500 you could draw \$2,000 and anything over that, by definition, becomes catastrophic. Then we tried a couple and I won't repeat my answers to Mr. Thompson with respect to disease management and the like.

Now you can model it in any way you want to. Senator Kirby, I think, recommended the line being at \$5,000. I chose the \$1,500 because it was above the \$1,200 which is the average for Canadians. I felt it was akin to what the actual needs were.

Work has to be done and you'll notice there from Mr. Lunney that the key of this recommendation was that we would not pump in money if they adopted our recommendation on catastrophic drug until 04-05. Do the preliminary work carefully. The provincial drug plans are up and down. Some coverages are wider than others, some are limited to social assistance. You need to somehow get all this data before you start moving tentatively into a national program.

🕒 (1705)

**The Chair:** Thank you.

Would Mr. Lee like to have a turn, seeing as he's sat here with us? No?

Would Ms. Skelton like to have a turn?

We'll start into the second round then and with our alternating system, it'll be Ms. Bennett and then Mr. Merrifield.

**Ms. Carolyn Bennett:** On the legislation that you'd called for and you'd called for a principle six on accountability, is there another way of going about that? Some people have thought that one of the main jobs of the House council would be transparency and accountability. Would you see that it has to be a six principle of the Canadian Health Act or would you think you could do it in some sort of legislative framework of setting up the council, that the transparency and accountability, say, part of the reporting structure, maybe not voluntary reporting, but that you could set up an accountability principle in effect, but around the legislation that would enshrine the council?

You mentioned the Social Union Framework Agreement which did talk about transparency, accountability, allowing Canadian to set priorities, reporting to Canadians on an annual basis, it's all sort of there in the SUFA framework. One of the interests to me was, of course, your consultation with Canadians which most of us feel was the best that's ever been done. Would you or Michel or Greg have any comment on the capacity of the council to be able to keep doing that, keep having a conversation with Canadians? If it's about the trust Canadians have in the system, how would you see this council's ability to continue on with the deliberative democracy, the online issue polling hearings? How would you see that look so we didn't have to have a commission every five years?

**Mr. Roy Romanow:** Dr. Bennett, on accountability, I'd simply make a very brief comment. I felt the legislative amendment was a statement to Canadians generally as opposed to governments or caregivers in compliance with their clear request to me that be set out. I thought it was a clear-cut six principle which was obvious. Can it be done otherwise? Maybe. With respect, I'm not sure it can be done through a health Council of Canada, this being dependent upon the people who make up the health council and it may be up and down, but with some statutory base, it would clarify it.

Again, mindful of the time, Madam Chair, but with your permission, what I'd like to do is call on Mr. Marchildon briefly and Mr. Amar, who were very helpful in the citizen participation consultation, to make a quick comment on your second part which I think is very interesting.

**Dr. Gregory Marchildon:** Thank you very much.

I think there are two ways in which the Health Council of Canada can play that role. One, obviously, is through representation on the governing council, if I can call it that, and direct public representation, and those individuals should be feeding back to the general public.

A second way, through engaging in--and this is the Health Council, itself, now--citizen engagement exercises on particular issues, adopting a similar methodology so that the very difficult trade-off issues are dealt with properly during these kinds of processes; in addition, too, what you would expect, the feedback, through annual reports and through occasional discussion papers, etc., the more passive forms. But I think there could be very much a role for this very active citizen engagement process. Of course, done appropriately and done in a way that will get the kinds of rich answers that are needed.

🕒 (1710)

**Mr. James Lunney:** Michel, very quickly?

**Mr. Michel Amar (Former Director, Communications and Consultations, Commission on the Future of Health Care in Canada):** I'll just comment quickly because I think Greg has pretty much covered it.

There is a real distinction between consultation and engagement that I think the health council has to take account of. One of the reasons our public consultations and our engagement strategies were successful was because we did a significant amount of public education before going out into the public. I think there are opportunities for the council to use the periodic reports. It provides the basis for a good public education campaign. The council should do more than just issue a report and leave it at that. It should use the report for the basis for educating Canadians, consult on what the report means and what to do about, and, as well, provide opportunities for Canadians just to feed in their views and perspectives on the health care system.

**The Chair:** Thank you, Mr. Lunney.

Mr. Merrifield.

**Mr. Rob Merrifield:** Thank you, Madam Chair.

Why don't we just pick up on that a little bit while we're in it, with the health council. It's very interesting, what I see as the potential to be a good thing. It's not that I wouldn't be negative about it, but I see a government that has a history of studies and not so much a very good history on accountability or best use of dollars.

This government has spent \$243 million just studying health care since it has come to office. Nonetheless, when you say, Mr. Romanow, that you're recommending this federal government and this health council would actually save money and be not an addition to bureaucracy, but actually a limit to it, I would say, "Well, what is it going to replace that was going to save a significant amount of dollars?". That's number one. And two, what kind of co-operation do you expect from the provinces, with regard to some of the aggressive nature of the committee that you perceived it to perhaps take on?

**Mr. Roy Romanow:** Well, Mr. Merrifield, first of all, I would stress again that my vision of the Health Council of Canada is that it is an intergovernmental body and not the federal government's alone. It would not work as the federal government and I did not recommend it as the federal government. It can only work if the federal-provincial-territorial governments, as part of our federation, buy into it. Of course, I would argue, bought in by the caregivers and the citizen groups. Therefore, if that buy-in is achieved, we've reached a huge plateau from which, then, we can build.

On the issue of the saving of money, it is, as I said, in response to somebody else earlier here, we have a dizzying array of advisory committees doing very good work, but this is work which, in some ways, is simply lost. It's just too wide and too diffuse and needs to be somehow more focused. So I argued that it can be made to save money, it being an intergovernmental body.

My idea is not getting very far when I talk about bringing CIHI into it, but CIHI is a wonderful database. CIHI is data, but it doesn't take the data to policy. That's where a health council might bring it to policy. There you have CIHI already, bring it in. Bring in COTA, the technology assessment: is it good technology or not, and maybe trim some of these ministerial committees.

So my argument is that it can be done, and I think it can be done without an additional wallop of taxpayers' money, if it is done this way.

**Mr. Rob Merrifield:** Lots of if's there and you know I'm not arguing that perhaps if we have full cooperation with the provinces there may be some economies of scale of savings. That's a very noble idea and hopefully it could be achieved.

But where I hear some of the provinces and the premiers comments coming out of the accord I suggest to you that perhaps the idea of this health accord and the vision that you have is significantly different than theirs. If they're going to get by and I don't see it happening, when we have this report carding actually happening. I think the first one was last September and really the provinces are saying, well they're doing this now, they're just going to give it to the federal government, they can do what they like with it.

I don't know how you take those comments but I certainly don't see the cooperation there. Am I reading it differently than what you are or do you still think there's a dream there?

🕒 (1715)

**Mr. Roy Romanow:** Somebody said, maybe not here, but today in the various meetings I've had about being ever an optimist. Let me say I just don't think we know yet Mr. Merrifield about the Health Council of Canada. We have until May 5, I think we have...I mean this is an non-partisan terms, a very effective Minister of Health who has experience in governmental affairs, which is a non-health related area in which she has to work with her colleagues.

Let's see what happens. It may very well work out that some combination of appointments/mandate will work. So there are if's, there's no doubt about it but I think those if's are very perfectly manageable given political will and leadership.

**Mr. Rob Merrifield:** Okay speaking on that one, my other question is, there's been a lot of talk about who is going to perhaps Chair this council, you know Mazankowski, Kirby or your name, is that something that you'd like, if it was offered to you, would you Chair the council?

**Mr. Roy Romanow:** Would you nominate me Mr. Merrifield?

**Mr. Rob Merrifield:** You know, I'll tell you what, I would if you would work collaboratively perhaps with Mr. Kirby and Mr. Mazankowski on that same council.

**Mr. Roy Romanow:** Well I want you to know that leaving the council aside, I'll get this just off my chest, I've had a very good working relationship with Senator Kirby and with Mr. Mazankowski, with whom I go back a long way, actually Kirby and I go back even further, back to 1980, on the constitution days, I know time is running out, so there's no problem working and agreeing where we can agree and disagree where we disagree.

Anyway my point is, I think that the minister's of health are charged with this task. I'm out of the picture they have to make their choices in the best interest of the provinces in the country.

**Mr. Rob Merrifield:** Was that a yes or a no?

**Mr. Roy Romanow:** I'm out of the picture.

**The Chair:** Thank you Mr. Merrifield. Mr. Castonguay.

[Français]

**M. Jeannot Castonguay:** Merci, madame la présidente.

Vous avez mentionné tout à l'heure que l'accord qu'ont signé ou n'ont pas signé les premiers ministres en 2003 sur la santé était un premier pas important, *a major first step*, ce qui laissait sous-entendre évidemment

qu'il devrait y avoir d'autres pas à faire pour, si je comprends bien, réaliser la vocation du rapport que vous nous avez soumis. Maintenant, au point de vue pratique, qu'est-ce que vous considérez comme un échéancier qui est raisonnable et réaliste pour mettre en place un tel programme parce que, vous voyez, j'avance en âge et j'espère qu'un jour je pourrai bénéficier de vos recommandations.

**[No Salutation Found] UNKNOWN UNKNOWN:** Tu vas vivre jusqu'à 120, Jeannot.

*[English]*

**Mr. Roy Romanow:** I'm with you on the latter sentiment.

Well this is not a flippant answer when I say my reasonable timetable is the one that we set out here, which is two years. Some don't agree obviously and I'd like to think it's a correctly analysed and well-argued case but I can't deviate from that because I'd be deviating from my report.

May five, ten, fifteen years from now when you and I are around somewhere, we might be able to say this was wrong and this is right but I think it can be done and could be done and should be done. Although it's a pretty impressive achievement 2003, that's my timetable, two years.

**The Chair:** Thank you Mr. Castonguay. Mrs. Wasylycia-Leis.

**Ms. Judy Wasylycia-Leis:**

Thank you, Madam Chairperson.

I'm going to ask three questions, very quickly, all unrelated, but I'm going to get cut off. Maybe the chair will give you some leniency in answering them?

First, back to the privatization issue. I appreciated your very thorough and clear answer. It seems to me that in the area of the threats to Medicare, commercialization in the area of diagnostic services is probably the greatest area for concern right now, given what's happening in some of the provinces. In your report you recommend in fact that there be a clarification to ensure that diagnostic services are covered under the Canada Health Act. I'd like some comments on that. What do you think it would do in terms of this whole area? And what we can do to advance that issue? And what benchmarks would you suggest to guide the current sort of experimentation in this whole area of for-profit delivery of public paid for services.

Secondly, with respect to the national drug agency, which I think is probably one of the most important recommendations of your report and probably the one that hasn't received enough attention, it seems to me that the provinces have already agreed to collaboration in terms of sharing of information and admission of new drugs into the health care system. Your proposal seems to build on that. Do you see any obstacles in terms of from the provincial side of advancing this proposal? And how do we in fact do as you've recommended; get the first ministers to delegate the authority to ministers of health to pursue this on a priority basis? And I'm referring to your February 19, 2003 speech.

Thirdly, with respect to the area of the health council, I'm glad you've reminded us that in fact there's only one month before in fact the deadline for the establishment of this council should have happened. I don't think we've heard anything from the Federal Minister of Health about developments in this area. In fact, I think, the health committee--although I'm not a permanent member--should actually be pushing the health minister for a status report on this matter. I was going to ask what you would recommend as critical components of this council, but you've already answered that in part. I'm more interested in how you think we can kick-start the process and get this deadline achieved by May 5, but along the lines that you've

recommended in a much broader way than appears to be the case with the federal minister of the First Ministers' Accord?

🕒 (1720)

**Mr. Roy Romanow:** Those are three very tough questions. I'll try to be very brief, Madam Chair, although they really require more length in explanation.

First of all, on the MRI diagnostic services issue, there are those who argue that this is, in their view, covered currently by the Canada Health Act under the diagnostic provisions which are related to hospital care through MRIs. And diagnostic doesn't necessarily mean advanced diagnostics only. It means blood tests and things of that nature, all of which are diagnostic and are covered by the insured services. But it is clear that there is a grey area when it comes to advanced diagnostics, in my judgment, outside of hospitals in particular. And we also note something else, that Canada now has fallen below the OECD countries average of advanced diagnostics like MRIs and CAT scans.

Well, everything abhors the vacuum, and so therefore that vacuum is filled, and outside hospitals and perhaps even inside hospitals, it's filled for sure outside hospitals by the private-for-profit sector. People demand that they be able to access advanced diagnostic equipment.

By the way, one of the biggest sources for waitlists getting that MRI or the CAT scan. Well the answer for us is clarify the problem by legislative amendment, invest money, which I am pleased again to commend the Minister of Health by her announcement through the MRI program which speaks to much of the issue of private versus public. It needs to be carefully analyzed in my view, but that's another discussion. So that is the rational. We're behind. We need to catch up, and the way to do it is to clarify it under the public service, the public funded service because if it's true that hospitals in their diagnosis are best carried out efficiently and for health outcomes through the single parent public system, the very heart of the 1984 Canada Health Act, it must be equally true therefore that MRIs are part of that as well. It's a natural extension.

You could put guidelines in there. You could say if they're outside of the hospitals into other sectors, you can't queue jump, you can't extra bill, and you've got to be CHA compliant. That's a level playing field, and anybody on the private-for-profit sector would have to follow that. And then there would be a real question on the private-for-profit side whether or not they could make a go, namely a private-for-profit if the field is equal to the public sector. That might help and I know it's the Ontario government's approach to it.

On the NDA, I'll only simply say this. On page 202 of the report, in detail, we set out what it should be responsible for. Without taking up more time, I'll simply read this: "establishing and managing a common national drug formulary to ensure that decisions on including or excluding particular drugs are based on the best available clinical, pharmacological and economic evidence". There are many more other issues.

Let me say from my personal experience as a premier, there's one which I didn't mention but perhaps I should have, and that is political pressure. Under the current system, if Manitoba adds something to its drug list which Saskatchewan does not have on its formulary, the pressure immediately mounts. You should have arasept, for example. One province does, another doesn't.

It's the breakdown of the national system, Mr. Merrifield, it worries me a little bit in our little discussion. If you leave it strictly to the provinces, then it depends upon capacity. Some drugs are covered to a larger extent in some provinces than others, some diagnostic and others, and you have a patchwork quilt of 13 or more regions which take place, thus the national standard.

This can be done. It won't be easy, but it can be done, and I would argue politically that it makes sense to do because then the premiers aren't, how should I describe, blackmailed--that's a hard word to use--politically because one province does it and you haven't done it. Well anyway, it sets it out in 202, and I think it could be managed.

On the issue of the HCC how to kick-start, I think there's only one way to kick-start it, and that's to get it done. I'm less concerned about it having an extensive mandate, am less concerned about many aspects of the report or other reports as to how it's done, but I think what my main concern is that there be men and women of quality who get going, even limiting themselves to the accord as the mandate in the first instance.

🕒 (1725)

You can expand it through trust and through confidence over the long period time.

By the way, Mr. Merrifield, I didn't mean to be critical and argue with you. I know what the rules of the committee are, but if you want to come back at me, if the chair will allow.

I didn't want to debate. That's the answer to those few points there.

**The Chair:** Thank you, Ms. Wasylycia-Leis.

With your indulgence, Mr. Romanow, I'd just like to tell the members of the committee that those who weren't here on Monday, it was a meeting to review a report. We can not review a report without 9 people present. There were not 9 people so I had to cancel the meeting. That meeting has been referred to an extra meeting next week which will be Tuesday morning at 9:00 a.m. I am hoping that most people will be able to be here so we can proceed.

In addition to the report there is another matter that has to do with having witnesses, on a different topic, witnesses who seem to be rather recalcitrant about coming and I may have to get your permission to use the power of the committee and the House to make sure those witnesses will come. That will require votes also. We have a potential motion from Madam Scherrer that we might want to vote on.

So Tuesday morning I will require at least 9 people and preferably the whole committee. Monday afternoon we will be hearing witnesses and three members will be sufficient to hear witnesses.

I'm sorry to have interrupted, but I had a feeling people were about to leave.

Mr. Lunney will be the last questioner.

**Mr. James Lunney:** Thank you, Madam Chair.

I just wanted to pick up on the question about privatization, this terrible lion or dragon that's been creeping in. Perhaps the reason that Canada falls outside the accepted OECD levels for diagnostics is because of the huge amounts of dollars that are going into...we're one of the few countries that they are trying to carry on a single pair system here basically and the huge amount of dollars, where there's no competition, cost spiral out of control. There's no incentive in our system for cost effectiveness and that seems to be one of the big problems.

Just as an example, I'm sure you heard about the example of Sunnybrook Hospital and cancer therapy. The public sector could not get anybody to work after 6:00. They'd shut everything down in their cancer clinic there and the wait list was huge. Now I know this program, I believe, was just shut down recently, but

there was a doctor with an MBA who took this on in terms of efficiencies. He said, turn it over to me in the evenings and we'll run it, the same equipment, in the evening hours, the same protocols. Over the course of a year they were able to treat 1,000 people in the same timeframe and cost that the public system could treat 600 and that's with a one week waiting period, they get in within a week rather than six weeks.

This is the dreaded private system that people are worried about. Now mind you the people getting the treatment didn't seem to object having to come in the evening for the treatment and the people working were not paid less, they were paid a premium for working in the evening hours.

Your comment.

🕒 (1730)

**Mr. Roy Romanow:** Well just a very brief comment--

--Sorry?

**Mr. James Lunney:** It was publicly paid for. I mean it was paid for with public dollars in the evening hours.

**Mr. Roy Romanow:** I'm not sure what comment I can make. I know time is running out, but if you would direct a specific question to me, are you asking me is this an efficient way, or are the health outcomes better, or more choice? What is it that you specifically want me to comment on?

**Mr. James Lunney:** Why is this model so scary to some people when there clearly are efficiencies that are escaping the public system in the present model? These are public dollars being spent in a private environment as it were.

**Mr. Roy Romanow:** My comment is basically two-fold. I don't think the evidence is there that there are efficiencies which are escaping the public system and only the public system. I think there are efficiencies that do escape public and private systems whether in health care or otherwise. It's the obligation of everybody to be as efficient as they can be.

I think the other issue is the question of whether or not, as a matter of values and principles in this country, we believe that the provision of health care...and this has been tried elsewhere by the way. Not only when you say Canada, the U.K. tried it and they're reversing it. In Sweden they've tried it, no more private hospitals. It doesn't work because of the simple fact that if you have extra ability to pay money you're in there, if you don't you're not in there.

**Mr. James Lunney:** The public system simply wouldn't work in the evening.

**Mr. Roy Romanow:** I don't want to get into a debate. My only comment would be, Mr. Lunney, that if we pay as a society  $x$  number of dollars after 6 p.m. to midnight to what I would call, just for the lack of a better name, I don't mean to be pejorative about this, a private-functioning system, as you describe, why wouldn't we be prepared to pay  $x$  number of dollars for a public system? There's no change in the money factor.

**The Chair:** Thank you very much, Mr. Lunney.

I believe that there could be some very strong clarifications on the example he chose to use. I think that if you talk to Dr. Bennett about it she's much more up-to-date on that particular Toronto experiment.

However, on behalf of all the committee members I would very much like to thank Mr. Romanow for coming back.

My question was going to be, “what can we do to push forward the agenda you outlined?” but I think the answer came up in the questions of my colleagues. It seems to me the first thing we should be doing is looking at that May 5 date and putting some pressure on our own minister to make sure that the health council, which seems to be key to the forward motion of all this is coming together in good time. By in good time I mean in or around May 5 as opposed to six months from there.

So, thank you for your guidance.

**Mr. Roy Romanow:** Thank you very much.

**The Chair:** Any time that you want our help and would like to drop a note to me, I know that my colleagues would love to hear what you have to say. If you think there's something else we can do in future to also push the agenda forward, please, do not hesitate to use us as you observe what's going on from your very unique viewpoint having been the author.

**Mr. Roy Romanow:** You're very kind. Thank you very much, Madam Chair, and thanks to all the committee members.

I will simply say in response to your request that I have every confidence in this committee and this House of Commons I really do. We'll sort it out. You folks will sort it out. I've done my bit and now it's up to you. So good luck and God bless you.

**The Chair:** Thank you very much.

This meeting is adjourned.

You'll recall that this room will be used for the briefing on SARS at 6 p.m.