House of Commons
CANADA

Standing Committee on Finance

FINA • NUMBER 089 • 1st SESSION • 38th PARLIAMENT

EVIDENCE

Thursday, October 6, 2005

Chair

Mr. Massimo Pacetti

Standing Committee on Finance

Thursday, October 6, 2005

● (0940)

[*Translation*]

The Chair (Mr. Massimo Pacetti (Saint-Léonard—Saint-Michel, Lib.)): Good morning, everyone.

[*English*]

Good morning.

Not everybody is here.

We're going to try to work this out as best we can. I've got to get this going because we have another group coming here in an hour and a half.

I just want to thank the groups for coming forward and appearing this morning and taking time out of their day. It's important for us, and I think it is important for the whole process.

[*Translation*]

Pursuant to Standing Order 83.1, the Committee is meeting to continue its 2005 pre-budget consultations. Witnesses have a maximum of seven to ten minutes to make their presentation.

[*English*]

It's for seven to 10 minutes. I don't want to cut you off, but if you can keep it within that timeframe, I would appreciate it. And the members are going to want to ask questions later on.

We can begin with the third group I have here, the Canadian Association of Retired Teachers, Monsieur Drouin.

[*Translation*]

Mr. Pierre Drouin (Executive Director, Canadian Association of Retired Teachers): Ladies and gentlemen, thank you for this opportunity to address the committee. I am here on behalf of the Canadian Association of Retired Teachers, which represents approximately 125,000 members through some 12 provincial organizations.

Our brief deals with six areas. Today we want to target three specific areas. Areas four, five and six are presented as cost-cutting measures in health care. This can be achieved only if the different levels of government co-operate more with one another.

We note on page 4 of our brief that the last federal budget contained a provision calling for a Seniors' Secretariat. This highly promising initiative could facilitate communications between government representatives and seniors' organizations. We would like to see an additional measure in place and we want the next budget to include special funding to allow senior's organizations to come together for discussion purposes. These organizations will need to identify common goals. Right now, many different submissions are made to the departments of Health, Social Development and Finance. It might be a good idea to reduce the number of briefs submitted through improved cooperation among seniors' organizations. The problem is that some associations have the necessary funds to prepare submissions, while other do not. For the sake of fairness, all groups representing seniors and volunteers should have some input in discussions on health and pension issues in particular. This is one of our recommendations which you will find on page 5 of our brief. We call for grants to be made available to a consortium of seniors' organizations so that the latter can fulfill its coordination responsibilities, gather ideas from seniors and draw up a list of issues on which the government should focus its attention.

The second area we deal with is caregivers. We know that many workers leave their regular job or cut back on their hours of work to care for a sick family member. The government has a duty to provide special compensation to these individuals for the loss of wages, seniority and benefits. Home care reduces the burden on our health care system. We also would like to see changes to regulations related to the Canada Pension Plan and to Employment Insurance so that caregivers are eligible for compensation to offset lost wages and benefits.

Some provisions of the Canadian taxation system are of more particular concern to us. We question whether a number of the budgetary measures implemented in fact lead to unfair situations. For example, the last budget proposed raising the ceiling on RRSP contributions to $22,000 in 2006. However, no mention was made of whether the ceiling was being increased to $22,000 while maintaining the 18 per cent cap on the previous year's income. The new $22,000 ceiling combined with the 18 per cent cap only benefits individuals with annual incomes of about $125,000. Clearly only high-income earners can benefit from this tax break. Another example of one such measure is the Registered Education Savings Plan. A person who contributes $2,000 a year to a RESP is eligible for a grant of up to $400. However, people earning around $40,000 would be hard- pressed to set aside $2,000 a year. We would prefer if parents were allowed to contribute whatever amount they could afford to this type of plan and still be eligible for such a grant.

On pages 9 and 10 of our brief, we discuss income splitting which would allow couples unable to benefit from the spousal RRSP provision to split their income in order to benefit from a more advantageous rate of taxation. It should be noted that the CPP allows for income splitting in order to benefit from a better marginal tax rate. Income splitting can also be applied to pension income in the case of a divorce. Couples can split pension revenues, something that they cannot do while married. Therefore, income splitting is a measure that should be considered for future budgets.

We have focused more specifically on certain recommendations. The age at which a person can currently convert an RRSP into an annuity or registered retirement income fund, or RRIF, has been lowered to 69 years. We recommend that the age limit be raised to the previous level, or even to 73 years, for the simple reason that people are now living longer. Increasing the age limit would allow them to keep some funds in reserve rather than force them to start drawing on their retirement funds at 69 years of age.

In recommendation 6, we ask the government to consider increasing the pension income deduction level from the current $1,000 to $2,000 or $2,500. This measure could benefit couples with lower incomes. Previously, a special deduction of $1,000 was allowed on interest income.We've noted that recent budgets have tended to favour more those persons investing in stocks and mutual funds, at the expense of those who choose GICs as an investment vehicle. Interest income has been overlooked and 50 per cent of capital gain income is now taxable. In our opinion, one class of Canadians is clearly being favoured over others.

WIth respect to medical expenses, we observe that increasingly, Canadians are being asked to foot the bill. We find the current formula where expenses are treated as tax credits to be unacceptable. If Canadians must pay expenses over and above those covered by provincial health plans, these expenses should, in our view, be treated as tax deductions instead of as tax credits. We're talking here about additional expenses not covered by provincial and private health insurance plans.

The same argument can be made for charitable donations. We feel that...

● (0945)

The Chair: Your ten minutes are up, Mr. Drouin. I must stop you there.

Are there costs associated with all of these recommendations? We asked you to identify two or three priorities, and you've come back with a list of 15 recommendations with no cost attached. If you have costed out your recommendations, I would ask you to share that information with the committee.

[*English*]

I'm going to go back to the beginning of the list—from the Canadian Association of Interns and Residents, Mr. Wright.

Dr. Nick Rose (Representative, Emergency Department, University of British Columbia, Canadian Federation of Medical Students): Good morning to the committee. I'll actually speak first.

My name is Dr. Rose, and I'm a first-year resident in emergency medicine in British Columbia at the University of British Columbia. I'm here today actually representing the Canadian Federation of Medical Students. Dr. Wright, sitting next to me here, is representing the Canadian Association of Interns and Residents and is actually a doctor from Alberta recently graduated in family medicine.

We'd like to thank you today for giving us the opportunity to speak to the committee on something that we think is of utmost importance to all Canadians. We're here today because CAIR and the CFMS are troubled by the significant burden of Canada student loans repayment that post-graduate residents in medicine are facing and by the negative impact this is having on Canada's health care system.

Last year at the 2004 first ministers meeting, the federal government acknowledged the significant barriers to obtaining a medical education. In a September 16 press release entitled “A 10-year plan to strengthen health care”, the government stated “The federal government commits to”—and they present a number of points, one of which is—“measures to reduce the financial burden on students in specific health care education programs.”

That's what we're here today to speak to you all about.

Specifically, while the cost of medical education continues to escalate across the country, little has been done on a federal or provincial level to offer respite to struggling medical trainees. Concern over the impact of increasing debt loads of medical trainees on Canada's health care system and over the health and well-being of those trainees has been reported in numerous studies.

For example, excessive debt has a direct impact on many areas, one of which is the choice of medical specialty that medical students are deciding to enter, i.e., higher-paying specialties versus family medicine. Another is the location in which new graduates decide to practise, i.e., rural versus urban areas. Perhaps most importantly, the debt load affects the accessibility of medical education to Canadians from different socio-economic backgrounds. This will be reflected in the future diversity of the physician population that will treat Canadians. It also impacts on Canada's ability to remain self-sufficient in the production and retention of physicians. And lastly, it will impact or has impacted on the health and well-being of students, residents, and new physicians.

These concerns have been most recently supported in a study entitled the “National Physician Survey” that studied Canadian medical students and residents and was undertaken by the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, and the College of Family Physicians of Canada, and most recently has also been referred to in a press release by Statistics Canada.

In response to this study, the Canadian Medical Forum petitioned the federal government to reconsider the unfair burden of Canada student loan repayment for postgraduate residents. They specifically call for an extension of interest relief and postponement of repayment of Canada student loans until the completion of the postgraduate residency period.

Immediate implementation of this recommendation by the federal government would represent a reasonable and modest investment in promoting a diverse and self-sufficient medical workforce. It would address the significant debt burden of residents, created in large part by insufficient government financial support for the costs associated with a medical training. Finally, the adoption of this recommendation would bring about a measure of equity with other postgraduate programs and recognize the role of residents as postgraduate medical learners.

A number of factors have contributed to the unimaginable debt loads experienced by medical students and residents. Almost all students entering medicine have completed a bachelor's degree or further graduate training. Statistics Canada estimates that students entering medicine enter with a total debt of approximately $33,000. These are numbers from the year 2000 and thus would be much higher at this moment. Additionally, medical school tuition has risen by over 200% in the past decade, with an average medical education costing approximately $12,000 per year. Funding from government sources, including both provincial and federal governments, does not even begin to cover the medical school costs associated with that education—and I'm not even talking about cost of living expenses; I'm talking about the tuition costs.

● (0950)

The CIBC acknowledges that personal lines of credit are now reaching the upper limits of $100,000 to $130,000 above and beyond government student loans.

According to a report by the Canada Millennium Scholarship Foundation entitled *The Price of Knowledge 2004*, medical students face significant costs during medical school above those of most other educational programs, and they have little opportunity to work due to heavy workloads at school. Many students are also forced to live away from home, incurring additional debt loads that might not be experienced by those people coming from urban areas.

I'll now hand over to Dr. Ryan Wright to speak about the postgraduate training period.

● (0955)

Dr. Ryan Wright (Representative, Doctor and Family physician, Canadian Association of Interns and Residents): Thank you, Dr. Rose.

Following completion of medical school, medical trainees must complete training in a post-graduate program, also known as residency, before they can become fully licensed and fully compensated physicians. While this training period is primarily educational in nature, residents are compensated, like other post-graduate learners, for their contributions to the education of other medical trainees, research, and patient care.

The average length of post-graduate training is 4.6 years, but can extend to 8 years or more, depending on the type of specialty or sub-specialty being pursued. During their residency training, residents continue to incur a number of educational-related expenses. For example, as a second-year family medicine resident last year, I spent more than $6,500 in areas such as registration fees and examination fees.

The skyrocketing costs of medical education have a significant effect on a resident's ability to repay their student loans during the postgraduate period. Repayment of loans begins on the seventh month following completion of studies, though for most residents interest begins accruing on those loans immediately after graduation. The combined cost of servicing government student loans and financing postgraduate training forces many residents to rely on commercial loans throughout their residency.

I'd like to emphasize the fact that many residents are borrowing money from banks so that they can pay back their government student loans. As referenced by Dr. Rose, these lines of credit are now reaching limits of $130,000 for many medical residents and students. Despite numerous reports on the inadequacy of government student loans for financing medical education, federal and provincial governments will only recognize monthly payments on government loans for the purpose of calculating interest relief. As we've mentioned, in many cases these government loans are only a small fraction of the total debt used to finance medical education.

The financial barriers to obtaining a medical education pose real threats to Canada's health care system and to the health and well-being of medical trainees. We realize that other students, such as those in dentistry and law, have experienced unprecedented increases in the cost of their education. However, the unique burden on medical residents merits government intervention for the following reasons. A dentistry student, for example, will enter the workforce at full earning capacity and is easily in a position to pay his or her loans. A law student articles for a very brief period, a year at most, during which their loans are under a grace period for six months. Residents, on the other hand, face an average of five years, and an upper limit of eight years, of training before they're at their full earning potential. Their salaries do not justify or permit repayment of their government student loans. Furthermore, as postgraduate learners at accredited universities in Canada, it would seem logical to extend interest-free status, as you do for other postgraduate learners in master's and Ph.D. programs.

In closing, we would like to stress that increasing debt hinders the recruitment of medical students who are representative of the Canadian population, and it makes it difficult to attract medical graduates to fields such as family medicine and rural practice. Given the current crisis with shortages of physicians in these areas, these trends should not be ignored. Therefore, we strongly urge the federal government to extend interest-free status on Canada student loans during the post-graduate period and to postpone payment of interest and principal until completion of residency. This would be one positive step in following through on commitments to address financial barriers to medical education.

Thank you.

The Chair: Thank you.

The Canadian Council for Tobacco Control, Mr. Walsh.

Mr. Bob Walsh (Executive Director, Canadian Council for Tobacco Control): Good morning, and thank you for the opportunity to present to this committee on behalf of the board and members of the council. Further, I would like to thank you for the opportunity to talk about tobacco control within the context of productivity.

Our brief will follow; it is currently being translated. My presentation will be highlighting aspects of that brief.

Tobacco is still the number one preventable cause of death in Canada, responsible for one in five deaths. It's estimated that 37,000 Canadians died in 2002 because of tobacco products. But there is lot that Canada has done, and done quite well, in terms of tobacco control. We are a global leader in tobacco control. There have been considerable successes in tobacco in Canada, including the ratification of the framework convention on tobacco control, the cigarette ignition propensity regulations that came into effect this week, and the lowest smoking rates in the general population that we have seen in years.

I am here to propose that, just as in business, it's when a program is showing success that you want to invest, that you want to continue those successes. There is still much to be done in tobacco control in Canada.

Looking at tobacco use and productivity, there is a study from the Conference Board of Canada—in fact, there are many studies within quite a body of literature—that links tobacco use to reduced productivity. The Conference Board study gives a dollar figure of about $2,500 per employee per year in reduced productivity. That speaks to increased absenteeism and decreased productivity through smoke breaks, those types of things, and an increase in insurance premiums.

These costs are borne mainly by the employer. Let's use the federal public service as an example, with 367,000 employees, as reported last year by Statistics Canada. If we assume that 20% of the federal public service workers smoke—that's the national average—and we make a very crude calculation not taking into account a gender analysis or different pieces like that, we're looking at a cost of about $188 million in 1995 dollars. Bringing that into 2005 dollars, we're looking at productivity losses of about $230 million. If, through tobacco control measures and employer programs, a reduction in 20% were able to be achieved, that could result in a $45 million increase in productivity.

In terms of looking at tobacco control, the two aspects that I believe fit well with how the request was to be structured are investment in human capital and investment in physical capital. We believe most of the investment in human capital comes from sustaining and increasing the amount of investment in the tobacco control program at Health Canada. The $110 million that the brief speaks to is from the plan that had been put into place, the national strategy on tobacco control. That was the dollar amount in the fourth and fifth years of the strategy. That money is needed in terms of the mass media, prevention, policy development, cessation and education, research, monitoring, surveillance, legal support—a host of different pieces.

As well, the brief asked for advice around the approaches, both broad-based general population approaches or targeted approaches. We would suggest that the achievement of the reduction in prevalence that has occurred has actually been an example of how we need to actually pay attention to both of those types of strategies. By paying attention mainly to the general population, the goal of a 25% reduction to 20% of the population smoking was achieved, but in doing so it created greater health disparities. A number of sub-populations have astronomical smoking rates and can't be part of the tobacco control strategy, just because getting from 52% prevalence to 15% represents a bit of an impossibility. There are also professions and industries that have quite high rates as well.

Further, in terms of looking at physical capital investment, the suggestion is around investment in the communication and information infrastructure, the knowledge exchange. Tobacco control is one of the health portfolios where there is too much information, so clarity is what's needed. Many non-government organizations are involved in tobacco control. The recommendation is that the voluntary sector accord be used as a framework for looking at different mechanisms for funding above the grants and contributions mechanisms, so looking at different ways of engaging and building the sustainability needed within the non-government organizations.

● (1000)

Finally, there is an opportunity to work with Labour Canada—again, within that same bucket of dollars—to look at improvement in making all federal workplaces smoke-free.

All of those would have an impact on productivity.

We also see that this is not a trade-off. There is no need to trade one for the other. There is still an opportunity to raise federal taxes. In fact, with the recent increase in discount cigarettes, taking up about 40% of the market now, we believe there is even more opportunity. The last increase was in 2003 and was for $3.50 a carton. We're recommending $10 per carton, and also closing the loophole that exists between loose-leaf tobacco and tobacco sticks. So that would be about a $20 increase on loose-leaf and about a $15 increase on tobacco sticks.

Even if only half of that were taken, so let's say an increase of $5 on a carton of 200 cigarettes, and the loophole were closed, that could still result in—using a bit of a sensitivity analysis, we came up with this number—$900 million going into federal coffers. We also know, from Canadian Cancer Society research, that smokers actually even support tax increases if the dollars are tied to prevention and cessation.

In conclusion, tobacco control efforts are working, but more needs to be done to decrease the morbidity and mortality caused by tobacco products. Federal leadership is required. As more provinces are bringing smoke-free legislation and being challenged in the courts, leadership is required in that bridging between provinces and federal and other jurisdictions. Federal workplaces need to catch up with the provincial and territorial jurisdictions and become completely smoke-free. Investing in tobacco control has a positive impact on productivity, and through this, and by improving the health of Canadians, can improve the standard of living in Canada.

Thank you.

● (1005)

The Chair: Thank you, Mr. Walsh.

From the Episodic Disabilities Network, Ms. McKee.

Ms. Eileen McKee (Project Manager, Episodic Disabilities Network): Thank you.

I also want to thank you for the opportunity to address the finance committee. My name is Eileen McKee and I'm acting as secretary for the Episodic Disabilities Network.

For the sake of clarity, I'll begin with some definitions of both episodic disabilities and the Episodic Disabilities Network. Episodic disability is the term that's being used for disabilities that because of their periodic nature move a person in and out of the labour force in an unpredictable manner. Cancer, multiple sclerosis, AIDS, lupus, and mental health, including schizophrenia, are examples of episodic disabilities. With better medication and therapies to reduce the frequency or severity of episodes, the number of people with disabilities who can now consider work is growing.

The Episodic Disabilities Network is a national network of episodic disability communities that promotes and advocates for people with episodic disabilities. Among its participant organizations are the Multiple Sclerosis Society of Canada, Lupus Canada, the Canadian AIDS Society, the Canadian Mental Health Association, the Schizophrenia Society of Canada, the Canadian Working Group on HIV and Rehabilitation, and the Canadian HIV/AIDS Legal Network, all of whom have endorsed the pre-budget submission you have before you.

The Episodic Disabilities Network has identified income support and labour force participation as its priorities. There's a need to recognize that disabilities can be positioned along a continuum from those who are permanently disabled and will not be able to re-enter the workforce to those who have periods of wellness that allow them to return to the workforce, even full time, and perhaps even permanently, but maybe only until their next episode. Along this continuum are those who are in a position to move from permanent disability to part-time work, according to their health potential. However, the Canada pension plan disability, or CPPD, program recognizes only “permanent” and “severe” as eligibility criteria for disability income. This becomes a disincentive for recipients whose health status allows them now to consider part-time work.

I want to take this opportunity to congratulate the CPP plan for offering automatic reinstatement for CPP disability income recipients who do return to work full time and then within a two-year period of time, because of the same diagnosis, need to go back on CPP disability income support. This is a powerful incentive to return to work with the knowledge that disability income support will be automatically reinstated if needed. The benefits when a person does return to work include the following: the individual has a significantly higher income; there is social inclusion; and there is the possibility for qualifying for other extended health benefits through private work plans. If we project to their retirement, they're likely to qualify for a higher CPP payment and other pensions, and there's also the potential for retirement savings or even investments. Research is still needed to determine what the impact would be on their physical well-being, the number of episodes they have in the future, the severity of them, and the cost to the health care system. For the system itself, there is less draw on CPP disability payments, CPP contributions are happening later on in life, and there is income tax as well as the increased spending power these individuals have when there is an incentive for them to return back to work, even on a part-time basis.

The finance committee, in its invitation for views on policy changes to enhance Canada's productivity, has recognized the importance of human capital and productivity as areas for action. The finance committee has an opportunity to also recognize the right of people with episodic disabilities to participate in the labour force to their potential. For these reasons, policies that contain systemic disincentives for people with episodic disabilities to participate in the labour force demand careful scrutiny. How can the finance committee take advantage of this opportunity? Increase the degree of flexibility of labour force participation—namely with things like part-time employment—for CPP disability income recipients. With CPP disability income, benefits would be scaled to diminish as the earned income increases.

In the submission you have before you, there are six additional recommendations, some of which cross several jurisdictions. Therefore, national leadership is needed to establish strong, integrated, and coherent policies that prioritize labour force participation for all Canadians, including those with episodic disabilities.

● (1010)

In conclusion, actions such as increasing the flexibility of CPP disability income to allow for partial disability income support when a recipient engages in part-time work are not trade-offs. Instead, they are investments in human capital, in human rights, in productivity, in labour force participation, and in the Canadian economy.

Thank you.

The Chair: Thank you.

From VON Canada, Ms. Shamian.

Ms. Judith Shamian (President and Chief Executive Officer, VON Canada): Mr. Chair, members, ladies and gentlemen, thank you for the opportunity to appear before you today to express VON's view of where the Government of Canada can invest in our health and social system to make Canada an even stronger and more competitive country.

As you know, VON is a national health care organization and a registered charity caring for people in communities since 1897. VON's more than 50 different community health and social services are delivered to more than one million Canadians and their families every year. We employ 8,000 paid staff and have 15,000 volunteers.

You may be wondering what role VON plays in the productivity of the country. VON branches identify unmet needs in the community and mobilize the resources needed to address those concerns in areas of home care, volunteer visiting, adult day centres, people in crisis, and caregiver supports. These are examples of programs and services that keep people independent and at home longer, lessening the burden on the health care system.

More importantly, these programs free family members to continue their careers, knowing that their loved ones are cared for. This independence allows them to contribute to society and be productive, rather than a financial burden on our health and social system.

Mr. Chair, if you were to look at the progress that has been made on improving our health care system, you would see that the last year's first ministers accord does not go far enough for those in the home and community care sector. Canadians are looking at the home care and community care sector to relieve some of the pressures on the traditional system where care is delivered in institutions. In order to offer the needed relief from the acute care sector, home and community care must be properly supported and resourced.

The committee should take a look at the 2004 OECD long-term care study, which includes home care. It shows that Canada spends less than 1% of GDP on home care. A country like Sweden, for example, spends 2.5% on the home care sector. Furthermore, Canada spends less than most of the OECD countries in the area of home and community care.

Mr. Chair, if this sector is not properly resourced, we will find ourselves dealing with the same issues we are dealing with in the hospital setting: long wait lists, a shortage of health care professionals, and a poorly supported workforce. This will no doubt affect our ability as a nation to be competitive and productive.

VON recommends that the Government of Canada significantly increase its financial support of home and community care services above that which was allocated in the 2004 accord by earmarking additional dollars for chronic home and community care and for community support services. The emphasis is on “chronic”. Most of our funding now is for post-acute. We also recommend setting aside significant dollars to retain and recruit the best and the brightest to a growing sector. Finally, we recommend examining our country's home care needs, including the use of technology in the home and incentives for not-for-profit organizations that will fill this gap.

In my remaining time I want to make some comments in four areas: one, the voluntary not-for-profit sector; two, caregivers; three, electronic health records; and four, aboriginal home care.

Let me talk briefly about recognizing and supporting the role of volunteers and the role of the voluntary not-for-profit sector. It is impossible to look at the health care system and talk about how to make this country more productive without acknowledging and supporting the role of volunteers and the contribution made by the not-for-profit sector. Canada's not-for-profit sector—and I'm excluding the hospitals, universities, schools, and municipalities—is a significant player, representing 6.8% of the GDP, estimated at over $60 billion. When we add the valuable contribution made by volunteers, the GDP contribution is raised to 8.6%.

● (1015)

It is the non-profit organizations, their staff and volunteers—and you heard some examples today—that provide care to the elderly; undertake research that allows us to compete with other nations; give shelter to those less fortunate; raise our children in caring and safe environments; provide support to those who are new in this country; identify new and changing health and social needs; and help develop programs to meet those needs.

Augmenting the sector with the valuable contribution of volunteers is significantly contributing to our economy. VON volunteers alone offer over 700,000 volunteer hours every year.

VON recommends that the Government of Canada provide the following.

The first recommendation is for a tax credit for certain expenses incurred while volunteering—for example, for Meals on Wheels, a tax credit could be given for gas expenses, because we all know the price of gas today. The second recommendation is for a change in the way credits are calculated for charitable donations versus political donations, to encourage more Canadians to donate to charitable organizations. Third is an examination of how to involve more of our youth in volunteer activities. Finally in this section, provide funding to support the work of the voluntary sector so that the sector can continue to grow and contribute to the productivity of Canada.

Let me turn my attention for a couple of minutes to caregivers. The shift from institutional-based to home- and community-based health care is well under way, but primarily it has been an acute care substitution; yet there has been no responding shift in funding to support the unprecedented demand for home- and community-based care for both acute and chronic care. As a result, millions of Canadians find themselves in a caregiver role.

It has been estimated that family caregivers provide more than 80% of all the care needed by people with long-term health problems. Numerous caregivers, be they family or friends, provide these services. They are unpaid, at the expense of their own physical, mental, and financial health. Yet despite the obvious value of and contribution being made by caregivers, there are few services aimed at helping them maintain their health and balance. It is estimated that caregivers save the health care system more than $5 billion annually by providing vital supportive care to loved ones who might otherwise be institutionalized.

VON recommends that in this area the Government of Canada support a caregiver portal, a one-stop source for information. The second recommendation is a simple and obvious one: establishing a 24-hour, seven-day-a-week 1-800 hotline for caregivers to have access to information and to a network of other caregivers. The third recommendation is to provide tax credits for caregivers so that as a nation we recognize that this is really care work and that there are financial burdens that need to be offset and can be addressed in part through tax credits.

My third point is around the electronic health record, and I will say very few words about it. The federal government over the last couple of years has invested significantly in Canada Health Infoway, and we are calling upon you to continue to do so, and to recognize that the electronic health record has to be extended beyond, to the areas of home care. We recommend that the Government of Canada commit funding for technology in the home and community care sector as well as the hospital sector to ensure the continuum of health information across the country.

Finally, I have a few words about aboriginal health. As an organization that is national in scope but local in delivery, we know all too well how important it is to provide services that are appropriate to a particular population. It is my understanding that currently Health Canada funds for first nations and Inuit in the area of home care are around $90 million. While this has addressed some of the more significant gaps in services such as case management, nursing care, in-home respite care, and personal care, in a small and remote community even these essential services are minimal and not available. We understand that the gaps are in palliative care, rehabilitative care, respite care, and mental health.

Simply put, the VON calls on the Government of Canada to provide a higher level of continuing care in first nation communities. As we are all aware, hospital closures, introduction of early discharge programs, and other changes have placed serious pressure on first nation communities. This pressure must be addressed with substantial and sustainable funding for home and community care.

● (1020)

I guess my time has run out.

In conclusion, I would like to thank you for being here. You have our commitment that VON will continue to serve the country from coast to coast to coast.

The Chair: Thank you.

From Vision mondiale Canada, we have Ms. Vandergrift.

Ms. Kathy Vandergrift (Director of Policy, World Vision Canada): Thank you for this opportunity to speak to you very briefly about predictability and accountability in the international assistance envelope. I'll try to be brief, because I know you've been listening a long time.

World Vision Canada appreciates that the finance committee included in its pre-budget recommendations for last year that Canada commit to achieving the international target of 0.7% of gross national product for international assistance. This recommendation, as you know, was supported and enhanced by a parliamentary motion in June recommending it be achieved by 2015. It now has the support of all parties in the House of Commons. We also appreciate the significant increase for international assistance in the 2005 budget, but it is not adequate to achieve the target now supported by all members of Parliament.

As well as increasing the amount, the 2005 budget restructured the fund, so I want to speak with you a little bit about that restructuring of the fund. In short, I'd like to recommend two steps this committee could take this year to help implement the will of Parliament with regard to both the quantity and the quality of Canada's international assistance program.

The first step is the establishment of interim targets with a timeline. This year there was considerable public discussion about global poverty and strong public support to do what it takes to eliminate absolute poverty, the kind that results in the death of a child every three seconds from avoidable causes such as hunger, malnutrition, and disease. More resources are needed, and this must be a priority also for this budget.

But we are sensitive to the concerns that have been raised about making commitments that may not be met and about making good use of resources. With that in mind, we suggest that Canada establish an interim target of 0.5% by 2010 and then establish the timetable and the progressive elements each year. Canada must do better to maintain international leadership, and we believe an interim target may be one way to improve our declining record among nations.

Secondly, I would like to speak with you briefly about clear mandates and accountability for the use of resources.

You may not be even aware that the 2005 budget included a new framework for the international assistance envelope. It's now divided into five components: development, international financial institutions, peace and security, a crisis fund, and development research. Two of these, the fund for global peace and security and the crisis fund, are new funding channels. Both require interdepartmental cooperation to be effective.

These funds are central for implementing the government's new integrated approach to foreign policy, particularly for weak and failing states. Policy coherence, a central theme of that document, means better coordination between departments, but it should not mean lack of clarity about mandate and accountability for the use of funds. At the moment, you should be aware that there is a lack of clarity about the mandate of each of those funds, the criteria governing allocations from them, who makes the allocation decisions, and what the accountability structure is.

I submit to you that public confidence in Canada's international assistance program is essential. We believe public confidence would be increased by clear mandates and clear accountability for the use of funds in each of the five pillars of that restructured envelope.

World Vision shares with you the concern about public confidence in international development. We have the support presently of over 400,000 Canadians individually and of many companies across the country. Public confidence overall in international development is exceedingly important, for us as well for the government.

We are suggesting that the finance committee reinforce the parliamentary motion that calls for the adoption of legislation for the aid program, but similarly, that this committee call on the government to provide clear mandates with clear accountability for the use of funds in the other components of the restructured international assistance envelope.

Thank you.

● (1025)

The Chair: Thank you, Ms. Vandergrift.

We're going to go directly to the members. We'll try a seven-minute round.

I have Ms. Ambrose and then Mr. Bouchard.

Ms. Rona Ambrose (Edmonton—Spruce Grove, CPC): Thank you, Mr. Chair.

Thank you for your presentations.

I have a question for Mr. Walsh and a subsequent question for Mr. Wright and Mr. Rose.

Mr. Walsh, I'm really interested in what you're saying about preventative health. We've formed an organization in our party called the young Conservative caucus. There are 20 of us under the age of 40. What we're focusing on this year in particular is preventative health. We've been working with the Diabetes Association to help raise public awareness around healthy eating and type 2 diabetes.

Obviously, we look at public policy. Public policy is behaviour modification, as you well know. You're looking at tobacco control policy. I have some specific questions for you, because you're talking about tax increases per carton. How much tax money—and I think you said this, but I just want to make sure I have it—is collected by the federal government through the sale of cigarettes or tobacco? Do you have that figure?

Mr. Bob Walsh: I don't have that figure with me, but I could get that.

Ms. Rona Ambrose: That would be great.

Did you make note of how much funding goes to cessation and prevention by the federal government?

Mr. Bob Walsh: I did not make note.

Currently, the total budget for the tobacco control program is $110 million. I believe the estimate in the last fiscal year was $70 million and that $8 million was for prevention, cessation, and education, but I could definitely get that figure as well.

Ms. Rona Ambrose: Do you have just an estimate of how much federal tax money is collected through cigarette sales?

Mr. Bob Walsh: No, I don't.

Ms. Rona Ambrose: If you could, just talk a little bit about public awareness and what you've been working on. Obviously, there's a huge tobacco industry in Ontario, so that's an issue for the government to deal with.

I'm going to assume there are a lot more tax dollars collected than there are tax dollars for prevention and cessation. You were saying you want to tie the two together. Most of the public supports a tax increase as long as it goes to cessation and prevention instead of general revenue or other purposes, because obviously there's a sense of conflict there.

What do you suggest to ensure some sort of accountability, or what are you doing to increase the public awareness around that issue?

● (1030)

Mr. Bob Walsh: The Canadian Cancer Society survey showed that even smokers agree with a tax increase when there is one.

I do think it is very safe to say that the amount collected exceeds what is spent on prevention, cessation, and education; I would think it's even safe to say exponentially. So in terms of that, the hope would be that there could be some type.... I know that's a whole different parliamentary concern, to tie taxes to a particular thing, but when it is done that way, that is where there is public support.

Ms. Rona Ambrose: And for Mr. Wright and Mr. Rose, we have long advocated for interest-free status on loans and also on income-contingent payback, so I'm supportive of what you are saying. But one of the things you mentioned quickly was that law students who are articling have a grace period, but that medical students who are in residency don't have the same grace period.

Dr. Ryan Wright: Sorry, no, that's not what I attempted to communicate. When they graduate from a program, all students have a six-month grace period during which the student loans aren't repaid. Medical residents would be included there. The distinction I made was that the duration of residency is, on average, five years, and as long as eight years, so they have an exceedingly long period of time during which they're repaying their student loans, and they encounter great difficulty with that, as opposed to an articling student, whose duration is one year.

Ms. Rona Ambrose: Just to clarify, because we're working on policy in the area, are you asking for this for other students as well, in terms of residencies, or is this particularly for medical students?

Dr. Ryan Wright: This would be for all postgraduate medical trainees. The training process for medicine is that you do an undergraduate degree, followed by a medical degree, followed by postgraduate training. Right now, interest-free status exists for the first two portions of training but not for the last. So we're asking for extension of the interest-free status and non-repayment of student loans during postgraduate training, similar to what other postgraduate learners in Canada are given.

Ms. Rona Ambrose: Is there a time limit? You mentioned that an average residency is for five years.

Dr. Ryan Wright: Correct, an average residency is for five years, but it may last as long as eight years, depending on the specialty or sub-specialty being pursued.

Ms. Rona Ambrose: Thank you.

Dr. Ryan Wright: You're welcome.

The Chair: Thank you, Ms. Ambrose.

Ms. Wasylycia-Leis.

[*Translation*]

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Mr. Chairman.

[*English*]

The Chair: You have to thank the other members for allowing you this opportunity.

[*Translation*]

Ms. Judy Wasylycia-Leis: I want to thank Mr. Bouchard for his generosity of spirit, as I'm scheduled to speak to Bill C-57 later in the House.

[*English*]

I'd like to follow up on where Ms. Ambrose left off.

It is an issue that I think we dealt with quite thoroughly last year at this committee, and it has been around for a while. The issue is on the deferral of student loan repayments for doctors or medical students who are going into residency programs.

It seems to be a fairly easy thing to do, and it would be good for all of us, especially given the current critical health care situation. It seems to me that it ties in directly to our goal to make society more productive, in terms of meeting the needs of people on the health side so that they can be more productive, not to mention the productivity of doctors, which contributes to our economy.

Why is it taking so long? Would it be the fact that other graduate students and other postgraduate students are able to carry on with their studies, make money doing research jobs or teaching jobs, and have their loans deferred, whereas that's not possible in the case of medical students going into residency and postgraduate work?

● (1035)

Dr. Nick Rose: I'll attempt to answer that question.

Medical residency for medical students in postgraduate learning seems to have fallen through the cracks in that it's a very unique situation. During the residency period, residents are affiliated with universities. They pay registration fees to the universities. They take exams for licensure throughout that period. Yet according to the definition of Canada student loans in HRSDC, they don't qualify for interest deferment. It becomes quite complicated, but according to the departments of postgraduates at the various universities, residents are not recognized as postgraduate trainees.

Having been through the process, Dr. Wright is perhaps in a better position to answer it than I am. But it comes down to each individual provincial association of interns and residents negotiating with provincial ministries of health how they enter repayments or how they receive stipends. HRSDC doesn't recognize them as being typical postgraduate learners, i.e. someone who is doing a master's degree or a postgraduate degree.

It's something we're attempting to rectify here by recommending that the Standing Committee on Finance allow residents to fall under that jurisdiction and be recognized as postgraduate learners.

Ms. Judy Wasylycia-Leis: Before you briefly respond, Mr. Wright, I want to ask one more question.

Is it true that last year or within the past couple of years the Minister of FInance gave some indication of actually moving on this? Perhaps all we need is a quick reminder for him in our report.

Dr. Ryan Wright: Yes, you're absolutely right.

In response to your first question, I think Nick is right. I think we have fallen through the cracks. Why the same status as other postgraduate learners isn't extended to us remains a mystery to us.

Everyone we've talked to says this makes sense. We were told by Human Resources and Skills Development that this would be going through in last year's budget. The day before the budget was released, we were further told by the health minister that this was being addressed. Everyone we've talked to has been on side with us.

I think it's a complicated issue because it's shared by so many different ministries. It's shared by Skills Development, by Health, and by Finance. People haven't managed to get it together.

We're here to help you follow through on your commitment to extend this to us and to make sure it happens.

Ms. Judy Wasylycia-Leis: My other question, quickly, is for Judith and Pierre and Eileen, and Bob as well, because it has to do with time lost from productive work due to health concerns, family issues, and mental stress. I don't know if we have a figure, or if any of you have a figure, for time lost at work due to sick leave, mental health, and family responsibilities. We haven't supported those areas well enough through our budgeting practices here in Ottawa.

Judith, perhaps you could start with a response.

Ms. Judith Shamian: I don't think we have clear figures simply because it's not a recognized legitimate time off. You will get absenteeism, sickness, and so on. You wouldn't be able to capture the real source of the absenteeism.

I think there might be some Statistics Canada data, and we would be pleased to look at it and get back to you. But I'm not aware of a clear figure. Maybe my colleagues are.

Ms. Judy Wasylycia-Leis: Or the concern generally, Pierre—

Mr. Pierre Drouin: This is an area that should be researched because many people will leave a regular job to take care of sick family members without going on record that they're doing it. It's just a need for the family. I can look into that and try to get some statistics back to the committee, .

● (1040)

Ms. Eileen McKee: Members of the Episodic Disabilities Network have requested that kind of information, so we're trying to collect it right now. In addition, Social Development Canada has funded a project, part of which will be looking at that kind of costing. What does it cost when a person with a disability has a disincentive to return to work? And what would change if there were inherent incentives for them to return to work, with the disincentives being removed?

We're doing a costing of that, so in the very near future—certainly by January or February—we'll have it done.

Mr. Bob Walsh: In terms of tobacco control, a 2005 study by Group d'Analyse Économique de Montréal found that $752 million is lost due to increased absenteeism. The study also has gender analysis regarding both the workforce and smoking rates. From lost productivity, they estimate $2.9 billion.

The Chair: By the way, Ms. Wasylycia-Leis, you should also thank the Liberals because Mr. Hubbard saved your place as well.

So I have Mr. Bouchard, Mr. Hubbard, and then Mr. Bell.

Thank you.

[*Translation*]

Ms. Judy Wasylycia-Leis: Thank you, everyone.

Mr. Robert Bouchard (Chicoutimi—Le Fjord, BQ): Thank you, Mr. Chairman.

I'd also like to thank each witness for making a presentation.

My first question is for the Canadian Association of Retired Teachers.

You've recommended a number of measures to improve the tax treatment of seniors. Among other things, you mentioned a ceiling on RRSP contributions, income splitting, extending the period before RRSPs must be converted into RRIFs, as well as a number of other deductions. I'm not sure if you're aware of the federal government's decision to impose a moratorium on personal trusts.

Did you look into this question and if so, in your opinion, does this moratorium penalize seniors?

Mr. Pierre Drouin: In our recommendations, we wanted to underscore the principle of equity in taxation matters. We consulted with seniors and identified problem areas. I've presented some areas of concern to the committee. For example, with respect to RRSPs, a new ceiling of $22,000 will be introduced in 2010. However, the budget didn't say if the actual ceiling would be $22,000, or 18 per cent of the previous year's earned income, that is whichever is lowest. As far as our association and seniors are concerned, a measure like this clearly favours high income earners. This new $22,000 ceiling will provide a tax break only to individuals with an annual income of $125,000. In other words, an exclusive few will benefit.

We're now looking into the whole question of a moratorium on trusts. As has been the case in the past, few seniors will have the means or the opportunity to set up a trust. Two major reports on seniors can be consulted. I believe the aging and seniors division recently released a report that clearly identifies those areas in which the federal government needs to invest in order to meet the needs of seniors. While some seniors are well off financially, others are not and therein lies the problem.

We're calling for certain programs to be put in place and for a fund to be set up to provide compensation to all Canadian taxpayers when the surplus exceeds a given amount. Wouldn't it be better to give more to those in need? These are the kinds of questions that our members are asking.

Mr. Robert Bouchard: My second question is for the Canadian Federation of Medical Students and for the Canadian Association of Interns and Residents.

You stated that some students in these disciplines face higher costs than students in other areas. You maintained that it was difficult for medical students to work and study at the same time. You also mentioned restrictions such as higher exam costs, tuition fees and interest charges. Can you tell me what the average debt load is of a medical student upon graduation? How does that compare with students in other disciplines?

● (1045)

[*English*]

Dr. Nick Rose: I can try to answer that question. The recent 2004 study that came out from the national physician survey said that on average, medical students are graduating with a debt in excess of $100,000. That's between $100,000 and $120,000. That's compared to the Statistics Canada report that came out in approximately 2000 that said that in undergraduate programs, people are graduating with debt loads of approximately $33,000. Other professional programs—for example, dentistry and law—have debt loads similar to medical students. Again, it comes back to Dr. Ryan's point that these other graduates enter their workplaces and are immediately able to make the income to allow them to pay back those debt loads, compared to residency, where it's only after a five-year period that physicians are able to make enough to pay back those debts.

Dr. Ryan Wright: The other point I'd like to make in terms of average debt load is that they are now escalating, because deregulation of tuition for medical school has only happened within the last five or six years. So new graduates are experiencing unprecedented levels of debt. The numbers of $100,000 are bound to rise to $150,000 and over $200,000 with the increasing cost of tuition.

The Chair: Thank you.

Mr. Hubbard.

Mr. Charles Hubbard (Miramichi, Lib.): Thank you, Mr. Chair.

We've had some very good presentations. The biggest problem, of course, is that all of these have so many related factors.

I'll start with Mr. Walsh. When you look at the socio-economic aspect of our smoking population, often it's people with low incomes. A pack a day is $300 a month. If a man and his wife are both smoking, it's $600 a month. Often food is not on the table and other things are neglected because of smoking. Now as parliamentarians, how can we overcome this problem? Do you agree with what I said? You only have a minute, probably, to reply because I do have some other questions, too.

Mr. Bob Walsh: Certainly. Yes, I do agree with what you have said. I think the role of a regulation is to help make the healthy choice the easy choice, and that means making other forms of nicotine—nicotine replacement therapies—available at a price point where they're much easier for people to get, so giving them a safer form.

Mr. Charles Hubbard: With our doctors—and of course our medical professions are always in short supply—I think probably, Mr. Chair, the problem goes beyond that. It's not simply people in medical careers, but also the average Canadian who graduates from university. We know that in terms of earning power, that earning power is a very big factor in how difficult debts are to repay.

Some have said that maybe we should have a program where you would be assessed a certain percentage of your income for the first 10 years after you get a so-called good job. We do find that at $40,000 or $33,000 of debt, many of them don't get good jobs for the first few years they're out of university, and they're faced with payments of $400 to $500 a month to meet their obligations in terms of the Canada....

We also have the problem of many of our medical people leaving the country. In fact, I know at least two or three very close associates and families who, as soon as they graduate, go to Texas, go to Georgia, go somewhere else. Really, as individuals, and more important as a country, we've invested heavily in the training of medical people. We also have to realize that we have South Africans and people from all over the world coming to be doctors here.

But is there a better solution than simply the one you're presenting today in terms of how we can adequately train a sufficient number of Canadian doctors? How can we balance this problem in terms of training people who leave for better pastures, probably because of the debts they have? Have you considered a better solution than the one you present here this morning? You tell us the problem, but I wonder if there shouldn't be some bigger way the Canadian government can advance training for doctors and see that we have an adequate supply and that we don't have hundreds of thousands of Canadians today without a medical doctor.

Mr. Wright is just ready for this one.

● (1050)

Dr. Ryan Wright: I think, Mr. Hubbard, you're absolutely right, and you've identified that there are numerous barriers and problems with the medical education process in Canada. The Canadian Federation of Medical Students has issued a more comprehensive document that highlights many different suggestions.

The reason we're presenting this suggestion today is because we believe it would be a measure that would offer immediate relief and tangible relief to medical trainees, and it would be the most easily administered.

It's not just a federal issue. It's complicated by the fact that education and tuition and all those matters are handled at a provincial level, whereas Canada student loans are a global thing that can impact every medical trainee in Canada. So we've identified them as our first area of concern, and after that I think there are many other recommendations we will be bringing forward. But this is—

Mr. Charles Hubbard: Mr. Chairman, I think there's something we really have to address. The problem they brought to us today is in fact a minor problem in a sense. The bigger problem is what I suggested.

With World Vision, you talk about 800,000 Canadians who participate in the program, and maybe I missed it, but I didn't hear what your budget is in terms of this. How much do you collect nationally? Secondly, in terms of that, how much money do you lever from our government in terms of the work you do around the world?

Ms. Kathy Vandergrift: The number was around 400,000 donors, and then there are companies, and I don't have a precise number on that, but certainly it's hundreds. Our budget last year was over $200 million. Less than 20% of that came from the Canadian government. The percentage that's going to NGOs out of the aid program has been decreasing over the last five years—I can give you those precise numbers. The direction of Canada's aid programming is a concern of ours—so NGOs have been getting less and less of that programming over the last five years.

Mr. Charles Hubbard: With the hurricane in the Pacific last year at Christmastime, how much did you lever from our government for that? We had a lot of groups that collected for World Vision, and we were told that if you gave $1, the government would give so much more. That was one of your big fund raisers, I assume.

Ms. Kathy Vandergrift: I could get you those exact figures on the tsunami; I don't have that broken out right now. I think what the tsunami experience also showed us is that the Canadian public did respond when they became aware of the need. We do appreciate that. In that case, the government did do the matching program. My understanding is that this would now be funded out of the crisis fund that has been set up, and certainly we are working with CIDA to be accountable for each and every dollar that has been matched in those programs, for the long-term redevelopment of that area of the world.

I think the learning for the finance committee is that when people understand the need, they support Canada doing more. I guess in addition to the recommendations I named, at least the budget should state the truth about Canada's record in this area, because we find when people understand how little Canada is giving—less than half of the international target—then people support doing more. That's what happened with the tsunami; there was a concern Canada wasn't doing enough, and once the people became aware of that, they opened their pockets.

Mr. Charles Hubbard: Mr. Chair, I have another second here.

In terms of caregivers—and, more importantly, we had some changes to our budget about two years ago that reflected very badly on parents who had disabled children over 18 years of age at home. At that time, we brought in a program where people could certainly write off medical expenses for children over 18 years of age, up to a maximum of $5,000. But for parents who had a child that might be 19 or 20, who was unable to work and was at home...and if they had to make major modifications to their homes, they were not able to write off most of the cost because of the $5,000 limit. I think it was offered because the Minister of Finance thought it was something that would help people having students at university who have medical expenses, but in terms of those who have long-term caregiving responsibilities for adult children, it has been a serious problem in the sense that if they made a $30,000 modification, the most they could write off in terms of their medical expenses was $5,000.

Mr. Drouin, you have talked about caregivers, and we've had terms like “catastrophic drugs” and “medical deductions”. All of them have costs, but in your organization have you looked at all of these in terms of proposals directly, which ones should be increased or decreased, as a result of the experiences that some of your associates may have had?

● (1055)

Mr. Pierre Drouin: When we looked at the income tax system, it was a question of providing a level playing field for all Canadians. This was the main principle that came out of our discussions with other groups. It was also to look at areas where Canada must define some social priorities. If you recall, back in 1985 Parliament adopted a resolution, unanimously, to eliminate child poverty in Canada by the year 2000. In 2005, we have more children living below the poverty line than we had in 1985. We would recommend that all other recommendations be put aside to eliminate child poverty, and poverty among seniors, any time.

The Chair: Thank you, Mr. Hubbard.

Mr. Bell, five minutes.

Mr. Don Bell (North Vancouver, Lib.): Again, welcome. Many of the questions I wanted to ask have been asked, so I'll only zero in on a few. One was to Mr. Walsh. Did I understand you to say that presently...is $3.50 a carton the federal tax, or that it increased by $3.50?

Mr. Bob Walsh: The last increase in 2002 was $3.50.

Mr. Don Bell: How much is the total right now on a carton?

Mr. Bob Walsh: I didn't bring those figures. I apologize.

Mr. Don Bell: I'm a non-smoker, so I don't know.

Mr. Bob Walsh: A pack right now can range anywhere from $6 to about $8.68 a pack in Ontario, and that's comprised of a number of different taxes.

Mr. Don Bell: A pack is a deck.

You mentioned that $5 a carton—a further $5, I presume you're talking about—would raise $900 million, did you say?

Mr. Bob Walsh: Yes.

Mr. Don Bell: Okay. I appreciate that.

The other question I had was to Judith Shamian. You talked about Infoway. Can you tell me what Infoway is?

Ms. Judith Shamian: Infoway is basically funded by the federal government to work on an electronic health record. It's an investment that was done around four years ago, and currently they've funded up to $1 billion. It tries to connect all the health care systems across the country, but it doesn't scratch the surface. There's really not sufficient funding to do what we need to do. It's a system that if you need health care in Vancouver or you need health care in Halifax, your records can be accessed and looked at and proper health care can be provided.

Mr. Don Bell: And a billion dollars...?

Ms. Judith Shamian: A billion dollars has been invested so far, and it probably requires several more billion to get the connectivity we need from coast to coast.

Around the productivity line, it's also an opportunity for us to take leadership in the world in doing it. It's pretty ambitious. And it can be a very good area where we can really promote and market our success.

Mr. Don Bell: I don't think I heard you discuss it at length, but in your recommendations you suggested this caregiver portal, and that's something different. That's an access point. That's a one-stop service for information.

Ms. Judith Shamian: Yes, absolutely. The thing we hear from caregivers across the country—and there are several reports to that effect—is that they need information, and it's too complicated to access information.

It's a fairly cheap solution to provide a portal and then to tailor it to specific communities. You can be at home and find out where you can rent equipment, where you can get a special bed, or a special walker, or whatever, without needing to call 1,500 numbers to find an answer.

● (1100)

Mr. Don Bell: The 1-800 hotline is something different. That would be more of an emergency response for a caregiver who's got a situation and needs to know.... It's almost like phoning the poison line, isn't it?

Ms. Judith Shamian: Yes. It's having a person on the line so that you can ask a question and you can get some assistance.

Mr. Don Bell: Thank you.

Kathy Vandergrift, this committee and the House supported the 0.7% goal. Do you have an idea—I asked the question the other day—what that 0.7% amounts to in terms of total dollars?

Ms. Kathy Vandergrift: There were a lot of numbers thrown about during the debate about Make Poverty History. That's why we suggest approaching it with interim targets. Actually, for this next budget, in addition to the $250 million that was added, it would be $5 million more to put us on track with the 15% increase annually. So if you break it down annually, that becomes manageable. If you throw about the figures for 2015, it doesn't mean a whole lot because it isn't put up against what the budget and the economy will be in 2015. That's why we think interim targets with an annual progression toward the interim target of 2010 would be a good way to go for now. And we can give you those numbers.

Mr. Don Bell: We're presently at about, what, 3.5%, somewhere in that range?

Ms. Kathy Vandergrift: We're below that. They argue over the numbers a little bit. We're at approximately 0.33%. Some would say we're as low as 0.28%, if we take out the money we spend to help refugees in this country when they come here for the first year. So the highest estimate is that we're at 0.33%. We're probably around 0.3%.

I think it's useful for Canadians to know that we are at less than half of the target. And we will be at less than half of the target under the current increases built into the budget for the next five years. We will stay at less than half.

Mr. Don Bell: In terms of this money, one of the issues, aside from what I've heard, is that some of the countries that have committed to the 0.7% have done so with caveats. The Prime Minister wanted to be able to make a clear commitment, as opposed to some of these that provide, if you want to call it, weasel clauses or weasel ways to get out. And it's politically expedient to say “Yes, we'll do it”, assuming some things, and then if the answer is “Well, those assumptions or those conditions never came about”....

I think you talked about a lack of clarity for international assistance funds and about accountability. One of the issues that was raised, though, is the concern with some of these countries as to whether the funds are actually going to World Vision. Are you satisfied that the corruption factor in terms of the money being used for purposes other than for which it was intended...? Is the money that Canadians give and that the government would give being effectively allocated?

Ms. Kathy Vandergrift: We certainly share the concern about the accountability and wise use of these funds. I would just highlight for you that several countries have already exceeded the 0.7% and are heading toward 1%. A country like the Netherlands, which has the same average per capita income as Canada, is on the road to 1%. So six have already completed that. For others, yes, we do need to track that, but I guess we would say to you that Canada is in no position to hold other countries accountable when its own performance is as low as it is now. So that's a good reason to increase ours and also to hold other countries accountable.

In terms of how money is spent, I would just highlight for you... Sweden has adopted legislation in terms of how the money may be spent, and there is public accountability. I think it stands as a good model, a best model out there, for how to approach this and indeed reduce the concerns about the misuse of funds.

Mr. Don Bell: Thank you very much.

The Chair: Thank you, Mr. Bell.

I just have a couple of quick questions. I think it was Mr. Wright who said that student loans were on the rise. They're reaching levels of $100,000. You're predicting that they can go as high as $150,000, but even if you increase tuition by $1,000 or $2,000, I don't think that will make the difference.

I'm just wondering, is it because of lifestyles that a loan goes from $100,000 to $150,000?

Dr. Ryan Wright: We're not talking about $1,000 or $2,000. Tuition in Alberta has gone up from less than $4,000 when I started medical school six years ago to $14,000 a year. If you take the averages, for tuition alone, in Toronto, for example—

● (1105)

The Chair: Is this per year? And this was six years ago?

Dr. Ryan Wright: Per year.

Tuition for medical school in Toronto is $16,000 a year. For a four-year medical degree, tuition alone will be over $60,000, not counting the undergraduate degree that preceded that, which was for five years on average. Tuition alone will cost $100,000 for a medical education, not considering books, fees, living expenses, or anything else.

The Chair: Thank you.

Ms. Shamian from the VON, in one of your recommendations you're asking for a tax credit for caregivers. What exactly is that? We already have a tax credit for caregivers.

Ms. Judith Shamian: I think tax credits were brought in for end-of-life caregiving. So if somebody's dying, the caregiver can take a few weeks off and their job will be protected and so on. But we are talking about chronically ill people who need care for years and years and years, and their families are either not working or need to take time off work to do that. This needs to be recognized in the form of a tax break, assisting them in being able to manage the financial burden on their family.

The Chair: Well, there is a tax credit for caregivers presently. If I hire a caregiver, I can take a credit for that.

Ms. Judith Shamian: I understand your question now. I'm sorry, but I misunderstood it earlier.

We're talking about unpaid caregivers, family members or friends and neighbours, who actually need to leave the job market in order to stay home and look after family members, but overall the family does not get any tax breaks for that.

The Chair: And how would you propose we do that? We're looking at something for volunteer sectors. I don't know if that would be the same type of thing, but if you can perhaps give us a little more information.... I'm not sure how we'd be able to do that and build it into the tax system.

Ms. Vandergrift, I just have a quick question. We keep throwing around this 0.7% figure, but does your organization know what the 0.7% figure of GDP is that we keep pointing to?

Ms. Kathy Vandergrift: Today?

The Chair: Yes. How much would it represent for the Canadian government?

Ms. Kathy Vandergrift: When we talk about the 0.7% figure, I think it's important to go back to the principle.

The Chair: No, I understand that, but in dollars, does your organization—

Ms. Kathy Vandergrift: Yes, I have those figures with me, and I can certainly make sure that you get those and that they're very accurate.

The Chair: I can help you with that: it's about $7 billion to $8 billion. I just wanted to put it on record. It's a lot of money.

Ms. Kathy Vandergrift: It gets averaged, that's correct, but when you look at the needs in terms of addressing global poverty, we don't think it's an unreasonable amount.

The Chair: Thank you.

I just want to thank the witnesses for coming by. We actually stayed on schedule and are only five minutes over time. Thank you again for taking time out of your day.

The meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

Also available on the Parliamentary Internet Parlementaire at the following address:
Aussi disponible sur le réseau électronique « Parliamentary Internet Parlementaire » à l'adresse suivante :
http://www.parl.gc.ca
