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Mr. Massimo Pacetti

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● (1535)

[*English*]

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

I hope everybody is well. It's been a long day for some of us.

I want to thank the witnesses for taking time out of their day and coming to appear before the committee.

Pursuant to Standing Order 83.1, we're here for the 2005 pre-budget consultations.

For the witnesses who are not familiar with the process, I'm going to allow you a seven- to ten-minute intervention to explain your brief, or the recommendations you're making, to the committee. I don't want to cut you off, so if you can stay within the seven to ten minutes, I would really appreciate it.

We have some housekeeping duties.

[*Translation*]

The management committee met and wishes to submit two or three motions.

I therefore move that, pursuant to Standing Order 97.1(3)(*a*), the Committee request an extension of 30 sitting days for Bill C-285.

(Motion agreed to)

[*English*]

The Chair: It is also moved that, pursuant to Standing Order 97.1 (3)(a), the committee requests from the House an extension of 30 days for Bill C-265.

(Motion agreed to)

[*Translation*]

The Chair: The committee moves that we adopt the pre-budget consultations 2005 operational budget of $48,900.

(Motion agreed to)

[*English*]

The Chair: I have a list of witnesses; I think you have the same list, so I am going to go in that order. The first association I have is the Association of Canadian Academic Healthcare Organizations, and Mr. Glenn Brimacombe.

Mr. Glenn Brimacombe (Chief Executive Officer, Association of Canadian Academic Healthcare Organizations): Good afternoon.

My name is Glenn Brimacombe. I'm the chief executive officer of the Association of Canadian Academic Healthcare Organizations.

I'm joined today by Dr. Bernie Bressler, who is the co-chair of the ACAHO subcommittee of vice-presidents of health research. Dr. Bressler is also the executive director of the Vancouver Coastal Health Research Institute.

The Association of Canadian Academic Healthcare Organizations appreciates the opportunity to appear before you to discuss a series of focus recommendations that look to strengthen the relationships between the health and productivity of Canadians, the effectiveness of the health system, the economic competitiveness and prosperity of Canadians, and the vital role that members of our association play in supporting and advancing these specific national policy objectives.

The association, known as ACAHO, is the national voice of teaching hospitals and regional health authorities that have overall responsibility for the following integrated activities. We provide Canadians with access to a range of specialized health care services and some primary care services. We represent all the principal teaching sites that train the next generation of Canada's health care professionals, and we provide the large majority of infrastructure to support and conduct health research, medical discovery, and innovation across the country.

There are no other organizations in the health system that provide the unique combination of health services that our members do. We consider our institutions as important hubs in the system in addition to being a national resource.

We also see a critical link between the federal government and our members in addressing the strong complementary relationships between investing in the health of Canadians and our collective ability to continue to build a dynamic and vibrant society that will compete and prosper on a sustained economic basis. In short, it's about strengthening the linkages between health and wealth.

The September 2004 first ministers agreement identified a number of steps forward in addressing the national objectives of our health system while providing sufficient flexibility for the provinces and territories to address their pressing policy priorities. While there remain ongoing policy questions about how the agreement will be implemented and monitored, ACAHO is of the view that there are a number of related policy recommendations that the standing committee should give careful consideration to and would be seen as strengthening the overall direction of the federal government in health and health care.

If the system is to thrive and not simply survive, we must ensure continued investment in our most prized assets: health care professionals. In order to increase the number of health care trainees, it will be necessary to invest resources to expand the physical infrastructure of teaching centres. That is why ACAHO recommends the establishment of a five-year, $1 billion national health human resource fund, to build capacity to educate and train Canada's health care professionals. If the system is to be truly flexible and responsive to the changing health needs of Canadians and, most importantly, able to provide timely access to a range of quality health services, we must ensure that we have an adequate supply of health care professionals. Simply put, this is a national health policy issue that requires the federal government to step up to the plate now. Otherwise, the crises we face from coast to coast to coast will become a full-blown catastrophe.

It is also important to ensure that the health system has the physical delivery capacity with which to provide Canadians with a quality health care experience. For members of ACAHO, the reality is that many provide care in facilities that were built at the turn of the century. While provincial governments from time to time provide limited resources to renovate or expand capacity in the system, it is clear that operational resources continue to have first call on the public purse.

It's also important to keep in mind the following comparative figures from the OECD, the Organization for Economic Co-operation and Development. Canada has the highest acute care occupancy rate, 87%, among G-7 countries, and ranks second highest out of the 21 OECD countries reporting. Canada has 25% fewer acute care beds per 1,000 population than the OECD average, ranking 13 out of the 25 OECD countries reporting. And Canada has 25% fewer physicians per 1,000 population than the OECD average, ranking 23 out of 29 OECD countries. Combined, these figures speak to the limited capacity of our system.

ACAHO believes there's a natural role for the federal government to assist the provinces and our members in rejuvenating the physical capacity to deliver quality health services to Canadians through the creation of a health delivery infrastructure fund. Such a fund is consistent with other time limited and targeted funds that have been initiated by the federal government to assist in the development of additional delivery capacity.

More importantly, what we are asking the federal government to do was undertaken in 1948 with the creation of the hospital construction grants program. Given that 57 years have since passed, the health system is in dire need of some upgrading.

● (1540)

Dr. Bernie Bressler (Co-Chair, Health Research Committee, Vice-President of Research, Assistant Dean Research, Association of Canadian Academic Healthcare Organizations): ACAHO views research as the oxygen of an evidence-based health system. It is the basis of many sound public policy decisions. It is the backbone of a health system upon which cost-effective clinical decisions are taken and quality care delivered.

Research is the foundational building block that facilitates innovation in at least three dimensions. It contributes to improving the individual and collective health status of Canadians; it impacts on the architecture of the health system and the manner in which we deliver cost-effective and quality health services; and it produces leading-edge, world-class discoveries that provide opportunities to leverage major economic benefits as well as health gains.

The research, innovation, and commercialization process is an essential component and a distinguishing feature of our members' mission and mandate. Members play an essential role in the advancement of health research, medical discovery, knowledge creation, and innovation in Canada. In fact, teaching hospitals and centres and their research institutes account for a large proportion of the physical infrastructure that supports Canada's health research community.

Given the breadth and depth of health and research investments by the federal government, one might be tempted to say that the time has come to address other important national priorities. ACAHO maintains that while the tide has turned, through enhanced investments in Canada's health research enterprise we must continue to sustain the momentum we have created so we can continue to participate in the benefits that come from future world-class research findings.

ACAHO understands that there are a number of strategic pieces that need to work effectively if we are to maximize our investments in Canada's health research and innovation value chain. As a result, the association would bring to the attention of the standing committee the need to resource the different dimensions of the research equation—infrastructure, basic and applied health research, and indirect costs—and maximize the full economic benefits of world-class, breakthrough health research.

Retrenchment in funding the health research enterprise would have serious consequences in our ability to attract and retain world-class researchers, not to mention our ability to advance the process of discovery and innovation. Canada currently invests more money for health research than ever before in our country's history. Indeed, we have created an entire biotechnology industry that is spun out of our universities and their affiliated academic health science centres. Let's not go backwards. Do we want to fall out of step with those countries that place tremendous value on the linkages between creating knowledge and its spinoff effects, particularly in a global economy that relies on the advancement and translation of knowledge?

Please note that recommendations in this area are built on the publicly funded and administered platform of our health system. This alone presents Canada with a very unique opportunity to continue to harness the multiple benefits that flow from health research and innovation.

Mr. Glenn Brimacombe: In closing, our brief is about building a better society. It's about investing in a modern, dynamic, and responsive health system. It's about competing and winning in an increasingly interdependent and global economy. It's about nation-building. In sum, it's about investing in health and generating wealth—healthy and productive citizens, combined with the right tools and knowledge to compete successfully.

ACAHO looks forward to remaining an active and constructive partner in the national dialogue about the symbiotic relationship between investing in the health of Canadians and the multiple dividends that can accrue to society.

Thank you.

[*Translation*]

The Chair: The next group is the Canadian AIDS Society.

Mr. Lapierre.

Mr. Paul Lapierre (Executive Director, Canadian AIDS Society): Thank you, Mr. Chairman.

My name is Paul Lapierre. I'm the Executive Director of the Canadian AIDS Society. With me today is Mark Creighan, who is responsible for media relations and some policy analysis.

[*English*]

I do not intend to speak for the whole eight minutes. I think you have already received the brief. I just want to highlight a couple of key elements.

HIV and AIDS is still a factor in our country. Every year more than 5,500 Canadians are infected. It comes down to a new infection every two hours. By the time we depart the Parliament buildings today, I'm sure a new Canadian will have been infected, and this is a challenge.

In 2004, the federal government acknowledged the need for more to be allocated to the fight against HIV and AIDS in our country by increasing the federal funding to $84 million per year. Unfortunately, that funding will occur in 2009. In light of the financial situation of our country, we are urging the committee to make a recommendation that the $84 million become available not in 2009 but in next year's budget, if deemed appropriate.

In addition, what is the reality faced by AIDS service organizations around the country? It's volunteers. At the root of many organizations, volunteers are running those organizations. The federal government launched the voluntary sector accord. Unfortunately, that accord is becoming dormant because of lack of resources and commitment to implement the accord. So we are urging Parliament to take that into consideration in the preparation of the next budget.

Many people living with HIV and AIDS are also facing other infections, such as hepatitis C. We are recommending that instead of having a one-year program to address hepatitis C, which we've had for the last five years, we also do a multi-year commitment to look at hepatitis C infection. Keep in mind that in both hepatitis C and HIV, prevention is the only cure. For people infected, treatment is very costly. So we are going back to the Romanow report, urging the creation of a catastrophic drug plan. We are not seeking additional resources; we're looking at coordination with the provinces, coordination of resources to allow bulk purchasing of medication and therefore reduce the cost.

In closing, I urge everybody to think about prevention in public health. As was mentioned in one of the throne speeches, prevention is often the only cure. When it comes to HIV and AIDS, we must invest in prevention, meaning we must address determinants of health: we must talk about poverty; we must look at housing; we must improve the quality of life of all Canadians, including people at risk of infection. Often when we talk about IV drug users, inmates, aboriginal people, people from various ethnocultural backgrounds, we're looking at discrimination and stigma; therefore, people are often in the underground, acting in a way that is causing harm to themselves and to others.

So we are urging the government to move forward with the harm reduction framework, addressing the determinants of health, investing in prevention, so that one day in Canada we will be free of HIV and AIDS.

Merci. Thank you.

● (1545)

[*Translation*]

The Chair: Thank you, Mr. Lapierre.

That's a time saver.

[*English*]

which is very valuable. Thank you.

The next group I have is the Canadian Dental Association, and Mr. Cottrell.

Dr. Jack Cottrell (President, Canadian Dental Association): Good afternoon, and thank you for inviting me here to address you on behalf of Canadian dentists.

My name is Jack Cottrell. I'm the president of the Canadian Dental Association. I live and I practise general dentistry in the small community of Port Perry, Ontario.

Joining me today is Mr. Andrew Jones, director of corporate and government relations at the Canadian Dental Association offices here in Ottawa.

I'd like to start my comments today with some good news. The previous two CBA presidents who addressed this committee talked about the need for a centralized role for dentistry at the federal level. This year we were gratified to report the position of chief dental officer for Canada having been created and filled by Dr. Peter Cooney. Dr. Cooney has already been in regular contact with us, and we look forward to a long-term working relationship. Together, we have important challenges to address.

For too long, public investments in dentistry and oral health have been shrinking, to the point that now less than 5% of the $9 billion spent on dental care annually is publicly funded. According to a recent report of the Canadian Institute for Health Information, this places Canada among the lowest of the OECD countries for public investment in dental care.

While the majority of Canadians continue to have access to dental care through privately funded dental plans, the portion that does not remains significant. Until now, we've had no way of knowing just what that means in terms of unmet dental needs, but now, with the leadership of the chief dental officer, we will begin to collect statistical data to determine where the greatest areas of need exist. That is the first piece of the puzzle.

The next step is to decide what to do about it. Already, dentistry has begun to mobilize, to address access to care issues. It has been the subject of many forums at the provincial and at the national level, and many professionals are putting their energy and their thoughts into creative solutions. In addition, individual dentists in this country are helping every single day by quietly taking care of people in need without fuss. But we cannot do it alone.

As our understanding grows about the important connections between oral and systemic health, the urgency to address unmet needs grows also. If your mouth is sick, the rest of your body is affected, and the effects can be quite major.

We don't have all the answers yet, but it looks like periodontal disease—gum disease—may be a complicating and/or causative factor in heart disease, pre-term and low-birth-weight babies, and there is definitely a connection, a proven connection, with diabetes. These are big health care concerns, both in terms of their impact on quality of life and their cost to the health care system. If dentists can help to prevent or reduce the severity of some of these illnesses, it will be great news indeed.

Of course, it's not just the disease cycle that impacts on a person's well-being. It's also the quality of life issues that go along with poor oral health. Children with rampant dental caries, or cavities, have a harder time concentrating in school, sleeping properly, and eating a healthy diet. Most provinces have at least some kind of system in place to ensure access for children, in spite of significant cutbacks, but unfortunately for seniors it's another story entirely. In most regions there is simply no public coverage for seniors. In addition, those who would have had private dental plans throughout their working years often lose that coverage on retirement. Added to that, many nursing homes have no facility to provide dental care. We see a real problem brewing here.

This is the time for creative ideas. Dental schools, no doubt, are part of the solution. Traditionally, dental school clinics have been a source of low-cost care and community outreach, but dental schools are struggling with low government funding, and we're having to make some tough choices about what programs we can continue. So one thing we're asking for in our brief is restored funding to these dental schools.

We're also asking for a greater investment in oral health research to tease out those connections between oral and systemic disease cycles, so we can really start to intervene effectively. In addition, we're recommending that this committee investigate a new type of medical savings plan, or, as we're calling it, the personal wellness investment fund. This idea is still in its infancy, but we think it could have tremendous potential.

● (1550)

Essentially, when a retired person is converting funds from their retirement savings plans to a retirement income fund, some of that money would be placed in a special tax-free holding account, to be spent on medical expenses, including dentistry, that are not covered under the Canada Health Act. Many other ideas and solutions are awaiting discovery.

Our brief contains a number of other recommendations aimed at improving oral health for Canadians. In it, we acknowledge some of the genuinely good work on the part of this government to improve the dental program for first nations and Inuit Canadians. We also recognize the increases to registered retirement savings plans limits. We ask for your consideration on a number of new issues, such as family leave for self-employed professionals. I know you will take time to consider it carefully, and I thank you for that.

With the assistance of my colleague Andrew Jones, I would be happy to answer any questions you may have today, or just feel free to contact the Canadian Dental Association at any time in the future.

Thank you very much.

The Chair: Thank you, Mr. Cottrell.

From the Canadian Healthcare Association, Ms. Sholzberg-Gray.

[*Translation*]

Ms. Sharon Sholzberg-Gray (President and Chief Executive Officer, Canadian Healthcare Association): On behalf of the Canadian Healthcare Association, I'm very pleased to be here this afternoon.

[*English*]

On behalf of the Canadian Healthcare Association's board of directors and our provincial and territorial members, I'd like to thank you for this opportunity to participate in these pre-budget deliberations.

I'd like to tell you that CHA is the federation of provincial and territorial hospital and health organizations across Canada. Our members represent the entire continuum of care, including acute, home and community, long-term and palliative care, as well as public health, mental health, and other health-related services.

I should tell you that the teaching hospitals so ably represented by Glenn Brimacombe and ACAHO are part of our membership network as well, so we support and endorse the points of view they express.

CHA's board members, who are the trustees and managers in our health system from across Canada, bring to the CHA board table the realities of the front lines. In our brief you'll note that CHA and its members continue first and foremost to support a responsive, publicly funded health system. We believe that this kind of system is in the best interests of Canadians serving to enhance competitiveness and economic growth while affirming the core Canadian value of access to health services based on health need rather than on ability to pay.

As well, we continue to advocate for sufficient ongoing and predictable federal funding that is tied to the achievement of pan-Canadian objectives. To this end we support the investments agreed to in the 2004 10-year plan to strengthen health care and we acknowledge that progress has occurred across the country in various ways. However, CHA believes that there remains unfinished business and unmet needs in a variety of areas including—and this list is not conclusive—wait times, home and community care, health human resources, primary health care reform, access to pharmaceuticals and electronic health records, enhancement of public health, moving forward on an aboriginal agenda, and so on. And more has to be done.

Canadians deserve access to comparable services across a broad spectrum. All parts of the care continuum, therefore, require sufficient funding. While hospitals need appropriate levels of funding to address wait time issues and to meet the needs of acute care patients, we believe that part of the solution is to move forward in other areas as well, in the community, in primary care.

I'd like to focus today on a few issues that are of particular concern and interest to Canadians and to CHA's members.

The first is the important link between the health sector and the Canadian economy. Our publicly funded health system is respected internationally for ensuring healthy workers and affording businesses based in Canada a distinct competitiveness advantage. Many industries here today would not operate in Canada without our health system. Our health system is also a potential source of wealth creation, exports, and 21st century jobs for Canadians. Our single payer system provides economies of scale that could serve to drive the development of a domestic export industry by building upon our first-class health professional training programs—in need of further support, but first class, nonetheless—our first-class researchers, our delivery systems, and information technology development.

It is our view, rather than seeing investments in research and health innovation, in health system reform, even in health system delivery as a burden, we should in fact approach them as investments in product development, and we should recognize the health sector as a potential creator of not only jobs in Canada but also exports.

The second is the issue of public-private funding and the delivery of health services on a private basis as well. I'd like to make some comments on this because I think it's very relevant to our economy. In the wake of the Supreme Court Chaoulli ruling on private health insurance, there has been increased debate on the effectiveness of Canada's health system. There are some who contend that countries with public and private funding and delivery options for acute care services outperform Canada's single payer system. However, our analysis of recent data from the OECD refutes this claim, showing that as a percentage of GDP, and on a per capita basis, Canada's publicly funded health system is less expensive than that of the countries to which it is compared. We would like to note—and it's important to note this—that those who contend that Canada's health spending is high typically base this claim on total expenditures, public and private combined, which is misleading. We should be comparing public to public.

● (1555)

The CHA would like to reaffirm its position that the appropriate public-private mix in the funding and delivery of health care must be linked to the principle of access to health services based on health need. I should add, though, that we regard private sector involvement as neither inherently evil nor a panacea to the challenges facing our health system.

We support an evidence-based approach as to when and how private funding or delivery could and should occur, and we would advise those who advocate for more privatization to be more cautious, since solutions that shift the burden of health costs to the employers of this country could have a negative impact on the economic competitiveness I've just described. With a higher Canadian dollar, we should be particularly wary of these kinds of magic solutions.

Third, I'd like to talk about wait times, which remain a top concern for Canadians. The federal government has stated that reducing wait times has become a litmus test of the government's commitment to universal, high-quality, publicly funded health care. Growing concern over waiting times has increased the likelihood of citizens turning away from the public system—and this is the public system, by the way, that gives us all of the advantages I've just outlined.

The CHA and our members share this concern. We all know that to reduce wait times the federal government will be investing $4.5 billion over six years, $5.5 billion over 10 years, through the wait times reduction fund. We also know about the five hot spots that have been singled out to try to achieve meaningful wait time reductions in cancer, heart, diagnostic imaging, joint replacement, and sight restoration by March 31, 2007. Our organization's assumption is that these hot spots are a beginning and not an end.

We see the wait times issue in the broader context of a complex health system with multiple issues to be addressed. A focus on quantity is important, and Canadians deserve timely access to the procedures they need, but we have to be concerned also about quality and appropriateness of care. So we have to address the critical issue of appropriateness and distinguish between need and demand.

Canadians expect tangible results, publicly reported information about health outcomes and costs, clear lines of accountability, and above all, access to timely and quality health care when they need it.

The CHA and its members will be working to help governments achieve results while holding their feet to the fire regarding the meeting of their deadlines as agreed to in the 10-year plan. I remind everyone that the first deadline—for pan-Canadian benchmarks or targets for wait times—comes at the end of this year.

I'd like to also refer to four issues that I think are important to address and for which we're asking extra money at this time. We understand, of course, that the 10-year plan created a tremendously new and larger fiscal envelope for the future.

We need to move forward quickly on an electronic health record. There's not enough money in the pot to have the pan-Canadian operable system in a short timeline, and there's not enough money in the pot, frankly, to broaden its perspective.

Home and community care, acute care replacement, is not enough, even along with some mental health and palliative care services provided in the 10-year accord. The real issue is that we haven't addressed on a pan-Canadian basis ongoing chronic care and continuing care issues for a growing elderly population in the community. This must be addressed.

Research I've already mentioned. We need enhanced investments in research, and as you will note in our brief, we ask that some of the co-payments or matching funds for some research programs be reduced or eliminated, which will mean more research investments needed by the federal government.

I'd like to talk about the CST. It's important to note—and a previous speaker has—that determinants of health such as income status, educational level, housing, social services, and healthy lifestyles are all critically important. Since these factors play an important role in ensuring a healthy society, we advocate for an escalator in the Canada social transfer comparable to that in the CHT. We would even say that if you have a choice between putting more money—and it's very difficult to say this—into the health system, while it needs it, we have to address the CST as well, and we would urge that be done.

● (1600)

In conclusion, it's crucial that our health system be effective, efficient, and accountable, in light of its relationship to and impact on the Canadian economy. CHA and its members applaud the progress being made across the country, but we urge everyone to address unfinished business as soon as possible. Our economy depends on it; Canadians depend on it.

Thank you for hearing us. The details are in our brief, and we'd be happy to answer any questions. Thank you.

[*Translation*]

The Chair: Ms. Marrett, from the Canadian Mental Health Association, over to you.

[*English*]

Ms. Penelope Marrett (Chief Executive Officer, Canadian Mental Health Association): Good afternoon, Mr. Chair. Bonjour, monsieur le président and members of the committee.

My name is Penny Marrett. I am the CEO of the Canadian Mental Health Association.

CMHA welcomes this opportunity to address the theme of prosperity and productivity, chosen by the committee for this round of pre-budget consultations.

We are here today to challenge the committee to look outside the traditional economic model of small, medium, and large businesses and consider whether Canada is making the most of the existing potential of its citizens. If Canada wishes to remain at the vanguard of nations that embrace inclusion and equality of opportunity, the Government of Canada must look at ensuring that individuals affected by mental illness, or other mental health problems or other episodic disabilities, are not marginalized. If Canada is a nation that wishes to leave no one behind, then the next federal budget must build on principles enunciated today and provide funding for housing and programs to support not-for-profit businesses employing those with unique abilities.

As you know, depression and other mental health issues are costlier to the Canadian economy than cardiovascular disease. According to Health Canada, the economic burden on employers is close to $30 billion a year. The World Health Organization has declared that one in four families has a member experiencing a mental illness. Just look around this table: with one in five Canadians affected by mental illness, how many in this room can say they have not been touched in some way?

CMHA is asking the government to dedicate a portion of the $41 billion committed already to health system reform to ensure there is proper diagnosis and treatment of Canadians affected by mental illness and other mental health problems. This funding should be committed for the development and implementation of a strategy for mental illness and mental health that will include the eradication of stigma, the inclusion of mental illness in the chronic disease strategy, and tax relief for companies that implement mental wellness programs.

CMHA appreciates the support of parliamentarians for the motion last spring that included the need for an overall strategy for mental illness and mental health in Canada.

● (1605)

[*Translation*]

Since work is an integral part of participation in society, the loss of paid employment can have serious psychosocial and economic effects. In making this policy statement, the Canadian Mental Health Association recognizes that access to useful paid employment is a fundamental human right.

[*English*]

Employing talented Canadians, no matter their disability, is good business practice and contributes to our common prosperity. When employers invest in the health of their employees, savings are achieved in reduced absenteeism and increased productivity.

CMHA asks the federal government to take decisive action to ensure that minimum wages across this country allow Canadians to earn what is needed for basic food and housing needs; to encourage active participation in the workforce of persons affected by mental illness, other mental health problems and other episodic disabilities, according to their capacity to work; to protect the existing child tax benefit from clawbacks by other levels of government; and to ensure that education is not outside the means of Canadians who would like to pursue their studies.

[*Translation*]

Having a home is the starting point that enables us to live as we wish in safety. We must be able to choose where we live, the people with whom we have relationships and the way in which we behave.

At home, we should be able to think and relax in peace in the privacy of our home. We should be able to decorate and maintain our home as we wish. The place where we live is the centre of our social lives. It can be argued that these are prerequisites for the mental health and well-being of every person. Housing programs should necessarily take them into account, and these rights should not be considered as privileges granted to certain persons.

Security, freedom of choice, independence, financial self-sufficiency, privacy and power are all an integral part of the recovery process. No one should be deprived of these rights.

[*English*]

CMHA asks the federal government to address the lack of affordable housing by making a commitment beyond the recent one-time investment. Canada needs a housing strategy that will be ongoing and stable, one that works, not only for the top half of the income percentile, but one that ensures that all Canadians, no matter what the income, can have access to proper permanent housing. Housing determines access to opportunities and employment and it also determines health. It supports sustainability and employability. It plays a significant role in reducing the waste of human potential.

Canada stands proud at being singled out internationally. However, it remains the only G-8 country without a strategy for mental health and mental illness. It is now time for Canada to show the rest of the world that it believes in the good mental health of its citizens; that people experiencing a mental illness or other mental health problems have the same rights of citizenship as others; and that all Canadians have a chance to contribute to the prosperity and productivity of this country.

Merci. Thank you.

● (1610)

The Chair: Thank you.

The Canadian Paediatric Society, Mr. Walker.

Dr. C. Robin Walker (Past President, Canadian Paediatric Society): Good afternoon.

I'm Dr. Robin Walker, the immediate past president of the Canadian Paediatric Society. Outside of these walls I am an academic physician who works in one of Canada's academic health sciences centres—the one here in Ottawa. My clinical work is in newborn intensive care. I'm also an educator and a researcher.

Good health is the cornerstone of modern, well-performing economies, and it is key to economic growth and sustainable development. There is ample evidence that investing in health brings substantial economic benefits. In a World Health Organization study, Dr. Jeffrey Sacks noted that increasing life expectancy at birth by 10% increases economic growth by 0.35% a year. Ill health and shortened life expectancy, on the other hand, account for about 50% of the growth differential between rich and poor nations.

Good health is not achieved through a laissez-faire approach. It requires far-sighted, proactive, and long-term measures. It requires policies and programs that not only treat those in ill health but that promote good health through evidence-based prevention strategies. It is an investment in our future, and it leads to longer, happier, and productive lives.

Let me first speak to national injury prevention. Unintentional injuries are the number one killer of children, adolescents, and young adults. Children die of injuries more than all other childhood diseases combined. They are the major cause of disability and morbidity. They represent a huge financial burden on the health care system, and they have a very significant negative impact on productivity and the economy.

We have made remarkable progress over the past 50 years in instituting various safety measures, but we remain far too complacent about the inevitability of so-called accidents and injuries. Research has shown that well-organized efforts to provide safer physical and social environments can result in marked and often rapid reductions in injury mortality and morbidity.

The cost of injuries is staggering—an estimated $9 billion in Canada in 1995—but the potential economic benefits of investing in injury prevention are equally impressive. WHO data show that one euro spent on child safety seats results in a saving of 32 euros to the economy—that's 32 to 1. One euro spent on bicycle helmets saves 29 euros, and every euro spent on injury prevention counselling by pediatricians saves 10 euros.

The WHO framework for any country wanting to address the problem of injury includes the development of a national plan; the formation of an inter-sectoral injury prevention committee to ensure the proper integration of this issue into different government policies; a national surveillance system, strengthening the national capacity to respond through primary prevention and care; legislation and government programs; the promotion of evidence-based practices; and research and development into primary prevention and care.

In view of the very significant importance of this issue to the national economy, the Canadian Paediatric Society recommends that the federal government allocate $20 million this year for the development of a federal-provincial-territorial strategy on injury prevention, together with a multi-year financial commitment that would facilitate the effective implementation of related policies and programs. Those numbers are not just pulled out of the air. We have the actual cost of the very successful national immunization strategy for comparison.

Health in childhood determines health throughout life and into the next generation. The early years are critical, and ill health or harmful lifestyle choices in childhood can have a lifelong impact that in turn causes financial, social, and health burdens to a society. Studies show a strong link between healthy adolescents and their decision to remain in school. Early intervention strategies aimed at health maintenance can maximize high school graduation.

There is increasing recognition that schools can play a vital role in encouraging healthier lifestyles. Some jurisdictions are considering or have implemented mandatory daily physical activities, smoking cessation campaigns, bans on junk food and drinks, and nutrition education programs, but more could be done. Schools present ideal venues for other early intervention programs to promote mental health, avoid addictive or risky behaviours, and prevent injuries.

The federal government can play a pivotal role in encouraging the provinces and territories to implement comprehensive school-based health strategies. We recommend, therefore, that the federal government allocate a substantial investment of $40 million to facilitate the implementation of comprehensive school-based strategies.

We have spoken in the last two years on the national immunization strategy, and the $300 million allocated for the purchase of new childhood vaccines has been an outstanding success. Almost all governments now make these new vaccines available, and they are publicly funded.

● (1615)

There is a gap. It is that the patchwork of varying immunization schedules means that while all governments provide most of the new vaccines, they don't all comply with recommendations on optimum age, etc. We'd like to see a uniform schedule. Nevertheless, the NIS is an excellent program, having a very positive impact on children, and it should be continued.

We recommend that current funding for provincial childhood vaccine programs be made permanent and that it be reviewed annually to ensure it is sufficient to assure that all Canadians, regardless of where they live, have equal access to new vaccines approved by the National Advisory Committee on Immunization.

We also recommend that the funds for first nations and Inuit immunization programs be utilized to ensure that aboriginal children and youth of Canada have equal access to immunizations.

Last, we recommend the continued allocation of $10 million per annum to the Public Health Agency to ensure that the objectives of this strategy are achieved.

Millennium development goals. Worldwide, 11 million children die before the age of five, including four million in the first month of their lives. Another four million babies are stillborn every year. The economic cost of so many deaths is staggering, yet most of those deaths are easily preventable.

Canada is very much a part of the global economy, and health is acquiring a global dimension. We have to contribute and share in improving health in the global community, and not just through altruism. Helping the developing countries develop their health systems and fight disease benefits them, but it also contributes to our own health and economic security. Our society has urged the Prime Minister to fulfill the government's own commitment to increase international aid to 0.7% of GNP by 2015, and we call on the government again to increase its annual allocation to international development to a percentage that will enable it to meet that pledge for 2015.

Finally, on health human resources, all of our health strategies risk being compromised without the appropriate number and distribution of health professionals. We are all aware of the imminent human resource crisis on our doorstep. While the federal government has initiated work to reduce wait times and increase the number of health professionals, none of this addresses pediatric issues.

The effects of this lack of attention are beginning to emerge: delays of two years for children to get mental health care. That is here in Ottawa, and it is far longer than any of the five hot spots that are being addressed. It is surely a clear statement of the need for a national mental health strategy.

A mother who cannot find a pediatrician for her 11-month-old baby with special needs—almost 20% of Ottawa's children are in that position. Newborns are being airlifted to other communities because there are no local neonatologists or pediatricians.

In view of the serious health implications, the Canadian Paediatric Society calls on the federal government to work with our organization on a pediatric wait times initiative, and to allocate $500,000 for this project, a mere drop in the bucket compared with the moneys being spent on wait times for other populations.

In conclusion, you will all agree, even though it's a cliché, that our children are indeed our most precious resource. In an increasingly competitive world, maintaining their good health is fundamental to our future social and economic progress. This has never been more true, given our declining birth rates and a growing elderly population. Investing in these measures will help to protect and promote children's health and will contribute immeasurably to sustainable development and long-term prosperity in this country.

The Chair: Thank you.

Seven-minute rounds: we have Mr. Merrifield, Monsieur Loubier, Mr. McKay, and then Ms. Wasylycia-Leis.

Mr. Rob Merrifield (Yellowhead, CPC): Thank you very much.

Actually, it's a great opportunity for me to be able to be here, because health care is really near and dear to my heart, and I've spent most of my time on the health committee. I almost wonder what I'm doing here at the finance committee talking about health, but I'm glad I am, because all of you put forward very good arguments as to why we should invest in health and health care. I don't think there's anyone who could argue that one is more powerful than the other. You could all make very strong cases for it. But it's very key I think to understand in health care, if we're going to have a serious debate about health care in this country, the problem that is about to face this country. It's not about whether we have a little more private or a little more public. That's a nonsense debate that is going nowhere and is ridiculous. The real debate should be on how we are going to sustain health care over the next 40 years as we see this baby boomer bubble coming and we see an obese population of our youth going to hit that system at the same time. Until we can address those, we're not going to sustain our system.

That becomes really important in the debate here of you asking for dollars, because if you think the pressure is on you as different organizations now, give it 10 years and see how aggressive you'll be at trying to claim the public purse for your own cause. So what we have to discern as politicians is how we can drive to accountability for the dollars that are spent in health care and use those in the most effective way possible.

That takes me to the question.... There are so many questions here and I have only seven minutes, so I'm trying to focus in on the dollars and cents, because this is finance.

My first question is to Ms. Sholzberg-Gray. You talked about something specific in your deliberation to the committee, and that is on Infoway, suggesting that Infoway needs a significant amount more dollars. I fully agree with what they're trying to do, which is electronic records following the patient. We see the problem, the deaths that are happening within our hospitals because of mistakes that are being made. So I believe that is one of the solutions. But Infoway has had $1.4 billion for five years and has only spent.... Well, they still have over $1 billion in their account, last I saw, and they were asking for more dollars.

I see provinces that are well ahead of the bubble, way ahead of Infoway on this, and I see precious little coming out of Infoway. So I would like to ask you how you can justify coming and asking for more dollars for Infoway when there's no accountability for the dollars that are being spent at the present time.

● (1620)

Ms. Sharon Sholzberg-Gray: First of all, I just want to say that I agree with you about the long-term sustainability based on having a well population. There's no question. That's why we like to look at a complex set of solutions and not just deal with wait times here, in isolation from keeping people well in the first place so they might not have to be on those wait lists. That's our challenge.

With respect to Canada Health Infoway, I think we have to distinguish, first of all, between the amount of money you might have seen in their bank account and the amount of money that's already committed. What we find out in speaking to the people from Canada Health Infoway is that they've committed a lot of money, which has to be delivered by the end of this fiscal year. That's number one.

Number two, one of the reasons there wasn't enough uptake fast enough for the kind of money they were offering to various provinces and to various programs is—and I'm not trying here to put their case for them, as I'm sure they're doing it themselves—the fact that they were asking for a 50-50 matching contribution. They've now moved that to 75-25, so those provinces that are poorer can invest their 25 more easily than they can invest 50. But that has used up more of the Canada Health Infoway money in terms of their future commitments.

The other thing is that they're committed to 50% of the Canadian population for the year 2009. It's not good enough to have 50%; we need 100%. And it's not good enough to deal just with hospitals; we need to have the entire continuum in the electronic health record and individual offices and individual health providers and so on.

All I'm saying is that we need to look at that big picture. Canada Health Infoway can't continue making commitments unless it knows that—

Mr. Rob Merrifield: Yes, but Canada Health Infoway has had this money for four years and has seen very little.... If they're doling the money out between now and the next year or the next few months, that's one thing, but we have provinces that are so far ahead of the curve of what Infoway is. My province of Alberta is one, where Wellnet is a perfect example—

Ms. Sharon Sholzberg-Gray: That's the one that has the money.

Mr. Rob Merrifield: —and that's because it invested earlier, but it invested much less per capita. That's 3.5 million people who would be on electronic records; that's 10% of the country. If they can do it in 10% of the country and they refine it, why not just flow this through the rest of the country so that we're not reinventing things?

I am very concerned with what I see happening with Infoway, or the lack of it, not only with its performance but in its lack of accountability. It's one of those foundations that is outside our opportunity to look into. But it struck me, when you were advocating for more dollars for it, that I think there are other hurdles it has to clear before we should be doing that.

I want to move on because I think we've exhausted this and there are bigger fish to fry.

I'd like to go to HIV/AIDS. I was one of the advocates for increasing the funds from $42 million a year to the $84 million to $85 million a year when it came to the health committee. The health committee actually advocated $100 million rather than $85 million—but for that we have to have accountability. We have to know that there are some goals that are achievable and that you're going to strive to be able to make this extra $42 million actually count for something.

That really is the thing that bothered me about what came out of the direction for the government. You're here saying, okay, let's have this money right now. My question back to you would be, how would you work towards prevention to be able to make sure we actually get some accountability, some results, for this? We have 4,000 new infections per year; we need to reduce that to 2,000 in five years. Is that something we can actually make happen? How would you proceed to make that work for the community and the people of Canada?

● (1625)

Mr. Paul Lapierre: It's a very good question. I don't think that I alone have the solution to this. We need to work in partnership. We need to increase—

Mr. Rob Merrifield: Let me stop you there. You're asking for us to advocate for that money right now, and I'm saying, okay, tell us how you're going to actually achieve the results and then you have a very good case. But without that, you're just another voice asking for money. That's why I issued my challenge to you.

Mr. Paul Lapierre: Currently, close to $57 million is allocated in four spending areas: CIHR, which is funding research; some of the money remained with the Canadian Public Health Agency through grants and contributions for programs for community-based groups; some of the money is directed to CSC for correctional services and programs in prison; and lastly, some money remains with Health Canada for the first nations and Inuit health branch and for a few international activities.

What I'm saying as part of an organization that submitted a funding proposal that met all the criteria to do community-based research around social behaviours is that the research was not funded because of a lack of money. We know that three years from today the money will be available, but since it's not available now, that research is on hold for another two years. That's one example of what we'd do with the money if we had it now. There are enough proposals and ideas there.

Engaging in social marketing and awareness is a multi-year commitment. Currently this year, in the social marketing resources, we cannot even launch a series of ads in all the national newspapers on World AIDS Day because the money for social marketing will be released next year. The urgency of initiating some awareness leading to prevention is right now and not in five years.

Mr. Rob Merrifield: Thank you.

The Chair: Thank you, Mr. Merrifield.

Mr. Loubier, Mr. McKay, and Ms. Wasylycia-Leis.

[*Translation*]

Mr. Yvan Loubier (Saint-Hyacinthe—Bagot, BQ): I'm going to continue along the lines of what my colleague raised earlier. The amounts available in the budget are enormous. The Conference Board has estimated a surplus of approximately $10 or $12 billion for next year. We agree with that estimate. However, matters may be viewed this way: $21 million today could save many potential victims in the coming years. We have the means, and the government is also looking for original ways to distribute surpluses. You say that this additional $21 million could save hundreds, even thousands of lives.

Mr. Paul Lapierre: We know it's possible to achieve a 100 percent HIV/AIDS prevention rate. However, there is still no cure. Every case of infection averted as a result of investment in prevention and education saves the government millions of dollars.

Mr. Yvan Loubier: You've just convinced me, and I hope all my colleagues will be convinced as well. We'll make sure that appears in the consultation report.

My next question is a general one concerning the health sector. An agreement reached between the federal government and the provinces in the fall of 2004 provided for the implementation of one of the suggestions from the Romanow Report: that federal government contributions rise to the 25 percent level. In view of that agreement, we had the impression that the entire matter of health funding was settled. That moreover is what certain government officials and representatives told us. However, I see there is under-funding, particularly for university hospitals. I see we have an unenviable ranking relative to the other OECD countries.

I'd like you to give me some details on the subject. We had the impression that everything had been going well since fall 2004, but we see that the basic issues simply haven't been resolved.

● (1630)

The Chair: Are you putting your question to anyone in particular?

Mr. Yvan Loubier: I'm addressing everyone because it concerns all sectors.

The Chair: Does someone wish to answer?

[*English*]

The Chair: Mr. Brimacombe.

Mr. Glenn Brimacombe: I'll take a stab at it. Certainly much of the debate over the past decade, and it really resonated around 1996 when the federal government made some significant cuts, was what is, generally speaking—and it's arbitrary—an appropriate share for the government to contribute to health care.

If you look at the recent spate of reports through the late 1990s and through the new millennium, with Romanow and Kirby, there was a general consensus that 25% for funding ongoing health care expenses was required. I don't think anyone is disputing that. To a large degree, many of us are pleased to see that contribution in terms of a raised level.

The other piece that comes with it, though, which others are talking about, is that other targeted strategic and time limited investments need to be invested into the system where there is a natural role for the federal government to make a contribution. So in a sense, it's about fixed and variable investments that the federal government is making in health care. At least through our eyes there is what is variable or fixed vis-à-vis the Canada health transfer and the 25% contribution, but there are also pieces of the puzzle, whether it's the electronic health records that Ms. Sholzberg-Gray spoke to or some of the other pieces that the panel has spoken to, where there really is an important opportunity. You mentioned the provinces, or where there is a surplus, and some of the provinces are certainly constrained in terms of the revenues they have, or at least claim to have. There's a role and an opportunity for the federal government to have some enhanced stewardship over the future direction of the system.

The Chair: Ms. Sholzberg-Gray.

Ms. Sharon Sholzberg-Gray: I want to say one thing. In our brief, which I think is in front of you, we actually outlined that history quite well. It's true that the contribution under the accord that was agreed to last year does reach that 25% level, but it deals with a very limited home care program, a two-week acute care home care program. So if we wanted to address, in terms of pan-Canadian funding, care in the community and in the home in a broader way for an ongoing chronic needs population—and everyone talks about the need to provide services to people with chronic conditions, so as to prevent them from going into the very hospitals that you say are still having problems—we need to focus on those areas.

We're not saying that the accord hasn't come a long way and done a lot; all we're trying to say is it hasn't done everything and there's still some to be done. Let's put this on the agenda at some future date or let's start working in that area now.

If we don't work on addressing chronic needs, if we don't work on keeping people well, if we don't work on primary health care reform—and all those are in the accord—and if we don't ensure that we adhere to deadlines and make sure it's done, then, as we know, the system won't be able to be sustainable over the long term, no matter who pays for it. In other words, we have to have an affordable system for the government, for private providers, and for everybody.

The Chair: Monsieur Loubier.

[*Translation*]

Mr. Yvan Loubier: It's true that after being deprived for years, one tends to consider the slightest agreement that results in an improvement as salutary. However, it would undoubtedly have been preferable for the people in the health sector to qualify their reactions somewhat. We had the impression at the time that the matter had been resolved. The political debate thus turned to transfers for postsecondary education because that issue fell under the CHST. Since we thought the health issue had been resolved, we heard a lot of talk about education, but very little about health.

So I invite you to qualify your remarks when you speak next. We now have a better understanding of the issues. We know that 25 percent isn't everything. There are other challenges that must be met.

Thank you.

The Chair: Thank you, Mr. Loubier.

Mr. McKay.

[*English*]

Hon. John McKay (Scarborough—Guildwood, Lib.): Thank you, Chair.

The first question is directed to Ms. Marrett with respect to mental illness.

I appreciate that your brief was somewhat directed towards housing security and income security—legitimate points. The concern you didn't express, and I want you to comment on, is the issue with respect to research in mental illness.

Arguably, mental illness, as I understand it...schizophrenics occupy about one in twelve beds in the hospital system in Canada, and depressive illness will be the leading disease burden by the year 2020, yet when it comes to research, it appears that mental illness is the poor cousin of medical research. So what's the problem here? Can't you elbow your way to the table and muscle aside the others? Are they just that much better than you are, the cancer folks, or the AIDS folks, or the cardiovascular folks, all of whom have legitimate claims? Mental illness seems to fall to the bottom of the table. Can you tell me why?

● (1635)

Ms. Penelope Marrett: I think there are several reasons.

You're right, we didn't comment about research this year. Through some research of our own over the last couple of years with other organizations, not just in the mental health/mental illness stakeholder community, we realized that housing and income security are two of the most important things for individuals at this time.

When you look at research, in a sense—and I have spoken to many researchers in this field—the stigma for researchers in this field is unbelievable, for individuals. So when we talk about stigma, we're not only talking about the individual experiencing a mental illness and their family, we're also talking about everybody around them, which would include the research community.

As a community, it has only really been in the last five to ten years that we have become much stronger and worked together in order to be able to advocate for more funding for research. We're nowhere near where we should be; we believe we should be much further along. We absolutely support some of the work that is going on with the Institute of Neurosciences, Mental Health and Addiction within CIHR, but we believe a lot more needs to be done.

We also believe that research for people with mental illness and other mental health problems is very cross-cutting; it is not just biomedical. We hope to see a lot more being done.

We have spoken to Senator Kirby and the Senate committee about the issue of research and the importance of ensuring that there is more research funding.

If today we were given six times the amount that the institute has now, we wouldn't have the capacity in this country to be able to roll it out immediately. We have to build that capacity. It is one of the last bastions of capacity-building within the research community that needs to take place, and we are extremely supportive of it.

Hon. John McKay: If it's built, will they come?

Ms. Penelope Marrett: I believe so, yes. I do not want to pick on anybody else, but because my colleagues from AIDS are here, if you looked at the stigma of AIDS many years ago, there were very few researchers in the AIDS community. When the money started to flow, more individuals began to look at AIDS as a possibility.

In the end we have to remember that researchers have families too. They need to be able to support their families. Although they may love research and they may love a particular part of research that they wish to do, if there's no money available for them to do that particular kind of research, how in the world can they support their families as well?

Hon. John McKay: Is that just a squabble among the various research groups, or is it somewhere that the government needs to give direction?

Ms. Penelope Marrett: I think the government should be giving some direction. I think the government has given direction in other chronic illnesses and episodic illnesses, and it's time now that something is done for people with mental illness and other mental health problems.

Hon. John McKay: Thank you very much.

Perhaps I could direct my second question to the academic folks.

Obviously this is a finance committee and obviously the concern for us is productivity. Frankly, the witnesses who tell us how to spend money seem to far outweigh the witnesses who seem to be able to tell us how to increase the pie.

I'm interested in how to increase the pie. What is it with Canada, in general, but some universities in particular don't seem to be able to translate Canada's leading position as a public research nation into private research and the commercialization that would flow from that? Am I totally off base, or is that, in general terms, a correct observation?

● (1640)

Dr. Bernie Bressler: I'm sorry, but it's not an entirely correct observation.

I happen to come from the University of British Columbia, which —

Hon. John McKay: You guys do all right. That's what I understand.

Dr. Bernie Bressler: We do all right, that's right. We also do all right, by the way, on mental health research and HIV/AIDS. In fact, they're not on a different level, but that's the previous question.

Hon. John McKay: That's part of the reason you do all right.

Dr. Bernie Bressler: Maybe it is.

We have done very well, but in general, as you look across the country, the commercialization of research has been extremely successful really from coast to coast to coast. All the universities gathered up the resources that were needed fifteen or twenty years ago. The time lag is large, but as I said in our brief in regard to the biotechnology community of this country, we grew it. It's home-grown to a very large extent.

The other thing we've seen is that the multinationals are coming in and buying our young companies, and they're staying in Canada. Certainly we've witnessed it in British Columbia. I happen to know it has occurred in Winnipeg because I've done a little bit of work there. And it's now going to have a huge impact on downtown Toronto with MaRS and the new impetus there. I spent last year actually reviewing their program at the University of Toronto. So we're seeing this in B.C. for sure, but I don't want to talk factually about other provinces because I don't have the facts at my fingertips.

Your perception is not completely right, but it's not completely wrong either. It's the lag time. It's the time it takes. For every $2 million of investment in research that the federal granting agencies make or disease-specific agencies make, we expect one disclosure to come, and that rate is getting even better now. At UBC we've been at $1 million for one disclosure.

Hon. John McKay: Sorry, but can you repeat that?

Dr. Bernie Bressler: For every $1 million invested in research by the granting agencies, you expect one technology disclosure to occur, which is a very good ratio. The standard is $2 million. We've exceeded that in different places in this country, including B.C., where $1 million—

Hon. John McKay: Is that a generally accepted standard of rate of commercialization?

Dr. Bernie Bressler: The $2-million-to-one disclosure is a generally accepted standard, and we all try to target doing better at it.

As you also know, we had this huge bubble burst around 1999-2000 in the entire biotechnology sector and the high-tech sector in general. It actually hit the non-biotech sectors greater, the telecommunications and the high-technology sectors. Now it's building back up, but the venture capital—that's the second piece, and a very important piece—that was there in 1999, 1998, and 1997, is not there any more in the same way, which speaks to the commercialization agenda that I know the government is working very hard on right now. That's part of Industry Canada, but I'm sure you're all well aware of it, and we're very supportive of it as closing the loop.

The Chair: Thank you.

Hon. John McKay: Thank you.

The Chair: Ms. Wasylycia-Leis.

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

Let's take this a little bit further and deal with John's dichotomy of increasing the pie versus spending money. We have a unique opportunity to actually make a case in this budget process for how areas that are normally seen as a drain on the public purse can actually help to enhance increased productivity. In fact, your work on AIDS, mental health, general health, pediatric health, dental health, is all in areas where we might be able to deal with the fact that many people are either not able to contribute to their fullest and be as productive as they would like, or where we can look at things in terms of lost capacity and a loss in terms of economic growth in output.

I'd like to hear from anyone who wants to jump in on this debate. How can you take your area of concern and turn it around from being seen as an area that's a drain on the public purse to one that is instead seen as vital to dealing with this topic of productivity?

Dr. Jack Cottrell : I'd like to jump in here just for a second.

Oral health, of course, seems to be one of these areas that falls to the bottom of the table, and I'd like to get it back up again. One of our key messages is the recognition of the importance of oral health and putting the mouth back in the body.

One of the members here mentioned the idea of long-term sustainability. Of course, it was brought out here that prevention is the key. We probably revolutionized the idea of prevention in the dental community a few decades ago, and we've shown that prevention in fact is the best way to go. It is the cost-saving method rather than dealing with disease through neglect and end-point processes.

We're saying now that with the evidence that's coming out fast and furious, the relationship between oral health and general health is an area where research money should be funded. Right now we have a dismal 1.6% of all of the CIHR funding that goes into.... So where the other agencies or the other players here have seen an increase in that funding, we have actually seen a decrease, from 7% in 1999 to 1.6%. In our brief we're calling for more research, because this is directly proportional. If we, through prevention in dental offices, can make a difference in heart disease and diabetes and low-birth-weight babies, then we have the ability to save this country a lot of money.

● (1645)

Ms. Judy Wasylycia-Leis: Thanks. I appreciate that.

I'll go to Penelope first and then Sharon. Is there any way to estimate the drain on the public purse and on our productivity because we don't invest properly in supporting people with mental health issues?

Ms. Penelope Marrett: We've had a number of projects over the years that have looked at this. First and foremost, for people experiencing a mental illness or other mental health problem, it's an episodic illness. It is not constant every day for the rest of their lives, specifically.

Some of the programs we've had, which have fanned out across the country, have really looked at what kinds of supports are needed to assist people who are experiencing a mental illness to get back into the mainstream workforce and also at the success we've had. There has been a tremendous amount of success.

First of all, employers need to be able to become more willing to provide the supports that are necessary. Some of those supports aren't supports that would occur naturally, or you would think employers would think they wouldn't occur naturally, but they would occur in any other situation. If someone had a family issue, an employer would generally let the person go home to deal with the family issue. When people are ill or feeling ill, maybe they need a few days to get themselves back on track. We need to be able to give people that opportunity.

People experiencing mental illness at certain points in their lifetime may need to see a doctor more often, so they may need to be out of the office more often. That doesn't mean their productivity has gone down. If anything, their productivity and their loyalty to that employer increases.

I think it's really important for us not to forget that they are not a drain on society. If anything, I've met more people who are working and who have a mental illness, who may not even speak about it publicly, who are more willing to work for their employer because of the supports their employer gives them in order to be able to live as productive a life as possible.

The Chair: Ms. Sholzberg-Gray and then Mr. Walker.

Ms. Sharon Sholzberg-Gray: I just wanted to second the kinds of things Penny was saying and point to the issue of productivity and our economic growth and its link to spending in the health sector—that spending contributing to productivity and economic growth rather than being a drain on our economy.

First of all, there are all kinds of people who think that anything that spends money on health and social services is government spending and inherently bad. Let's put the individual tax dollars, they would say, into the hands of individual taxpayers and they'll decide how to spend the money themselves. I've heard that kind of argument.

Of course, that argument doesn't build a health system or a social system infrastructure that will support the healthy population across physical and mental health and those kinds of things, which will be the productive workers we need. That's one of the reasons we think we have to have the appropriate spending. We need those healthy workers, and we're not going to get them if individual Canadians have to make decisions on spending that money.

So if we have a contest, so to speak, between cutting taxes, which everyone thinks is the magic solution to increasing productivity.... We'd say that enhancing the health of Canadians is another answer, which may be magical as well, but it can be done by appropriate programs.

Secondly, of course, is the whole research agenda that was outlined. That in and of itself creates jobs, economic growth, potential commercial opportunities.

Third is the whole issue of workers being tied to jobs. In other words, if you don't have an appropriate system of health and social services and you have workers who are tied to particular industries—only those that, let's say, provide health insurance, as happens in some other countries—that is not a way to run a productive society in which people can contribute their maximum to the economy. In other words, if they're stuck in a job because of the health benefits it provides, that's not the way to move and grow and provide to an economy.

Fourth, to all those people who point to countries in Europe and what not and say let's take this little part of theirs because they do this little part better than we do, I say let's take their entire system of health and social services together and spend the kind of money they spend on all of their services, ranging from health system investment and social service supports and all of the other supports, and see how we compare. We don't have those levels of expenditure. We don't have the figures that precisely show the outcomes and the benefits to these increased investments, but I think it's a no-brainer to say that an unhealthy population, one that's tied to certain kinds of jobs because they provide health insurance, jobs that.... And if jobs wouldn't be here because of our health system not being here, that would be another issue.

Note that General Motors just said the dollar is going to be 88¢, 90¢, so they're going to have to rethink being in Canada. Well, the only thing that's going to save us from their leaving is our health system as the dollar goes up, and so on.

So there's a strong link between the health system and the economy.

● (1650)

The Chair: Thank you.

I just want to give Mr. Walker 30 seconds to answer.

Dr. Robin Walker: Yes. I can be brief.

I spoke to the cost of injuries. The $9 billion a year, however, is just the cost of the injuries and the immediate care. It does not take account of the fact that every life lost, every disability that is lifelong, results in incredible economic loss; you've lost that productive person for life. The younger the person, the more the loss. I think the argument is a no-brainer if you're looking at kids.

I want to point out that none of the witnesses has actually spoken today about pumping money into the health care system. We have all concentrated on investments—investments in research, investments in prevention, investments in preventing disease and improving health.

I think it is important to recognize that there are no internecine squabbles here today. You're hearing the same message from all of us, but it's saying invest now, because if you don't invest now, you do pay later.

I know this government has a short life, but you have to look a long way beyond the usual four-year timeframe or the four-month timeframe, or whatever we're looking at now, if you're going to invest to save money so the health system is supportable.

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

I have three speakers. If we can, try to keep it to about three minutes.

Ms. Kadis, then Ms. Ambrose, and Mr. Bell.

Mrs. Susan Kadis (Thornhill, Lib.): Thank you, Mr. Chair.

To the gentleman who just spoke, you mentioned the reduction in waiting times for pediatrics, and you made a very compelling case, as everyone else did here today, which makes it very difficult in terms of prioritizing, obviously, all being very worthy areas. But you mentioned that specifically, and I'm wondering if that is not under our wait time strategy currently.

Dr. Robin Walker: In the current wait time strategy, I think, as Ms. Sholzberg-Gray said, presumably the current hot spots being looked at are just a start, because you cannot possibly characterize the whole system on the basis of hip replacements, cataracts, etc.

But the point I was making was that we are looking at wait times in a very narrow context right now. We have not considered anyone below, frankly, my age or well beyond in this current strategy. And that is a problem for two reasons: first of all, the wait times in the pediatric sector are in some cases much longer than in the adult sector, if you can get a doctor in the first place, which is a huge problem for kids. A far greater proportion of children are without a primary care physician than adults, but the wait times can be huge. And I specifically mention mental health because the situation there is devastating.

I have a six-year-old son. Fortunately, he is mostly very well balanced, but if he needed mental health assessment I would have to wait for one-third of his current lifetime to even get him assessed in the capital city of Canada. So that's the first point.

The second point, and it rolls out of that, is that at my age, if I wait a year to have my cataract surgery, I will probably still be productive during that time, even if it's reduced. If a kid waits two years for mental health assessment, the difference in that child's life may compromise that child's productivity for the rest of that child's life. That was the point I was making.

Even if you look at this in cold, hard economic terms, it makes no sense not to address wait time issues in the pediatric population.

● (1655)

Mrs. Susan Kadis: Thank you. Well put.

I want just one clarification from Ms. Marrett. Is mental illness not in the national chronic disease strategy initiative presently? I was under the impression that it was, having proposed and gotten parliamentary approval for Alzheimer's disease and related dementia being included, and I was under the impression that mental illness was in that package, in that new initiative.

Ms. Penelope Marrett: Yes and no. There is discussion now that it needs to be included, but originally, when the strategy was beginning, it was not, and funding wasn't allocated towards it. So we argued to the point that because so many people are affected by mental illness and other mental health problems in the country, it needed to be considered in the mix. So it is being looked at, how it can best be considered in the mix at this time.

Mrs. Susan Kadis: That's heartening to hear.

Finally, if I have a moment, Mr. Chair, I want to ask Mrs. Sholzberg-Gray about the electronic records issue, how you view that in terms of privacy versus the positive benefit it presents.

Ms. Sharon Sholzberg-Gray: First of all, there's a pan-Canadian harmonization process going on regarding health privacy, which is something we had urged for a number of years, and then it took a while, but everybody came in on the same page. And they've all agreed, I think every jurisdiction, to common rules for privacy regarding health records.

So I think those issues are well on the way to being resolved on a pan-Canadian basis. Then when it comes to the need to have the electronic health records—the outcomes, the safety, the economies of scale—it has to be done.

The Chair: Thank you, Ms. Sholzberg-Gray.

Ms. Ambrose, Mr. Bell, and then we have to wrap it up.

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

I have a question for Dr. Walker about the issue of preventive health. We put together a group of young parliamentarians, and our focus this year is preventive health. We've heard from a lot of different groups. In particular, we've been working with the Canadian Diabetes Association on some of the issues. And in the news lately there has been a lot of talk about obesity and child obesity. I wondered if you could just talk about any recommendations we could make as a finance committee, whether it's using the tax system or incentives or something, to increase fitness and focus on preventive health. There is such a strain on the health care system that a lot of people focus on the core and primary services, but preventive health is really the future, at least for the youth of our nation.

I wondered if you could just give us some idea of how we might go about doing that.

Dr. Robin Walker: Well, the easy way to answer that is to speak to the attention we've paid to school health in our brief, and because it's in the brief, I won't speak much more about that. But it's quite clear that initiatives through school are a very important part of a preventive strategy, particularly if you're talking about what I think has to be considered the obesity epidemic among young Canadians. That's one piece of it.

A broader strategy is to encourage healthy, active living, which has to be directed, of course, towards families and parents. That is somewhat under way. I mean, to be fair, Health Canada is paying some attention to healthy, active living, and it has been willing to partner with the Canadian Paediatric Society in some initiatives in that direction. But quite clearly, if you look in preventive terms at what we can do in our pediatric population now to prevent major health problems and costs down the road, the absolute priorities have to be in areas such as housing, which impacts hugely on kids, and in areas that relate to lifestyle issues, particularly healthy, active living and the burden of illness that results through the metabolic syndrome —diabetes, etc.—in later life.

The third thing I would stress, and even though it's not a huge proportion of the population, I think it's incredibly important when you talk about this issue, is the critical nature of addressing the problem of healthy, active living and obesity and diabetes in our aboriginal and Inuit population. We have been privileged to facilitate a process whereby the national aboriginal health groups will be coming together in December, not under the umbrella of government but of themselves—albeit with government represented—to discuss issues of aboriginal child and youth health. The number one priority will be in this area.

So those are a few of the directions that I think need to be addressed.

Ms. Rona Ambrose: Thank you.

I know that some of the provinces have looked at using the tax system to create incentives via healthy taxes, offering tax breaks on gym memberships and sports equipment for kids. I was thinking more along those lines, of whether you're supportive of them and whether you think they could help in the long term.

● (1700)

Dr. Robin Walker: Sure. There are several ways to address it, and some of it's carrot and some of it's stick. For example, the Ontario government is using the stick, if you want, by forcing schools not to sell junk food, etc. Some of it's a carrot at the schools, by encouraging healthy activity. I don't think there's any question that once you look at the strategy that addresses individual families, incentives toward healthy activity could be very, very valuable and very important.

Now I have to say, because we always express evidence-based opinions, there is more evidence of the efficacy of the stick than of the carrot, but I think it would be very, very useful—even if we did it as research—to look at the extent to which you could modify individual and family behaviours by using a tax incentive approach to encourage healthy activity.

Ms. Rona Ambrose: Thank you.

The Chair: Thank you, Mr. Walker.

Thank you, Ms. Ambrose.

Mr. Bell, and then we'll wrap it up.

Mr. Don Bell (North Vancouver, Lib.): My question is for Ms. Marrett. On page 12 of your report you talked about a recommendation for affordable housing and targeted some amounts there; I noticed $300 million to ramp up the affordable housing framework agreement, $150 million for homelessness initiatives, and $500 million over five years for a home rehabilitation fund.

You talked about the need for 20,000 new housing units—and is it plus 10,000 units of rehabilitated housing? I presumed it was 30,000.

Ms. Penelope Marrett: Yes.

Mr. Don Bell: Are the costs of that included in figures below? In other words, are you saying this is what's needed and this is how you achieve it, or is it plus those figures? Because you've got $850 million there—

Ms. Penelope Marrett: It's plus.

Mr. Don Bell: It's plus.

And you haven't put a figure on the 20,000 and 10,000, or on the 30,000 units.

Ms. Penelope Marrett: No, that's right. And some of that is dependent on what other possibilities exist within provincial governments and their housing initiatives and rehabilitation programs for housing, etc. They're all different across the country, but it's absolutely critical. Frankly, if you don't have a permanent place to live, how healthy can you ever be in the end?

Mr. Don Bell: I don't disagree, but I just wanted to clarify this. We did ask to have costs associated with recommendations where possible, and you did outline three different costs, but that first figure didn't have one, so I just wanted to get this clear.

I have lots of other questions but not enough time, so thank you all. I appreciated your presentations.

The Chair: Thank you.

Again, thank you to the witnesses for appearing. Some of the presentations were actually quite useful because the recommendations were highlighted, but some were not highlighted. It helps us when the recommendations are highlighted. I have to commend the first group who put them in order and did cost them. That's important for the finance committee. I know it's difficult to add costs to some of the recommendations, but it helps us. Again, thank you for appearing.

The meeting is adjourned.

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