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Chair

Ms. Bonnie Brown

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● (1535)

[*English*]

The Chair (Ms. Bonnie Brown (Oakville, Lib.)): Good afternoon, ladies and gentlemen. It's my pleasure to welcome all of you to this meeting of the Standing Committee on Health, a very special meeting indeed.

Before we begin, I would like to recognize the presence in the audience of members and representatives of the Canadian Lung Association, who always express their interest in the workings of this committee. Welcome to Parliament Hill.

But it's my great pleasure to welcome our Minister of Health, who is here today to talk to us about the health accord reached by the Prime Minister and the premiers and further discussed between the ministers of health of the provinces and territories and our minister.

The Honourable Ujjal Dosanjh will begin. He is ably assisted by what looks like the three Ians: Ian Potter, Ian Green, and Ian Shugart.

Minister, the floor is yours.

Hon. Ujjal Dosanjh (Minister of Health): Thank you. I understand you all know the three Ians. Sometimes it's pretty hard to tell one from the other. They're all handsome.

It is my pleasure to provide the standing committee with an update on the implementation of the ten-year plan to strengthen health care. As you know, on September 16 the Prime Minister and all premiers and territorial leaders signed a ten-year action plan that will lead to better health care for all Canadians.

The plan was signed by all first ministers, which speaks to the shared commitment by all governments to strengthen health care and work together. All governments are participating in current discussions with respect to the implementation of the plan. The agreement addresses Canadians' priorities for sustaining and renewing the health care system, and it also provides long-term funding to make those reforms a reality.

This agreement demonstrates the role of the Government of Canada in working collaboratively with the provinces and territories to ensure the long-term sustainability of the health care system and advancing federal leadership in health and health care issues such as health human resources, wait times, and public health, and in continuing to support innovation and research—for example, through Canada Health Infoway and its work on information technology.

The plan builds on work already under way as part of the renewal agenda set out at the first ministers' meeting in February 2003. The plan completes unfinished 2003 accord business on home care and catastrophic drug coverage and sustains the momentum in the key reform areas of primary health care, health technology assessment, and health human resources. The plan goes beyond these accord commitments by adding a wait times reduction strategy and a national pharmaceutical strategy to encourage optimal drug use and improved cost management.

First ministers have also committed to an unprecedented level of public accountability so that Canadians can see for themselves where the money is going and how it's making a difference. Health ministers committed to continue to report to their respective jurisdictions on progress. The second set of reports on comparable performance indicators will be released by November 30, 2004, flowing from the 2003 accord.

Also, participating jurisdictions agreed to an expanded role for the Health Council. The council will prepare an annual report on the health status of Canadians and health outcomes, and it will report on the progress of elements set out in the plan.

Achieving these reforms requires significant investments. The federal government agreed to provide new investments of $41 billion over 10 years in support of the action plan on health care. This will include: $3 billion over two years to close the short-term Romanow gap; a new Canada health transfer base, at $19 billion in 2005-06, including $500 million in 2005-06 for home care services and catastrophic drug coverage; an escalator of 6% applied to the CHT base from 2006-07; $4.5 billion over six years for the wait times reduction fund; $250 million ongoing in the Canada health transfer starting in 2010-11, primarily for health human resources; and a one-time $500 million investment this year for new medical equipment.

Additional federal investments of $700 million over five years support initiatives to improve aboriginal health agreed to at the special meeting with the aboriginal leaders. The federal government also agreed to provide funding to the territories totalling $150 million over five years to address their unique health care delivery issues.

I would now like to provide more details on the initiatives set out in the plan and the initial progress being made in implementation. Let's deal with wait times first.

A major part of the plan is the first ministers' commitment to reducing wait times and improving access. First ministers made a commitment to reduce wait times in priority areas such as cancer, heart, diagnostic imaging, joint replacement, and sight restoration by March 31, 2007.

To do so, the Government of Canada announced the creation of a wait times reduction fund that will augment existing provincial and territorial investments.

In addition, funding of $500 million will be provided for medical equipment, as I said, in 2004-05.

At the recent health ministers' meeting, health ministers reaffirmed their commitment to the following: to implement comparable indicators of access to health care professionals' diagnostic and treatment procedures, to be developed by December 31, 2005; evidence-based benchmarks for medically acceptable wait times for priority areas, to be developed by December 31, 2005; multi-year targets to achieve priority benchmarks, to be established by each jurisdiction by December 31, 2007; and annual reports by provinces and territories to their citizens on their progress in meeting their multi-year wait time targets.

Health ministers agreed to meet in early 2005 to continue their work on the implementation of these important initiatives.

In the area of health human resources, recognizing the important linkages between ensuring an adequate supply and appropriate mix of health professionals and wait times, first ministers agreed to continue work on health human resource issues.

Provinces and territories agreed to increase the supply of health professionals based on an assessment of gaps. They agreed to make their action plans public by December 31, 2005, and regularly report on progress to their citizens.

The wait times reduction fund will support the training and hiring of health professionals. In addition, the Government of Canada will add $250 million ongoing to the CHT base beginning in 2010-11, primarily for health human resources.

At the last health ministers meeting, health ministers approved a new approach for changes in entry-to-practice credentials for medical and health professionals. This will contribute to ensuring a sufficient supply of health professionals to provide timely and quality care in Canada.

Health ministers also discussed ways to enhance opportunities for internationally educated health professionals to practise in Canada and to meet the health care needs of all Canadians.

Regarding home care services, first ministers agreed to provide first-dollar coverage by 2006 for certain home care services, based on assessed need. This commitment is related to the unfinished business flowing from the 2003 accord where federal, provincial, and territorial governments were unable to reach an agreement on implementation of their earlier home care commitment.

Recognizing the complexity of this issue, negotiations resulted in an agreement at the September 2004 meeting that certain services related to short-term acute home care, short-term community mental health home care, and end-of-life care will be provided as part of public health insurance plans. First ministers agreed that each jurisdiction will develop a plan for staged implementation and will report annually to its citizens on progress.

The Government of Canada will provide additional funding of $500 million to the CHT base in 2005-06 for home care and catastrophic drug coverage.

Going to primary health care reform is also an important element for the renewal of our health care system and an area where significant progress is under way in the provinces and territories. First ministers recommitted to the 2003 accord objective of 50% of Canadians having 24/7 access to multidisciplinary teams by 2011. First ministers agreed to establish a best-practices network to share information and innovative ideas that could be useful. They also agreed to accelerate the development of electronic health records through Canada Health Infoway and accelerate efforts towards telehealth to improve access for remote and rural communities.

First ministers recommitted to their earlier 2003 accord commitment that no Canadian should suffer undue financial hardship in accessing needed drug therapies. Affordable access to drugs is fundamental to equitable health outcomes for all Canadians.

● (1540)

They also committed themselves to encouraging optimal access to and use of safe, effective, and cost-efficient drugs to improve cost management. When used optimally, prescription drugs can contribute significantly to improved health outcomes and savings in other system costs. Building on existing FPT work on pharmaceutical management, first ministers directed health ministers to establish a ministerial task force to develop and implement a national pharmaceutical strategy and to report on progress by the middle of 2006. Minister Hansen of B.C. and I will co-chair the ministerial task force, and health ministers will meet again in early 2005 to continue work on this strategy.

First ministers also recognize that additional public health efforts can lead to better health outcomes and contribute to the long-term sustainability of medicare by reducing pressure on the health care system. The government agreed to accelerate work on a pan-Canadian public health strategy, advance the integrated pan-Canadian healthy living strategy, and develop coordinated and proper responses to public health emergencies through the new public health network. The Government of Canada will also build on recent investments in immunization through the national immunization strategy.

Measures to help improve health services for all aboriginal peoples and close the gap between the health status of aboriginal peoples and non-aboriginal Canadians were agreed to at the special meeting with the NAOs, the national aboriginal organizations. The federal government committed itself to further investments of $700 million over five years to support initiatives to improve aboriginal health. It also committed itself to further investments in the health services it has historically provided to first nations and Inuit. Minister Smitherman and I will meet early in 2005 with aboriginal leaders and co-chair ministers of aboriginal affairs to initiate the process of developing a blueprint to improve the health status of aboriginal peoples and health services in Canada by September 2005.

Work has already begun to implement the initiatives set out in the plan. The federal-provincial-territorial ministers of health meeting on October 16 and 17 provided the first opportunity for health ministers to meet after the first ministers meeting. I am pleased with the progress made. The meeting, as we know, moved forward to meet commitments to reduce waiting times, improve access, and develop a national pharmaceutical strategy. Health ministers agreed to meet again in early 2005 to continue the ambitious agenda of health care renewal. I am confident that together we will deliver on the action plan from the first ministers meeting.

In closing, let me just say governments have already begun work on the implementation of the plan, so that Canadians can see the results quickly. I am convinced that the 10-year plan to strengthen health care will make timely access to quality care a reality for all Canadians. Let me just say in closing as well that I am here to answer your questions, but more importantly, I am also here to hear suggestions and advice you might have as to how we can carry this struggle forward to make sure that the 10-year action plan is implemented more quickly and more effectively with the cooperation of the provinces and territories across the country.

Thank you.

● (1545)

The Chair: Thank you, Minister.

We'll move now to the question and answer part of our meeting, and we'll begin with Mr. Fletcher.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you.

Madam Chair, could you let me know when the seven-and-a-half-minute mark arrives?

I'd like to thank the minister for coming to the committee today. It may not be the easiest part of his job. I also trust the minister will keep his answers concise and to the point, so we can get as many questions in as possible.

First, Mr. Minister, what, if any, measures in the new deal for health care will help control privatization in the health care system?

Hon. Ujjal Dosanjh: I think it's very clear there has been an argument across the country made by some, particularly the critics of public health care, that our health care is not sustainable. I have said before, and of course the Romanow commission found it to be true, that our health care is absolutely sustainable.

My view is that in terms of the percentage of the GDP that we spend on health care, it hasn't appreciably changed over the last 10 to 15 years. I believe that 15 years ago we would spend about 9% of the GDP on health care, and today it's about 9.6%, in comparison with the U.S. where they spend close to about 14%, if I remember correctly, of their GDP on health care. The cost of administering our health care is about 17% and their cost is close to 13%.

I believe that our health care is absolutely sustainable, particularly with the investment of $41 billion going forward over the next ten years. I believe it's sustainable and I believe in public health care. I support public health delivery as well. I think it's important that we recognize, with more funding available to the provinces, they can actually find innovative ways of dealing with these issues in an efficient fashion. They now have the resources, more resources than ever before, from the federal government to ensure that our public health care system not only survives, but thrives.

● (1550)

Mr. Steven Fletcher: Mr. Minister, I hope the sustainability is not a euphemismfor preventing innovative, efficient, and progressive health care.

Can you inform the committee on the official position of the government concerning private for-profit health care in Canada?

Hon. Ujjal Dosanjh: Let me take a stab at your position first. You've said very clearly, in the articles that I've read, that you support public health care, but you support private delivery. Maybe the paraphrasing in the article was wrong, but I remember that quite clearly.

My position is that we support public health care, and we prefer and support public delivery. Of course, it is quite true, delivery is generally in the hands of the provinces and they deal with those issues. That's why we've provided billions of dollars for going forward. It's why, in fact, the Prime Minister made this issue a very important issue as part of the public debate during the election. We believe in the public health care system and we want to strengthen it. We were there 40 years ago. We rejected the system that we had, hence we're here.

Mr. Steven Fletcher: Mr. Minister, the Conservative Party certainly supports the Canada Health Act, and we support the end delivery. We want the highest quality for the patient, including, for example, family doctors who are publicly funded, but are private operations.

I hope the minister isn't suggesting that he's going to nationalize all the family doctors in the country. I think a lot of people would be very concerned about that. I'm concerned about even the gesture, which indicates that you may not think it's a bad idea. That's a concern.

Moving on, how do you justify the lack of accountability measures, and why were they not included in the agreement to begin with?

Hon. Ujjal Dosanjh: Let me first deal with your remark about doctors. We recognize that 30% of health care across the country is in the hands of private practitioners. It has always been like that. Doctors have always been private entrepreneurs, and I'm sure they will continue to be private entrepreneurs.

In terms of the issue of accountability, in fact, if you go through the ten-year action plan, in different paragraphs, you would find the accountability provisions embedded in the paragraphs. For instance, with respect to benchmarks, we have to produce evidence-based, medically acceptable benchmarks by December 31, 2005. We have to actually have comparable indicators in place by December 31, 2005. All of the jurisdictions have agreed, in the body of the agreement, to report to their citizens on an annual basis as to the progress they have made.

The effort was made to make sure we have comparable indicators across the country, and that we have evidence-based benchmarks across the country, because science is the same everywhere. So of course as the Canadian health council and CIHI are obliged to do, when they do their national reports, we can then actually begin to understand how we're doing in different parts of the country relative to each other. That is what's important. An aboriginal child should have the same health care as a child in Nova Scotia or a child in British Columbia, aboriginal or non-aboriginal.

I think it's important that we make sure we are able to provide similar levels of health care to all Canadians, no matter where they live. That's why, in addition to seeking accountability from the provinces to their own citizens, based on the funding and agreement that's in place, we wanted to make sure that we're able to assess ourselves as a country on how we're doing in different regions.

Mr. Steven Fletcher: Mr. Minister, the fact is that the accountability measures in the accord aren't as strong as they were in the 2003 accord, which the Liberals neglected to follow through on. Having said that, I'd like to change the pace a little bit.

In regard to pharmaceuticals, has Health Canada given thorough thought or allocated resources to developing policy alternatives should evidence begin to mount that Internet pharmaceutical sales are endangering the stability of Canada's drug supply? If so, what are they? Secondly, has Health Canada begun to examine or develop contingency plans should Internet pharmaceutical sales rise to a level that could be proven to jeopardize the Canadian supply?

● (1555)

Hon. Ujjal Dosanjh: Let me first answer your remark about the strength of accountability in the 2003 and 2004 accords. Let me just put before you, for your consideration, the fact that there was no reporting with respect to home care. In fact, no specific steps had been taken after the 2003 accord. You now have, in three different areas, the beginning of home care for a two-week period in two different areas, and for end-of-life care, which has to be reported by 2006. You now have the obligation to provide and create evidence-based benchmarks for each of the provinces so that we can look at how they're doing. You now have, in fact, a clause in the agreement that says the funding arrangements within the agreement require compliance with the reporting provisions, which are many throughout the body of the agreement. So I think the 2004 accord builds on the 2003 accord and is in fact much stronger on the issue of accountability.

Let me deal now with the Internet issues. The prescription Internet issue, needless to say, is a complex one and a serious one. I don't take it lightly. I don't think any one of us takes it lightly. There is a whole industry that has built up over the last year and a half or longer in this country. We've been monitoring the issues, and monitoring them carefully; Health Canada has been doing that. We look at the pattern of sales, we look at those kinds of issues, and Health Canada has determined that to date there are no shortages at this point. But that doesn't mean this kind of situation can go indefinitely. You have, in fact, several states in the U.S. that have passed laws or resolutions to the effect that they should be able to bulk purchase in Canada for their drugs. You now have the supply of prescription drugs at about $850 million Canadian. It has stabilized, it has plateaued, but that's quite significant.

I don't think we can be the drugstore for the United States of America. I think they know that, and we know that. We are a large land mass, but a small country of 33 million people. We have a price regulation regime within our country for our domestic use. We want to make sure we put the safety and supply of drugs for Canadians first, and I want to make sure we look at options to that effect.

I'm coming to your options here. We have looked at the options. There are several options. I think the first one I've talked about is to encourage the doctors and the pharmacists who engage in what I believe to be unethical, unacceptable, unprofessional practices, to cease and desist from doing that, and colleges of physicians and surgeons should deal with those issues.

Yes, there are legislative courses of action that we can take. We are obviously doing a legal analysis on them. Once the legal analysis is complete, I'll be happy to share that with you.

The Chair: Thank you, Mr. Fletcher.

Mr. Merrifield.

Mr. Rob Merrifield (Yellowhead, CPC): For seven minutes?

The Chair: No, you don't get seven minutes. Mr. Fletcher was going to share his time with you or you with him, but he introduced a brand-new topic in his last question. It was only courteous to let the minister answer. If he had left that topic to you, you would have had a full seven minutes. I gave him a warning with one minute to go. So you now have five minutes.

Mr. Rob Merrifield: On a point of order on this, does that mean, then, that the minister could have gone for seven minutes and eliminated the time? Is that what you're saying?

The Chair: Not necessarily, but when a new topic is introduced to the minister and it's a complicated one that is introduced for the first time at the end of a string of questions on another topic—

Mr. Rob Merrifield: Yes, but if what you're saying is that they're our fifteen minutes, then we should have the courtesy to know what our time allotment is. If it's seven minutes for Mr. Fletcher, he asked you, prior to that, that we be notified of that.

● (1600)

The Chair: I told him at six and a half minutes that he had one minute left and he took 50 seconds of that minute in a preamble, and in his question he introduced a new topic. It would have been terribly rude.

But those problems about dividing 15 minutes between you are really your own. I did alert him.

Mr. Rob Merrifield: Okay, as long as we understand that. I would have interrupted the minister on that issue because I asked the question, since it was on my time that he was answering Mr. Fletcher's.

The Chair: Yes, but that's up to you and Mr. Fletcher to work out ahead of time. You will retain your five minutes despite this procedural wrangle.

Mr. Rob Merrifield: Sorry about that, Mr. Minister. We'll fix this later.

Let's get back to the Internet pharmacy. I'm just going to continue with that for just a little bit. You say you're encouraging the colleges of physicians and surgeons in the provinces to be able to deal with it. You also said that nothing has changed from what has happened a year ago. In fact you said it's actually plateaued.

So I'm saying what other legislative means...or what do you have to say with regard to this? I know the last few days you've been talking about dealing with the Internet pharmacy, but you've been pointing your finger to other legislative authorities to be able to deal with it. I'm asking you what you're planning to do about it if you sense and see that it is a problem that we become a drugstore to the United States, as you say.

Hon. Ujjal Dosanjh: My view is, with the utmost respect, that we should select or choose a legislative course of action only as a last resort. I think there are many other things we can do, that we are doing, that is, urging our provincial colleagues to look at this issue. I've corresponded with them.

Mr. Rob Merrifield: Under your authority, is there anything you are planning to do with regard to this if it gets into the place where we become a drugstore for the United States?

Hon. Ujjal Dosanjh: We obviously have legislative options. We're looking at some of the legislative options. We're doing some legal analysis.

Mr. Rob Merrifield: Do you know what they would be?

Hon. Ujjal Dosanjh: I've talked about one and not the others because that's the one that falls within my jurisdiction. That's the amendment to the definition of practitioner in the Food and Drugs Act. One could amend it to define a medical doctor, licensed by a provincial college of physicians and surgeons, who can prescribe medication to people who are resident in Canada or visiting in Canada.

Mr. Rob Merrifield: Okay, that's fine.

Getting back to the health accord, that's really what we're here talking about with regard to the $41 billion that is put into the health system over the next decade. On May 17 there was an announcement by the finance minister that you'd take the GST money and put it into medical equipment. I'm wondering, how much is in that fund, and has it been applied to medical equipment this year?

Hon. Ujjal Dosanjh: I understand that the finance minister did make that announcement. I'm not clear whether that amount is included in the $41 billion.

Mr. Rob Merrifield: I'm not either. That's why I asked the question.

Hon. Ujjal Dosanjh: I'm not clear. I'll be happy to get that information for you.

Mr. Rob Merrifield: If it is, then it's a fluctuating amount, because it's the GST money from the gasoline tax.

Hon. Ujjal Dosanjh: I understand the question, and I remember the remarks made by the Minister of Finance. My officials don't have the information either. We'll be happy to share that with you. I'll be happy to pass that on to you.

Mr. Rob Merrifield: Okay. So you'll get back to the committee as to how much is in the fund, how much has been applied to medical services.

Hon. Ujjal Dosanjh: Absolutely.

Mr. Rob Merrifield: The other thing is on the catastrophic drug coverage. The 2003 accord was to be implemented by the end of the year 2006. Now in the new deal you just say the progress report will happen June 30, 2006. Can you tell me, have you moved the yardstick on that catastrophic drug coverage?

Hon. Ujjal Dosanjh: I think what's different about the catastrophic drug coverage is that you now have the obligation to formulate a national pharmaceutical strategy, which didn't exist in the 2003 accord. The 2003 accord, if I remember correctly, talked about the catastrophic drug coverage and there was money provided for it.

There is additional money provided for home care expansion as well as catastrophic drug coverage in the CHT base in this new accord, $500 million. What is new about this accord is that it now obligates—

Mr. Rob Merrifield: Are you extending the deadline, or are you extending when Canadian citizens, the ordinary citizen out there, can expect the catastrophic drug coverage?

Hon. Ujjal Dosanjh: You have the deadline in terms of producing the strategy. Once we have the strategy, we are to report back to the first ministers. Obviously the implementation would take place at that time.

Mr. Rob Merrifield: So what you're saying is that will be reported back June 30, 2006.

Hon. Ujjal Dosanjh: Yes.

Mr. Rob Merrifield: So it could be a year, two years after that.

● (1605)

Hon. Ujjal Dosanjh: Obviously we have a strategy that we need to create.

Mr. Rob Merrifield: Yes, but in 2003 not only did you have a strategy, you had a deadline.

Hon. Ujjal Dosanjh: Let me say to you with the utmost respect that the provinces were given the money to provide catastrophic coverage in the accord in 2003. Not much progress happened. In 2004 we've provided in the accord an additional $500 million for that purpose. We've now imposed an obligation on the ministers of health to engage in developing a pharmaceutical strategy to deal with—

Mr. Rob Merrifield: That's fine. I think I've got your answer on that.

The Chair: Mr. Merrifield, that's your five minutes.

Mr. Ménard will be next.

[*Translation*]

Mr. Réal Ménard (Hochelaga, BQ): Mr. Minister, good afternoon and welcome. I have five questions. I would therefore appreciate it if you could provide me with concise answers.

Do you consider health funding under the 2005 accord to be unconditional for Quebec? Secondly, as regards payment provisions, will it be necessary to amend either the Canada Health Act or the act pertaining to transfer payments? Could you confirm that, should either of these acts be amended, Quebec will retain control on this issue and that there will be no additional reporting requirements?

[*English*]

Hon. Ujjal Dosanjh: I think it's clear that both of the agreements were signed by all of the first ministers present, and that makes it clear to me that all of the jurisdictions have an obligation to report to their citizens based on the obligations in the accords, with respect to benchmarks, comparable indicators, and wait times.

With respect to wait times, the areas are flexible; there's no question about that. If Quebec or B.C., for instance, don't have a wait time problem with knee replacement or hip replacement, they can pick another area where they need to reduce wait times; there is that flexibility. They will be reporting to their own citizens, not to Canada. In fact, I'm pleased to tell you that the Quebec government is working with other governments, for instance, in the development of comparable indicators.

[*Translation*]

Mr. Réal Ménard: In Quebec, a well-known journalist, as it happens Manon Cornellier from *Le Devoir*, the newspaper which was founded by Henri Bourassa, reported some remarks that you made. She reputedly said that in order for it to be possible to have access to these funds, you would have to amend the Canada Health Act or the act pertaining to transfer payments.

As regards access to these funds, be it funds for dealing with waiting lists or the three existing funds, are you planning on amending either of these pieces of legislation?

[*English*]

Hon. Ujjal Dosanjh: It is my understanding that for the funds to flow from Canada to the provinces, you have to have some legislation, whether it's budgetary legislation or amendments to some other pieces of legislation. Those are all issues that are being considered. Once that decision has been made, I'd be happy to share it with you.

[*Translation*]

Mr. Réal Ménard: Very well. Could you please table the chart showing how funds will be distributed amongst the provinces? At the time of the agreement, this information was not to be had. A general table was included in the media release. Could you, today or in the near future, table the documents which give a precise breakdown of funding for Quebec and for the other provinces? Unless you are able to give us that information today... if not, could you please send it to our clerk?

[*English*]

Hon. Ujjal Dosanjh: I'd be happy to provide that information and breakdown to you. I don't have it with me, but I would be happy to table it.

[*Translation*]

Mr. Réal Ménard: Okay.

One aspect of the accord which was cause for a degree of concern in Quebec is the issue of training health care professionals. A parliamentary secretary was appointed to deal with this specific issue. Training and qualifications approval are matters closely linked to areas of provincial jurisdiction.

I would like you to be more explicit about how you plan on training more nurses or recognizing doctors' credentials, for example, without encroaching on areas of provincial jurisdiction.

[*English*]

Hon. Ujjal Dosanjh: Obviously the areas of instruction in medicine, the colleges of physicians and surgeons, licensing, and all of those issues are governed by the provinces themselves, and it's not the intention of the federal government to interfere in that at all.

What we said, and what is part of the accord, is that we've made an offer to participating jurisdictions that we'd be happy to play the coordination function across the country if any jurisdiction would like us to play that role, so we could make it easier for health professionals, doctors, and nurses to be mobile across the country without having to redo exams and the like. Also, with the integrating of international medical graduates or nurses into the system, if there is help that we as the federal government could provide, we would be happy to provide it.

We are obviously looking at some issues of coordination within the federal government. When people immigrate to this country they bring skills and talents that can be utilized. We're looking at how we can make it easier for them to be integrated into the professions. Obviously, in terms of integration the ultimate decision has to be made by the provinces.

● (1610)

[*Translation*]

Mr. Réal Ménard: Are your analysts in a position to tell the committee when the federal government will begin to cover 25 per cent of health care system costs, in what year, as was requested by the Clair report, the Kirby report, and the Romanow Commission? That figure takes into consideration all the investments that you are about to make and for which all the first ministers have complained. When you were in British Columbia, you were very critical of the federal government. We would like to see this same critical capacity drive you today. So, when do you foresee the federal government covering 25 per cent of the health care system costs?

[*English*]

Hon. Ujjal Dosanjh: My understanding, and I think it's clear from what Commissioner Romanow has said, is that the funding that was provided to begin with closes the Romanow gap.

In terms of the percentages, I'd be happy to tell you what I'm told. These are numbers we can all kind of play with, but what do you take into account? Do you take into account the direct spending by the federal government on aboriginal health, or direct spending on—

[*Translation*]

Mr. Réal Ménard: I'm talking about what the premiers asked for.

[*English*]

Hon. Ujjal Dosanjh: So those are the kinds of issues we have to look at.

[*Translation*]

Mr. Réal Ménard: Mr. Minister, I'm referring to what the premiers are asking for. A campaign was carried out from one end of the country to the other and it was covered by all media. I'm talking about the direct operational costs of the health care system. The federal government has a responsibility to pay 25 per cent of those costs. Have you calculated what percentage the approved investments bring you to? I find it hard to believe that nobody at Health Canada has done that calculation. It's been said that Mr. Shugart is very good at math. On the other hand, we know that you don't like figures. You are of a more romantic disposition.

[*English*]

Hon. Ujjal Dosanjh: No, I'm actually okay with figures. I've never had any problems.

Let me just say this to you. Commissioner Romanow said that the Romanow gap is closed. Obviously $41 billion is being provided over the next 10 years.

If you're looking for percentages of participation in health care across the country, I'd be happy to provide that exact figure to you. I don't have it. I believe that's a figure there is much controversy about. You would want me to be absolutely prepared to back up what I say, and I'd be happy to provide that number to you.

But let me just remind you that during the first ministers conference, at 1 o'clock in the morning when all of the first ministers were around the table, I saw all of them praising the Prime Minister, absolutely unconditionally, saying this is the plan for 10 years.

[*Translation*]

Mr. Réal Ménard: Now you are getting lost in romantic reverie.

I have another question. Could you provide us with some reassurance regarding the particularity of Quebec's situation vis-à-vis health?

I would also like you to give us precise information as to the type of offence that Health Canada has identified regarding Internet pharmacies. Is it the fact that health care professionals are writing prescriptions without having seen a doctor? Given that this is an example of interprovincial trade, do you consider that the federal government has primary responsibility to act in this matter? What do you see as being your responsibility in ending the Internet pharmacy phenomenon?

● (1615)

[*English*]

Hon. Ujjal Dosanjh: I believe we have a responsibility to safeguard the safety of Canadians and the supply of drugs for Canadians. You know that we have a price regulatory regime in the country that's good for domestic use in Canada. I want to make sure that the regulatory regime remains in place for the use of Canadians. I also want to make sure that the supply and safety of drugs for Canadians isn't jeopardized. We are a small country and do things for ourselves; obviously that regulatory regime is not for the purposes of export.

The other issue, of course, is that anything based on unethical, unprofessional conduct emanating from the initial unethical and unprofessional conduct of a medical practitioner who does not establish a relationship with the patient and does not properly assess the patient is, at the end, not a transaction that can be satisfactory to us as Canadians. It is important for us to state that, and I've been stating that for the last week or so. We are obviously beginning to take action on that; I have written to the premiers, to the ministers of health, on this issue. I have asked them to deal with these issues as they see fit. I'm obviously going to be asking the colleges of physicians and surgeons and the pharmacists to deal with these issues as well.

The Chair: Thank you, Mr. Ménard.

Mr. Blaikie.

Hon. Bill Blaikie (Elmwood—Transcona, NDP): Thank you, Madam Chair.

I'd like to engage the minister for a bit on the whole question of privatization, a concern that he himself highlighted when he was first appointed Minister of Health. I think there's a certain obvious legitimacy to the argument that he makes and has made on a number of occasions when asked about privatization, that the more we fund the publicly administered health care system and the more adequate it is, the less temptation there is—in some quarters, anyway—to try to privatize or develop a parallel private system. There are different questions here: there's the whole question of a parallel private system, and then there's the question of private for-profit delivery within the publicly administered system of insured services.

I get the impression from the minister that having provided this $41 billion, he's satisfied that's what the federal government will do. I ask the minister, what can the federal government do, or what would it be willing to do, if it were obvious that it is not—in some places, anyway—a matter of resources but of ideological preference? For instance, one of the provinces where privatization is most talked about and most promoted is Alberta, which is one of the have provinces. So it's not a question of resources; it's a question of philosophical disposition.

I realize there's a mix now within the system, but if there were to be a whole new epidemic of privatization, of private for-profit delivery—even if it's for insured services—what would the federal government be willing to do about this? Or do you see that as strictly a provincial matter for which you have no responsibility or political concern?

Hon. Ujjal Dosanjh: I appreciate the question. I remember when we talked about the Montreal clinic, even you felt they may not be violating any tenets of the Canada Health Act.

I think it's important that we recognize that about 30% of health care across the country is in private hands, medical practitioners and the like. In fact, I was reading a very interesting statistic—not to come to the aid of Alberta, but to be honest about it—that the lowest rate of private health care is in Alberta, and that other provinces in fact have a higher degree of privatization in terms of medical practitioners and the like.

So I think that it is important, but it's important too for the federal government to look at the tools we have, and the tool we have is the Canada Health Act at the end of the day. The Canada Health Act deals with extra billing and deals with queue jumping, and I have said very clearly that we will enforce the Canada Health Act. In fact, my department has written to the four provinces with which we were carrying on a dialogue before being interrupted by the election with respect to some of the possible violations of the act.

I'm prepared to enforce the act, and that's the tool we have.

● (1620)

Hon. Bill Blaikie: You mentioned that the Canada Health Act is explicit about the five principles of medicare but also about extra billing and user fees. It doesn't explicitly refer to queue jumping, but obviously that's a concern because queue jumping does violate the principles of the Canada Health Act. If provinces allow situations to develop where people access diagnostic equipment on a basis of ability to pay, and then jump the queue on the basis of those tests, that, in your view, is a violation of the Canada Health Act. That's what you're talking about? Are we going to see how much that is happening, and where, in the annual report to Parliament on the Canada Health Act?

Hon. Ujjal Dosanjh: In fact, we are carrying on a dialogue with the provinces on that very issue.

Hon. Bill Blaikie: There's supposed to be an annual report to Parliament on violations of the Canada Health Act. This has not been followed up terribly well since the passage of the Canada Health Act. I wonder if it is your intention, now that you're the Minister of Health and you are engaging the provinces in this process.... Are we going to see a report at some point that says, this is the extent of queue jumping that's taking place and this is what the federal government is doing about it? For instance, there are penalties in the Canada Health Act for extra billing and user fees. In other words, what kind of leverage would you have, and what kind of leverage would you try to get over provinces that do this?

Hon. Ujjal Dosanjh: First of all, you know that we have agreed across the country that we will engage in the dispute resolution mechanism. With that dispute resolution mechanism, if we believe there's a violation and the evidence is collected and gathered...if we can't resolve the issue amicably, we would then obviously ask that a panel be appointed, one member by the province, one member by the federal government, and one chosen by the two as chair. Obviously the minister then has to look at the recommendations from that panel and take appropriate action. I do understand in the past that some deductions have been made from transfers, and I understand that information is available in the reports as they are filed. If there have been some reductions this year, they'll be in the report that's forthcoming.

Hon. Bill Blaikie: Do I have another question, Madam Chair?

The Chair: You actually have four more minutes, Mr. Blaikie.

Hon. Bill Blaikie: Holy smoke! Sorry, I didn't mean to mention smoke in the health committee.

Voices: Oh, oh!

Hon. Bill Blaikie: Madam Chair, with respect to the whole question of Internet pharmacies, because it has come up, I think the minister is right to be interested in this issue and to be concerned about supply, but I note that he was very firm about the fact that so far there is no danger to the supply of drugs for Canadians. I think Canadians need to know that, because even people who are very supportive of this are of the view that at the moment and for the foreseeable future there is no threat to supply. If indeed there was, the drug companies themselves would be in some difficulty, particularly with respect to brand name drugs, because they're obliged to keep up the supply of brand-name drugs; otherwise, and correct me if I'm wrong, regulations having to do with generic substitutes for those drugs would kick in earlier. So it's in the interest of the brand-name drug suppliers to make sure they keep the supply of drugs to Canada as it should be. Is that fair to say?

Hon. Ujjal Dosanjh: I think it's fair to say that the drug companies are concerned. I'm concerned about the ultimate issue because I don't think this can go on indefinitely. I believe, if I remember correctly, having heard it from some sources that some drug companies are actually choking supply to the pharmacies that engage in Internet pharmacy business so that they stop. I really want to make sure that we as a country deal firmly and fairly with these issues and not leave it to the drug companies to be police officers with respect to these issues.

That's why I moved on this issue to speak out first, to see if the pharmacists and the doctors would voluntarily stop this practice.

It is my belief, based on the information that I have been given, that at this time the drug supply is safe and there is adequate supply, but obviously there is a worry on my mind, and I want to share that with Canadians by speaking out.

● (1625)

Hon. Bill Blaikie: Madam Chair, I know it's a new subject and towards the end. The minister has been asked about this before, but perhaps he'd appreciate an opportunity in committee to explain why it is that the government is taking the position it is with respect to tobacco. Why is it intervening, or does it seem to be intervening, on the side of the tobacco companies in this suit over light and mild advertising? It seems to run contrary to what the minister did a long time ago when he was the Attorney General of British Columbia and he went after the tobacco companies.

Hon. Ujjal Dosanjh: I appreciate that. I think there can be a misapprehension on this issue and I want to make sure we all understand. I don't involve myself with the legal ins and outs of this issue in a complex kind of a fashion. I'm not the Minister of Justice, but I understand there are issues around the class action, with the nature of the class and the size of the class that's being sought to be certified, that raises concerns with the justice department.

It was the tobacco company that "third-partied" the Government of Canada as a party, which obviously meant that if they were liable we would end up bearing some responsibility, if we were seen to be liable too, to the tobacco companies for dealing with issues in a way that wasn't appropriate.

It is before the courts. That's why, in fact, I would rather not say very much, other than to say the issue with respect to our presence in court is not about the ability of the individual to sue successfully or about trying to prevent the individual from suing the tobacco company successfully. This is to ensure that the Government of Canada isn't exposed unnecessarily to a class that can be limited appropriately at this time, rather than to a large class that's being sought to be certified. I understand from the justice department that they will make an application to strike out the third-party notice, so eventually—who knows—we may not be a party in the end, which would be a good outcome.

The Chair: Thank you, Mr. Blaikie.

We'll move on now to Mr. Thibault.

Hon. Robert Thibault (West Nova, Lib.): Thank you, Madam Chair.

Before I get into too many questions, Mr. Minister, I want to thank you for appearing and for being so frank in your answers. When you mentioned to my friend and colleague from the Bloc that you'd be providing figures on the provincial breakdown, I would hope that would include all provinces. I think the committee has an interest in all those areas, and I would hope it would be done through the committee.

Secondly, this a representation for you, and hopefully you will use your good offices to the effect that I suggested or to give it serious consideration. Today I met, as many members did, with three different groups who are on the Hill—the Juvenile Diabetes Research Foundation, the Lung Association of Nova Scotia, and the Canadian Lung Association—as well as with groups interested in smoking cessation. All three groups pointed to a similar area for me. One was on the question of the amount of funding available for the Canadian Institutes of Health Research. I would suggest that this is a very good area for research.

We as a government have done a lot of investment in research capability within the country, within the health field, but also in other ways, with the National Research Council, with the universities, with research chairs, in all sorts of areas. A little additional funding to bring us to the $1 billion level might be worthwhile to address some of these specific areas, to give a little more flexibility, and also flexibility to the Canadian Institutes of Health Research that do multi-year funding arrangements. I don't ask it as a question; I do it as representation. Hopefully you would give that consideration and use your good offices to lobby your friend and colleague, the Minister of Finance, in the upcoming budget presentations.

As far as the subject at hand today is concerned, I have a number of questions.

● (1630)

[*Translation*]

Firstly, there is the issue of official languages. Does the 10-year agreement provide specific measures to meet our responsibilities to official language minority communities? Over the past few years, great strides have been made across Canada for French speakers living outside of Quebec and for English speakers living in Quebec.

People are worried as to whether funding for two areas will continue. The first is training health care personnel, in other words, doctors, nurses, technicians and others. The second area is the pilot project for primary care. Could you comment on this?

[*English*]

Hon. Ujjal Dosanjh: Thank you.

First, in terms of the issue you raise around the Canadian Institutes of Health Research, as you know, the Prime Minister announced just last weekend $194 million across the country for several chairs to be established at universities for research and the like. I also announced, a weekend earlier, $187 million from CIHR to be spent across the country on research. I was able to attend the lung association breakfast this morning and meet with Miranda and Mackenzie, two young girls who are assisting the lung association in doing a campaign on this issue, and it was wonderful to be there.

On the issue of the minority language services, there is a provision in the agreement that says:

> The federal government commits to...targeted efforts in support of Aboriginal communities and Official Languages Minority Communities to increase the supply of health care professionals for these communities....

I also know there are a couple of other issues as part of the Dion plan, and I'm concerned about them. There are two other issues in addition to this training. The funding for one of them runs out in 2006, and I have made it one of my priorities to make sure we're able to get that funding so that portion of that plan continues until 2008. In the meantime, we can work toward making sure the minority language communities—be they anglophone in Quebec or francophone in the rest of the country—get adequate provision of services in their language.

As an immigrant, I can tell you I came to this country...I went to England first, not speaking very much English. English is not my mother tongue. I could read English at a grade 4 level and speak a few words of it when I went to England in 1964 at the age of 17. I know what it means to be deprived of the ability to be able to converse with the person next door or while sitting on the train or on the bus, or while walking, whether or not you're able to talk to people. It is much more difficult, in fact, to seek and access medical services when you need to explain to the providers what you need and where it hurts. It's pretty difficult to do that if you don't know the language. So I am absolutely committed to making sure that at least in the health field—as are other ministers in their fields—minority language services are adequately funded and provided.

Hon. Robert Thibault: Thank you.

There are a couple of other areas I'd like to touch on. One, I would hope that we will make the cure of juvenile diabetes a national goal for this generation and that we will be able to achieve that. I think the Canadian Institutes of Health Research are an excellent element to work with, with people like Dr. Shapiro and the Montreal facilities.

One area that is of concern is the question of the Canada Health Act, including the enforcement, the standardization of care, the standardization of services across this country, and seeing how those will be achieved.

The area I would like you to comment on a bit is the fact that we've given ourselves the goal of 50% of Canadians having access 24 hours a day to medical services across this country. For a guy like me, who lives in a rural area, it seems to me to be easy to do with 50% of Canadians living in urban settings. How do we balance that between the urban and the rural? Are 50% of those going to be the rural communities that comprise 50% of the Canadian population? Are we going to do that 50% half and half between rural and urban, or are we going to pick the lowest hanging fruit? How do you work with the provinces on a question like this?

● (1635)

Hon. Ujjal Dosanjh: I think there are issues addressed in the accord with respect to primary care reform, which is the first issue you talked about in terms of 24/7 care. The goal, as I mentioned earlier in my remarks, is to have care for 50% of Canadians on a 24/7 basis by 2011. I think that's very important, but it's also important that 24/7 care be spread across the country, not only within 150 miles of the border with the U.S. I'm very conscious of that, and I think that's an issue where we need to work with the provinces and assist them with that.

There is a provision in the accord with respect to access to care in the north, which is specifically mentioned. I also want you to know that we've placed some emphasis on telehealth so that we can have the north and rural communities access quality health care without having to travel long distances. This is a problem, as you know, in this vast country. It's a beautiful place, but it has its disadvantages in terms of long distances and difficult terrains. Those are issues that we need to continuously work on with the provinces.

As you know, we deliver health care only to the aboriginal communities, and even there.... In fact, one of the issues we want to deal with is to try to integrate the systems of health care so the aboriginal communities can get the same level of health care that other communities get. I say in a way that's very clear to you that we haven't done a very good job of this. I'm new at this. But the Prime Minister has said very clearly many times that we've done a very poor job of dealing with the aboriginal community health delivery and we need to do a better job.

Hon. Robert Thibault: I see my time is running out, so I'll ask one last question that I'd like the minister to answer. How do we deal with enforcement of the Canada Health Act, the standardization, while at the same time maintaining the independence of the provinces and recognizing the different delivery levels there might be in certain areas? It would seem to me to be a very difficult balancing act.

In the interest of others who might be waiting, perhaps we can get to that in the second round.

The Chair: Mr. Lunney will be next.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you, Madam Chair.

I want to begin with a comment I heard earlier that the first ministers will be meeting early in 2005. There's a lot of talk, I understand, about increasing the supply of health care practitioners, training and hiring of human resources, and ways to speed up or increase foreign credentialling.

With respect to primary care reform, I heard you say a minute ago, Minister, that your target is for 50% of Canadians to have 24/7 access to multidisciplinary teams by 2011. That certainly seems worthwhile.

I want to draw to the minister's attention a study that I mentioned in the House the other day. It's current in the *Annals of Internal Medicine* of October 11, in fact. It deals with medical manpower and managed care. Now, we're talking about the United States, but it is reflective of what's been done in Canada. We're talking about a large sample study, Minister, of 1.7 million patients, a million of whom had access to standard medical care and 700,000 of whom had access to chiropractic care in addition. This is from the *Annals of Internal Medicine*. The doctors are saying that the overall health costs for the group that had access to chiropractic care was 12% lower and was due to decreased hospitalization, decreased expensive diagnostic tests, and increased outcomes.

This is consistent with what we have done right here in Canada. Dr. Pran Manga, right here from the University of Ottawa, back in 1998 did a report for the Ontario government and estimated $98.... It was a saving of about $100 million with back pain alone in Ontario and about $2.2 billion nationally. I'm wondering, if you're talking about multidisciplinary teams for 2011 in primary care reform, is anything being done to ensure that health care resources that are already here and currently underutilized are included in the primary care reforms to make sure Canadians get the best value for their health care dollar?

● (1640)

Hon. Ujjal Dosanjh: You raise an important and a difficult question. It is important that people are able to go to a chiropractor, if they so choose, or a massage therapist or an acupuncturist. I mean, it wasn't long ago in this country that acupuncture used to be illegal.

There are other traditional medicine issues and the like, but I don't think it's for me, as federal Minister of Health, to tell the provinces what services they should be paying for. I think that's the ultimate question that you've wrapped in the larger question. I would be absolutely irresponsible if I gave direction to the provinces. I do recognize that chiropractors are used by many people, and should continue to be used, but in terms of whether or not they should be part of a multidisciplinary team as the 24/7 care I envision for the country by 2011, I think you should you make your pitch to the provinces.

Mr. James Lunney: I find it rather interesting that when we're talking about health care costs that are spiralling out of control, the minister would not take a more proactive role, not in telling the provinces what to do, but if we're interested in reducing costs that are out of control, who's responsibility is it if it is not the responsibility of the Minister of Health?

Hon. Ujjal Dosanjh: Whether or not you should be a part of a team, if you ask a layperson like me who does not know the ins and outs of medicine itself—I know enough about health care now but not enough about medicine—I'd say if chiropractic treatment helps as part of the multidisciplinary team, you should be part of it. Now, whether or not the provinces should be listing you as an insured service, that's an issue the provinces have to deal with.

Mr. James Lunney: Regarding the health council, Minister, I understand you talked briefly about an expanded role for the new health council in an annual report, under Dr. Michael Decter. Could you tell us what has the health council been doing so far, and what are they expected to actually be reporting on?

Hon. Ujjal Dosanjh: I understand the health council is due to deliver their first report in January of the coming year. That would be flowing from the 2003 accord, because they had an obligation under that accord to report on certain elements of the accord.

You now have a new obligation placed upon them in the 2004 accord to provide an annual system performance report as to how our system is functioning across the country. Of course, they may choose to look at the reports from each of the provinces that are delivered to their citizens and see how we're doing across the country, based on common benchmarks and comparable indicators.

That's why it was so important during the election campaign that the Prime Minister talked about common benchmarks and comparable indicators, and it is why they're prominent in this accord. If we want to talk about wait times and the reduction of wait times and about whether or not we are actually expanding health care and whether or not we're actually moving toward the target of 2011, having 24/7 care in 50% of the country, whether we want to know how we're doing at one glance, I think that report would be useful. So would the report from CIHI be useful in terms of, specifically, the wait times.

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

We'll now go to Mr. Savage.

Mr. Michael Savage (Dartmouth—Cole Harbour, Lib.): Thank you, Madam Chair.

Welcome, Minister. I would like to offer my sincere congratulations on this health accord, and also to your parliamentary secretary, who was very helpful in achieving that. I mean that very sincerely.

I also want to thank you for the increased funding to CIHR. I had the opportunity last week to be your representative in Halifax, and we announced some very interesting funding. One of the great advantages to me—and it comes perhaps from my background in the Heart and Stroke Foundation—is that the money that goes into CIHR has to not only be looked at in terms of the base funding the government provides, but there's also the fact that it's matched, in a lot cases, by health charities and other organizations.

In Atlantic Canada there are a couple of very interesting studies being done, by Renée Lyons and Judy Guernsey, on population health and health systems research. I think that's important because CIHR has allowed organizations to not only fund biomedical and clinical research, but to get into the very important areas of population health and health systems.

That leads me to my question on the whole area of health promotion and national wellness and how we are doing in that area. In this accord, I believe Premier Hamm discussed it. I know, coming out of the meetings, the strategy will include efforts to address common risk factors, physical activity, and integrated disease strategies.

Coming from Atlantic Canada, we have the highest incidences of chronic disease, cardiovascular and cerebrovascular, diabetes, which is out of control, and a number of others. I understand it's being worked on and the provinces are involved. Can you indicate to me whether we're going to have a national wellness strategy? That's my term; you can call it what you like. How quickly might we have a national wellness strategy?

My other question is tied to that. What would be some of the benchmarks that we should consider in terms of obesity in children, inactivity, diet, and those kinds of factors?

Before you answer that, I only want to say that Nova Scotia is once again leading Canada. I think we're the first province to actually have an Office of Health Promotion. I congratulate Premier Hamm and the government on that.

Are we close to having a national wellness strategy? What would be some of the benchmarks in that area?

● (1645)

Hon. Ujjal Dosanjh: I believe the first ministers imposed an obligation on themselves in terms of the provinces, and on us in terms of the aboriginal delivery of health care, to set targets for public health and the promotion of public health. I think it's important that you and others know that there is a whole section on prevention, promotion, and public health in the accord.

From my perspective, in fact, in this accord, as we invested an additional $41 billion in health care, we also shifted to or at least focused somewhat more on promotion, prevention, and public health. I think the single, greatest, most important example of that is how the Public Health Agency is playing the role it's playing. We're hoping over time that the Public Health Agency plays the role of dealing with public health threats and managing those kinds of issues.

In terms of promotion and prevention, it plays a larger role. As it gains momentum, as it gains a profile across the country, as Dr. Canada truly becomes well-known in the living rooms of the nation, and as he carries on a conversation or a dialogue with Canadians, that becomes important.

You know that as ministers of health we are engaged in the development of a pan-Canadian healthy living strategy, and obviously that's the strategy you're talking about. I'm hoping that in the next short while we may be able to make some progress on that.

We all know that prevention and promotion will save us billions of dollars at the other end. Sometimes it seems as if we are dealing with the symptoms and not really with the causes before things happen. I think your question is a timely reminder that it's what we need to continue to discuss.

Mr. Michael Savage: For the $41 billion, is there any budget allocated towards what we would call health promotion, or could there be?

Hon. Ujjal Dosanjh: It could be, depending on the choices the provinces make. I think one way, for instance, of reducing cardiac lists would be to promote a healthy living strategy across the provinces, so that we don't get into cardiac problems and we're not on the waiting lists. I know the provinces are doing that work. I know from the ministers of health that they are. In fact, when we were there, we did privately and publicly talk about some of these issues on promotion and prevention of public health. We had, in fact, my colleague, Dr. Bennett, sitting with me, and we also had Dr. Butler-Jones at the conference.

● (1650)

Mr. Michael Savage: I know Dr. Bennett's commitment, and I would say that health charities like the Heart and Stroke Foundation, the Canadian Lung Association—Bill VanGorder, from Nova Scotia, is here today—recognize that a lot of health promotion is behavioural. But there are aspects of it that I would strongly urge to be budgeted and be allocated specifically, and I think the federal government could take a leadership role in some of them.

Thank you.

The Chair: Thank you, Mr. Savage.

Madame Demers.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): Thank you, Madam Chair.

Mr. Minister, I should first point out that I am happy to hear you say that some serious problems concerning aboriginal communities have not been broached. My comments will deal with this issue. I have three questions and a sub-question for you.

In a recent report on physical and mental health problems affecting the Attikameks, an aboriginal community living north of La Tuque, it was revealed that the youth suicide rate is so high that suicide has become a normal occurrence in the community. When another suicide occurs, the community grieves for a day or two, but then life moves on. There are situations where 10-year-old children who drink alcohol and show signs of advanced drug addiction stay out after 10 p.m. The next day, in class, they are unruly, and that's considered normal.

You spoke of $700 million being earmarked for health problems in aboriginal communities. How will the initiatives that you spoke of be chosen? How will the funds be allocated? Will you establish benchmarks to evaluate the relevance of the initiatives and to allow for changes to be made where necessary? Will something be done to evaluate the specific needs of subgroups such as women and children in aboriginal communities?

[*English*]

Hon. Ujjal Dosanjh: Thank you.

Let me first recount the additional money that's going into aboriginal health. That's an additional $700 million over the next five years.

● (1655)

[*Translation*]

Ms. Nicole Demers: That's over five years.

[*English*]

Hon. Ujjal Dosanjh: Yes, over the next five years. That's in addition to the $1.7 billion we spend annually on aboriginal health. That's going to be divided as follows.

We will have an aboriginal health transition fund that will be $200 million over five years to enable government and aboriginal communities to better integrate and adapt health services—what I was referring to—so that we can integrate the health systems so that we provide better services and meet their needs in a better way.

Secondly, there will be an aboriginal health human resource initiative, at $100 million over five years, to train more aboriginal health care workers. I think it's the same kind of issue when we talk about minority language health providers. We need to make sure we have aboriginal doctors, aboriginal nurses, and other aboriginal health providers who are able to better deal with these issues. They'll know the issues instinctively, because hopefully they would have grown up in those communities.

Finally, we'll invest $400 million over five years in key areas of health promotion and disease prevention. Those would be such issues as suicide prevention, diabetes prevention, maternal and child health, and early childhood development.

We want to make sure we have some upstream investments that are able to bear fruit for us in terms of ongoing better health for aboriginal people.

The other aspect you asked me about was how we are going to arrive at those issues. If you remember, the Prime Minister had an aboriginal round table in April of this year. Arising out of that round table were recommendations that we will have several sectoral discussions. One of those discussions was supposed to be the aboriginal health discussion, with aboriginal organizations and representatives from across the country, with experts, and with governments. That discussion took place a couple of weeks ago here in Ottawa, with about a hundred people coming together from across the country on health.

We agreed, amongst the ministers of health, that Mr. Smitherman and I, as co-chairs of the Conference of Ministers of Health, would meet with the co-chairs of the committee of ministers responsible for aboriginal affairs, and meet then with the aboriginal leadership and representatives from across the country, to try to create a blueprint for aboriginal health. We can then try to determine how this money needs to be spent, what the criteria ought to be, and how the projects ought to be approved, so that we can begin to do a better job in a more coordinated fashion and so that the aboriginal people, in a significant way, have a hand in crafting those polices and that blueprint.

[*Translation*]

Ms. Nicole Demers: Thank you. How do you plan on meeting departmental objectives in terms of home care for groups who fall under federal jurisdictions such as first nations, Inuits and veterans?

[*English*]

Hon. Ujjal Dosanjh: I think we have to meet those objectives the same way we expect the provinces to meet those objectives—that is, we're now working on determining how we get there.

If you remember, we signed the accord as the federal government as well; therefore, we have the same obligations to report in a similar fashion based on benchmarks and comparable indicators to expand home care. We are currently actually working within the department, and outside, as I said, there was a meeting recently. We will be meeting and creating a blueprint for aboriginal health and making sure we meet our obligations within the next few years as we move forward.

[*Translation*]

Ms. Nicole Demers: Could I ask one last question?

[*English*]

The Chair: Thank you, Madame Demers.

We'll move on to Ms. Dhalla now.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): Minister, thank you for taking the time to come today, and also for your leadership and your vision, along with the Prime Minister and the parliamentary secretary, in terms of signing the health care accord.

It has been touched on briefly, and you and I have had some discussions on this in terms of ensuring that there's an accessibility of physicians available to Canadians. As a health care provider I've had a chance to see first-hand some of the many challenges we face in the health care arena.

First and foremost, I think the average Canadian is having difficulty in terms of accessing doctors. Perhaps you could touch on the health care accord and what the vision is of the health care department to ensure that there's an increased number of physicians and availability of doctors to Canadians across this country.

Hon. Ujjal Dosanjh: I think we needed to start a few years ago when experts told us we had an oversupply of doctors and nurses. Most of the medical colleges reduced the number of physicians available, the residencies were reduced, and we're now actually bearing the fruit of those reductions. It's unfortunate, but we now have to make sure we are able to plan in a very coordinated fashion.

That's why in fact the federal government has set aside some money—I don't recall the figure, but I believe it's $65 million—to make sure we are able to deal with the issue of the integration of medical graduates and assist the provinces in dealing with those issues and in dealing with the residencies and increasing the number of residencies.

I understand that Ontario is in fact establishing a new medical school for northern Ontario. I understand that the University of British Columbia and the Province of British Columbia are partnering with the University of Northern British Columbia in Prince George, and they have some medical training happening there. I think we need to do that. We need to depend on the provinces to be able to do that, and we'd be happy to encourage them.

As you know, there is funding available within the accord itself. The funding for training health human resources is implicit in the $4.5 billion that's set aside for the wait times reduction fund. For 2010 and 2011, I believe, there is $250 million ongoing with respect to specifically training health human resources. That is because with the urging and insistence of the premiers—and they were right—we recognized that you can't begin to train health human resources today and then suddenly you don't need the money after the first four or five years. That's why the Prime Minister made sure there was $250 million. If you look at the table attached to the press release of the day, it has that $250 million ongoing to specifically assist the provinces in terms of ongoing training of additional doctors and nurses.

Ms. Ruby Dhalla: The next question I had, and I think one of my colleagues brought it up before, is in terms of the integration of chiropractic on a national spectrum. I must congratulate you on meeting with the chiropractic association last week.

What do you think the role of other health care professionals is in terms of the discussion, the debate, and the solutions surrounding many of the challenges we face in health care?

● (1700)

Hon. Ujjal Dosanjh: This is a much larger issue than we can deal with here. It's an issue of inclusion of traditional medicine, be it from China, from India. It's a matter of dealing with chiropractic treatment. As I said, acupuncture used to be illegal until some years ago—when I needed it.

It is important that we recognize we have to open our minds to alternative medical care that might be available. How we integrate it into our system would really depend on the experts—the practitioners, the nurses, the professors, and the like. Far be it for me to say how it should be done. I'm only the Minister of Health. I think it's important, though, that we keep our minds open and that we continue a dialogue.

What happens in many instances is.... I'm a lawyer, and lawyers deal with notaries. There are usually turf wars in those kinds of situations. I recognize those issues, and without appearing to pontificate on them, I want to say to you that we need to make sure we keep an open mind as we continue the dialogue. We are, as a society, much better today about these issues than we were 15, 20, or 30 years ago, because we have opened our minds to what else is available elsewhere, not necessarily here.

The Chair: Thank you, Ms. Dhalla.

Ms. Ruby Dhalla: Could I just say one last thing? I think you have to be congratulated on your mindset of inclusiveness. Also, while you're lobbying the finance minister, let us ensure, as my colleague Mike said, that we have a national wellness strategy, because I think prevention and proaction are very important—instead of being reactive.

Hon. Ujjal Dosanjh: And I need to restart jogging.

The Chair: Thank you.

Mr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): First I'd like to thank you, Minister, for coming and not only answering our questions but, as you said, being a little more open-minded about solutions.

Both my colleagues brought up something I would like to continue with a little bit—

Hon. Ujjal Dosanjh: It's a meeting of chiropractors here, isn't it?

Some hon. members: Oh, oh!

Mr. Colin Carrie: It is. You're getting surrounded.

With the issue of what the government says and what they end up doing, I would like to nail you down a little bit. I've spoken myself to chiropractors, nurse practitioners, paramedics, and pharmacists, and all of these different professionals believe they have a greater role to play in Canada's health care system, but because of the way the Canada Health Act is being implemented and enforced, there seems to be a financial disincentive for Canadians to see health professionals who aren't medically oriented or hospital oriented.

In your report, if I can quote it, the first ministers all agreed on an action plan, including "...reforms focused on the needs of patients to ensure that all Canadians have access to the health care services they need, when they need them...". You said it wasn't really a federal role, but I think we could have a leadership role in alternative therapies being presented to the Canadian public. Can you see any way we could help get the provinces on board with this?

Hon. Ujjal Dosanjh: I think you may have misunderstood me, and I offer my apologies if I misled you inadvertently. It was not my intention to say the federal government doesn't have a role. The federal government has a role.

If the federal government had not taken the example of Saskatchewan to try to make sure we have a national health care system, we wouldn't have a health care system. In that sense we have an advocacy role. We have a role to try to persuade the provinces to move in a particular direction by consensus, if we think it's the right way to do things.

I'd be happy to play a creative and positive role in that sense, and I don't want to give you the impression that the federal government does not have a role. It has a large role in health care. We spend a huge amount of money on behalf of Canadian taxpayers, but I want to tell you we will be proactive.

Can you re-ask your question more specifically?

Mr. Colin Carrie: Well, it's in regard to the principles of the Canada Health Act.

● (1705)

Hon. Ujjal Dosanjh: Okay, yes.

Mr. Colin Carrie: I know you believe in those principles. Let me quote Professor Pran Manga, an economist from the University of Ottawa. His criticism of the health management in Canada is that governments fail to understand the language of the Canada Health Act. The comprehensive clause was designed to ensure that the most appropriate professionals provide care, not exclusively medical doctors or hospitals. In other words, if a specific condition is covered in the act, the plan was designed to pay for fees of any licensed, regulated professionals who provide that treatment. Could we work on enforcing that from a federal standpoint?

Hon. Ujjal Dosanjh: You're correct, and the individual you are quoting is also correct, because the Canada Health Act deals with doctors and hospital services. But there's nothing preventing the provinces from listing any services as insured services, or delisting any services, other than perhaps the hospital services and doctors under the CHA. So I think you're correct, but if the services are insured, which means listed, then I think they are caught by the Canada Health Act. But you're saying we should amend the Canada Health Act to broaden its effect.

Mr. Colin Carrie: No, I'm saying to kind of enforce the definitions that are already there. Right now I see a real crisis—and Dr. Dhalla brought it up—with a doctor shortage. One-third of visits to medical doctors are for musculoskeletal issues—and this is just one profession like chiropractors—so by utilizing other professionals, I think we could decrease these waiting lists. That's where I'm coming from.

Hon. Ujjal Dosanjh: I understand. What you're saying is to utilize the comprehensiveness principle to then read into the act services that are not included or encompassed in the act. I think that would be a novel reading of the act that hasn't been done for a long time. I don't know whether that will withstand legal scrutiny.

The other issue that you need to concern yourself with—and what I need to concern myself with—is we are a federal country, and as a federation it is sometimes difficult, and never advisable, to really impose a prescription on provinces that might not have been intended by the legislation. I think that's the argument you might be met with. I know you're quoting an expert to me. I'll be happy to take a look at that, and we can carry on that conversation.

The Chair: Thank you, Mr. Carrie.

Mrs. Chamberlain.

Hon. Brenda Chamberlain (Guelph, Lib.): Thank you, Minister.

I have a few burning issues, actually. On waiting times, I believe this is the number one issue with the health care system today for Canadians right across the country. I don't go anywhere, Minister, without being stopped and told weekly, “I can't get in for my shoulder for an operation; I can't get in to see a specialist; I can't get in to see a regular doctor”. I believe we have a good health care system, and I think most people do too, but it has some very serious flaws right now.

In your opinion, when will we see improvement? How long will it be before that waiting list is actually pared down for people?

Hon. Ujjal Dosanjh: I think it's pretty difficult to pin down a particular date, but let's pick the date that's been mentioned in the accord, March 31, 2007, when we have to, as different jurisdictions across the country, report to our citizens significant progress in wait times. Obviously, between now and March 31, 2007, we have to be able to bring those wait times down and the wait lists down. That's the only yardstick I can give you.

That's the obligation that was accepted by all the jurisdictions, all the governments that were at the table. I think we should go by that, and hopefully all of us in our different jurisdictions will be able to report to Canadians in our jurisdictions that we have actually dealt with the reductions in a significant way by then.

● (1710)

Hon. Brenda Chamberlain: I was hoping I wouldn't hear that answer, because quite frankly, I don't think it's acceptable. I realize we have to work with the provinces, and I know this is a provincial jurisdiction in many cases, but I have to tell you, Minister, for constituents who come to me who are in pain and can't get relief, two and a half years is a very long wait to find out if we're even on the right course.

Hon. Ujjal Dosanjh: I think you may have misunderstood.

We have to begin to reduce wait times now. We made a commitment to begin to reduce wait times. We may not have all the tools that quickly. We need more doctors. We need more nurses. We may need more equipment. There's money for all of those things as part of the wait time fund, but you have to understand that it may be humanly impossible to do it that quickly.

However, despite all of those considerations, knowing the urgency of this issue on the minds of Canadians and the fact that this issue was the major issue in this election campaign, all of the first ministers imposed an obligation upon themselves to report to Canadians by March 31, 2007, a significant reduction—not to start making reductions at that time, but to report significant reductions in wait times at that time.

I think that's a pretty onerous obligation, knowing that you control only some aspects of the situation, that new doctors will take time to come on stream, new international medical graduates will take time to come on stream, nurses will take time to train, and we will have to learn to manage these wait times better. It's going to take time.

I'm an impatient man, but you're obviously even more impatient than I am.

Hon. Brenda Chamberlain: I'm extremely impatient in this area. I think we've had serious deficiencies—

Hon. Ujjal Dosanjh: I agree.

Hon. Brenda Chamberlain: Perhaps it's not doable, but I would ask the minister to consider that when he meets with his provincial counterparts he ask for an interim report on our progress. I think to wait for almost two and a half years to see significant progress is too long. Again, I state that. If we could get some sort of interim report, my wish is that it would be brought here to this committee so we could have an ability to continue to see this thing through.

Minister, I don't want to wait for two and a half years and then see that we're not far enough along, that we really haven't made the progress. Then we'd be almost starting from two and a half years in.

If everything goes the way you hope it will and it's really significant, then hooray for us, good. But it may not be. So I guess I am a little bit of a doubting Thomas. I do like to have progress reports, and I'm wondering if that's a possibility.

Some hon. members: Hear, hear!

The Chair: Hear, hear! Yes, we'd all like that.

Hon. Ujjal Dosanjh: First, let's recognize that it is in the interests of the provincial governments themselves to reduce wait times. It is an issue that will dog them when they go into their elections. The obligations we've imposed upon ourselves as different governments are in addition to that political obligation that they have on an ongoing basis. I believe all of the jurisdictions, if I'm correct—and I'll stand corrected if I'm wrong—currently report to their citizens on the state of health in their jurisdictions. I think that would give them an indication.

We also have an obligation, in fact, under the accord to provide annual reports to their citizens. So you may get some reports before March 31, 2007, that may tell you that in 2005 and 2006 the reductions have been ongoing, or they haven't happened. Hopefully, "the reductions have happened" would be the message.

But the obligation to report significant reductions is by March 31, 2007, because everyone recognized that in a year there might not be significant reductions available to us.

Hon. Brenda Chamberlain: Minister, do you think it's possible that in six months we could get some sort of report from you?

Hon. Ujjal Dosanjh: If there were reports available from the provinces, we would collect and table them in the House. But we are at the mercy of the provinces for those reports, because they report to their citizens, and we, of course, report on the aboriginal health delivery.

When is our report coming, do you know?

● (1715)

Mr. Ian Shugart (Assistant Deputy Minister, Health Policy Branch, Department of Health): Later this month.

Hon. Ujjal Dosanjh: Our report will be ready later this month. We may have another one in a year's time, and then you'll know how much progress we're making.

Can I make this point? Sometimes we believe we have these august powers as the federal government and we just flick a switch and the provinces will give us the reports. You know we are a wonderful federation, but we are a difficult family sometimes, and it is important for us to work cooperatively with each other, to cajole, convince, and persuade each other. I think the provinces are doing these reports on their own, and I'd be happy to access them for you.

Hon. Brenda Chamberlain: Let me say this, Minister. You talked about the provinces being dogged in the next election. So shall we be dogged, all of us, on our response and progress in this area. I think Canadians probably expected something more concrete, something quicker than that. I'll leave that with you.

I know my time's up. I just have a couple of other things.

One, I want to say to you that the telehealth is absolutely excellent. Anything we can do in that field we should carry on, because it's a real winner for us.

Second, the doctor shortage is serious. We do have to progress in that. People cannot wait.

The Chair: Thank you, Mrs. Chamberlain.

Mrs. Demers.

[*Translation*]

Ms. Nicole Demers: I'm going to pass, Madam Chair.

[*English*]

The Chair: You're going to pass.

Mr. Merrifield, then Mr. Thibault.

Mr. Rob Merrifield: Thank you very much.

On the reporting—and I found Madam Chamberlain's comments absolutely true—I believe in the 2003 accord the provinces have to report on an annual basis. If they report on an annual basis, there's no reason we can't get those reports—unless they're null and void after the last accord.

Hon. Ujjal Dosanjh: I think I said they report on an annual basis anyway. That's the 2003 accord. In fact, there is a report due at the end of this month on comparable indicators pursuant to the 2003 accord. It's every two years, but most provinces, I think, report to their own citizens every year anyway.

Mr. Rob Merrifield: I believe it's yearly.

At any rate, one of the other issues that really struck me was a report that we did, which we tabled in the House. We had further information on it in the middle of the election campaign—a study that came out showing adverse events within our acute care hospitals. This report showed there were 24,000 deaths, I believe, in the year 2000 because of adverse events within acute care hospitals in Canada.

With regard to that, we had a significant number of recommendations on how to deal with adverse drug reactions and adverse events. Further to that, I put forward a private member's motion that was passed in the House unanimously—well, I don't think it was unanimous, but very close—to make sure adverse drug reactions were reported. We know that only 1% to 10% are actually reported across Canada now.

I'm wondering what you have done under your watch so far with regard to that motion and with regard to the problem that has been addressed in this study.

Hon. Ujjal Dosanjh: On the issue of general patient safety, I think that's a concern across the country, as is, in fact, the safety of health care providers when they're dealing with difficult patients. I think those are issues of general concern to all of us.

I will specifically address your questions with respect to the adverse drug reactions. I have discussed that issue with my department—why we do not have a mandatory adverse reaction reporting policy in the country. I was given some advice. The department is looking at it. If it is advantageous, if it can save lives, then we need to make sure there is mandatory reporting of adverse drug reactions.

I am told, however, and I will say this very cautiously—I haven't seen the research—that in places where this is the case, it doesn't seem to have resulted in a higher number of reports than before. So voluntary reporting, as it is in Canada, I am advised, is appropriate. However, I can tell you I am not satisfied with that answer—I'll share that with you. My investigation into this matter continues because I'm of the view that we should do the utmost to save lives.

I understand that medical doctors voluntarily report adverse drug reactions. Let me ask Ian. I think he knows more about the issue than I do.

● (1720)

Mr. Ian Shugart: We have in fact taken additional measures through the reporting systems put in place in hospitals and other primary facilities across the country. The minister is absolutely right that this remains a voluntary system. There are, for the federal government, jurisdictional issues in any imposition on provinces of a mandatory reporting system, or at least that is a concern that requires some real care in terms of jurisdictional assessment. There is a risk of that crossing the line into our regulating the practice of medicine.

The establishment, with funding, of a broader system for the reporting of medical errors, and institutions such as the Canadian Patient Safety Institute, occurred in response to the department's concern about adverse medical events, and particularly prescribing error.

Mr. Rob Merrifield: We're going to watch with some interest to see how you progress on this.

Hon. Ujjal Dosanjh: Let me say to you that I would be happy to hear from you at any time on this issue. I myself am not satisfied currently with what we're doing. I think we may be able to do more, and perhaps we should do more. So that's an issue that's on my mind.

Mr. Rob Merrifield: Just one more, Madam Chair?

The Chair: No, you're at 5:47 already.

Mr. Thibault.

Hon. Robert Thibault: Thank you, Madam Chair.

I'll make just a couple of points and invite your comments.

First, if you look at the situation in Nova Scotia and the care to rural residents of Nova Scotia, the biggest concern, as was pointed out by members previous, is having access to a family physician. That goes not only to the question of health care but also to the question of administration of programs. We often ask that our veterans, our seniors, visit medical practitioners on a regular basis and supply a report to us, the federal government. While the administration of health care might be provincial, often in our acts, in our regulations, and in our administration of programs, we require a doctor to have signed off.

So perhaps we could look there. In some areas of rural Nova Scotia, we now are starting to have—and I congratulate the current government on this—nurse practitioners in place in remote areas where it's impossible to have, or the population will never justify, a doctor who can operate there profitably. If nurse practitioners were able to use their professional abilities to do some of that work, it would alleviate a lot of problems in certain cases.

And the gentleman to my right, his father instituted a great home care program and a great ambulance program in Nova Scotia that's been able to service rural areas and all of the areas a lot better than in the past. We continue to develop that.

In an area like rural Nova Scotia—and I think it would be no different anywhere else in the country—when we ask Canadians who've had access to the heath care system if they're satisfied, the vast majority tell us they're very satisfied with the health care system. When we ask Canadians who haven't necessarily had access what they think of the health care system, they're quite concerned. They're concerned about the sustainability.

That's the element you mentioned when you started, in your first invention, the sustainability of the health care system. But I think that's what Canadians are very concerned about, often because they don't have access to a family physician. We often hear that a lot of families don't have it.

So I think when we look at the accord, and we have the ten premiers who tell us they are satisfied with it, with the advice of their ministers of health, the three territories and the federal government, that this will give us those things and give us the sustainability of the health care system, then I, as a rural Nova Scotian, take it to mean that, in time, we're all going to have access to a family physician, that we're going to have access, in the critical areas of intervention, within a reasonable amount of time, to eye surgery, hip surgery, orthopedics, cardiovascular, cancer treatment, diagnostic, and so on.

Are you comfortable that we're going to be able to achieve this, that we have the groundwork, that we're going to be able to give confidence to the Canadian public that we can achieve all these things?

● (1725)

Hon. Ujjal Dosanjh: Given the will on the part of the provinces and territories, and given the fact that the federal government is absolutely willing to cooperate with them in any way, shape, or form on some of these issues without necessarily impinging on their jurisdiction, I think it's doable.

On the issue you raise in terms of the availability or accessibility to a practitioner, sometimes it doesn't have to be a medical doctor; it could be a nurse practitioner. Those are issues of the "scope of practice", as they say in medical lingo. The federal government is prepared to assist any jurisdiction, in any way, to resolve some of these scope-of-practice issues. These are essentially turf issues, and we should resolve them as early as possible so that we can have access to the practitioners we need.

The Chair: Thank you, Mr. Thibault.

Mr. Merrifield.

His name was down before yours, Mr. Ménard.

[*Translation*]

Mr. Réal Ménard: You are going to have to allocate time a little more fairly. We've been allowed two questions, while they're at their eighth question. This would be our third question.

[*English*]

The Chair: Okay, I remember now. Madam Demers passed when it was your party's turn, so we will go to you, Mr. Ménard.

Could you make it really short, though, please?

Voices: Oh, oh!

The Chair: If you have a question, fine, but we don't need a three-minute speech.

[*Translation*]

Mr. Réal Ménard: Mr. Minister, I didn't understand what you said earlier about Internet pharmacies and the legislative option that is available to you.

I would like you to table with the committee the information that you have about what you feel is achievable. When you spoke about wanting to amend the legislation concerning practitioners, I didn't grasp the link that you were making. Could you send us some written information on this subject?

[*English*]

Hon. Ujjal Dosanjh: One of the options within my department that we can look at, and that we are looking at—we haven't yet completed the legal analysis—is to amend the regulations that define the term "practitioner" for the purposes of that particular act, to amend, without infringing the provincial jurisdiction of governing medical practice, the definition of practitioner to mean a practitioner who can prescribe medication to people who are resident in Canada or visiting Canada. Once we have that, I'd be happy to share it with you.

Mr. Ian Shugart: I would very briefly add that part of the analysis we would do, Minister, is on whether legislative amendment or regulatory change would be required, and particularly the issue of jurisdiction.

Mr. Réal Ménard: Short enough?

The Chair: Excellent, Mr. Ménard. You'll have to do that next time as well.

On behalf of the committee, Minister, I'd really like to thank you. I must say, though, I really think you're far too humble. You said a couple of times, I'm not a health professional, I'm just a lawyer, I'm just the Minister of Health. Sir, we see you as the captain of our team of federal politicians who are interested in the better provision of health care in this country and the promotion of good health among Canadians. You're not just a lawyer. You're not just the minister. You're the captain of the team. We want you to flex your muscles.

Hon. Ujjal Dosanjh: I think that comes from my being from a different culture. I grew up in India, and you're always...or I always try to be humble, in any event. I come from a humble background. It's also part of the culture that I come from, where when you speak in public, you're always self-deprecating.

● (1730)

The Chair: It's very charming.

Hon. Ujjal Dosanjh: I am humbled nonetheless.

Thank you very much for having me here.

The Chair: I want to say one more thing, Minister, on adverse drug reactions. We had a member last term, named Deborah Grey, whose personality was rather strong. When we found out that there were only 13 people in Canada receiving the calls on drug reactions, she dubbed the system the "1-800-We-Don't-Care" system. We all had a good laugh over that. But the issue of adverse drug reactions was raised by my colleagues, and it's in our report. I mean, 13 people is not sufficient to respond to these things that can sometimes kill people.

Hon. Ujjal Dosanjh: Yes.

Thank you very much for asking me to appear. It was a great introduction, and I think we should carry on this dialogue whenever we want.

The Chair: Good. Thank you very much.

This meeting is adjourned.

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