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Ms. Bonnie Brown

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● (1540)

[*English*]

The Chair (Ms. Bonnie Brown (Oakville, Lib.)): Good afternoon, ladies and gentlemen, and welcome to the eighteenth meeting of the Standing Committee on Health.

This afternoon we have before us Dr. Michael Decter, the chair of the Health Council of Canada. He is here in response to the request by the committee to meet with him to hear about an update on his work, as the council is now about a year old.

Mr. Decter, please, the floor is yours.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): I just have a point of order before we begin.

The Chair: We have a point of order from Mr. Fletcher.

Mr. Steven Fletcher: Just on procedure, I know we'll be sensitive to the time of our special guest, but many months ago a motion was passed by the health committee to have the Prime Minister come to testify, as there were some questions raised by the former Deputy Prime Minister, in a book, about the Prime Minister's commitment to the Canada Health Act. I'm wondering if you, after these many months, have received any response from the Prime Minister, and if you could share that with the committee.

The Chair: I thought I reported this to you, but maybe I forgot, in the press of business just before the Christmas break. We did, and I believe the clerk has made copies for everybody. So if this will please you, I will hand them out today.

Mr. Steven Fletcher: Thank you very much.

The Chair: Thank you.

The point of order has been dealt with. We'll now move back to Michael Decter.

Mr. Michael Decter (Chair, Health Council of Canada): Thank you very much, Madam Chairperson and members of the committee. Thank you for the invitation to appear here today and to report on the activities of the Health Council of Canada. The council values the interest of the committee and its members, and we look forward to meeting today and in the future to discuss the progress of health renewal in Canada.

As you'll remember, the first ministers announced the Health Council of Canada as part of their 2003 accord on health care renewal. Just over a year ago, the council began its work focusing on its unique mandate to independently monitor and report to Canadians on progress being made toward health care renewal and on the status of the health of Canadians as set out in the first ministers accords.

I'm pleased to report to you today that the council is organized and ready to carry out its mandate in partnership with the federal, provincial, and territorial governments and health care providers across Canada. There are 27 councillors made up of representatives of the participating provinces, territories, and the Government of Canada. They are, in my view, a terrific group of people—at least 26 of them—and represent a broad range of experience from government, health care management and research, and communities across the country. They have individually, and we have collectively, a strong commitment to improving the system. We have a small but highly skilled secretariat, and our work supports greater accountability and transparency in advancing health care renewal.

The council takes very seriously its independent role, and we will speak out constructively on the issues facing Canada's health care system. We see our job as one of both witness and advisor, to provide a dispassionate view on the pace of progress, highlight obstacles, and suggest ways to resolve them.

Our first report to Canadians, “Health Care Renewal in Canada: Accelerating Change”, was released on January 27 just down the street in this city. It speaks about the successes to date, but also about the urgent challenges we face. We had some 200 stakeholder representatives at the release of the report, and the feedback has been very encouraging. There is a real appetite for change.

We concluded that there was a great deal of goodwill, and there were innovative health practices emerging across Canada. However, our strong view was that the pace of renewal needed to accelerate. If we do not accelerate the implementation of changes, we may lose the early momentum, as well as some of the achievements to date.

We identified four critical areas to address so Canadians will have a quality health care system that is sustainable, accessible, and affordable. First is strengthening health human resource management so we have the health care workforce we need throughout Canada. Second is accelerating the creation of multidisciplinary teams as the basis of primary health care reform. Third is immediately broadening the use of information technology for patient health records and care. Fourth is reducing health disparities, particularly among our first nations, Inuit, and Métis—our aboriginal peoples.

First let me speak to the health human resources challenges. Quite simply, we do not now have enough health care providers to meet our future needs. We need a comprehensive health human resource strategy for the health care workforce. This renewal needs proper planning, education, and training. If we do not address this challenge fully we will not have the workforce with the skills needed for multidisciplinary team delivery to achieve primary health reform, reduce wait times, and meet ever-increasing service demands. Without enough professionals, be they technicians, nurses, doctors, home care personnel, or pharmacists, all other renewal efforts will flounder.

Our concern, having looked at all of the initiatives under way across the country, is that there are many good things going on province by province, jurisdiction by jurisdiction, but if you put them all together we're still not certain they will achieve the sufficient critical mass we need. To assist jurisdictions and health providers, we are sponsoring a summit this June in Toronto to look at practical steps that can be taken to improve the situation. We intend to bring together key stakeholders to identify ways to make health human resources more effective in achieving a sustainable work-force.

● (1545)

If I might mention here, it's clear that we're facing two challenges at the same time. The first is the current shortages and the second is the demographic. Essentially, about the time the baby boomers are going to need a lot more care, the baby boomers within the one-million-person health workforce will be retiring, so we have two challenges, not one.

Our second point is the need to move quickly to multidisciplinary teams in primary health care. We believe the team approach is the right way and the right vision for future health care, and we've noted in our report and in our presentations innovative programs already in place, which show great promise. There is a need to get there sooner. There is a need to remove professional barriers.

Our third recommendation is to immediately broaden the use of health information technology. Our banking system leads the world in the use of technology; it is time for our health care system to do the same. Accelerating the use of information technology will result in more timely and effective delivery of quality health care. For example, Canadians in rural, northern, and remote communities will have a higher quality of service and access through telehealth technologies.

Perhaps the most important element of health information technology is establishing the electronic patient record. A modern, secure, and efficient electronic patient record for storing and sharing patient information will pay huge dividends in improving the quality of our health care. It will improve patient safety and save lives. It will help avoid potentially life-threatening errors. It will help deliver more timely access and care by simplifying the transfer of records and patient information and by reducing duplication of tests and lab work.

Another benefit will be to improve information sharing critical to supporting team care. We highlighted in our presentation three examples: British Columbia's PharmaNet, Saskatchewan's Surgical Care Network, and in Ontario, the electronic patient record at the University Health Network in Toronto.

Canada Health Infoway is moving forward on its agenda to have an electronic health record in place for 50% of the country by 2009. It is estimated that this could be completed by 2020. The council believes this must happen a lot sooner. We believe this goal could be achieved in five years, that is by 2010, rather than 15, with some additional investment and the resolution of privacy issues.

The fourth challenge for the health care system is to reduce health disparities. We cannot successfully renew health care without reducing health disparities, especially those too long endured by Canada's first nations, Inuit, and Métis communities.

Our council met in September in Nunavut and we saw firsthand the difficulties of attracting and retaining qualified staff, developing teams, and adapting technology in remote, economically challenged communities. Most daunting are the gaps in health status between first nations, Inuit, and Métis peoples and other Canadians. Life expectancy is lower, and suicide, infant mortality, and diabetes rates are all higher than those for the rest of Canada.

We suggest two important actions: first, develop a first nations, Inuit, and Métis health care workforce; second, invest effectively beyond health care in housing, education, training, and social programs to address the socio-economic determinants of health and reduce gaps in health status.

Reducing disparities will go a long way to alleviate pressure on Canada's health care system, shorten wait times, reduce demands for home care, and produce better health for Canadians. Through concerted action, we will be able to reduce or prevent diseases like obesity and diabetes, better manage health care costs, improve the quality of life and socio-economic opportunities, and achieve some expenditure reductions in areas such as social assistance.

I've covered the four main areas highlighted in the report, but we do touch on several other areas, including drug program costs that are increasing at a rate faster than inflation or population growth. We advocate the development of an information resource that is independent and supports appropriate drug prescribing. We also believe there is a need to define a minimum standard for drug coverage that applies across Canada so all Canadians can have access to basic drug plan coverage.

● (1550)

Home care is another area under pressure. With an aging population and more demands on the health care system, home care can relieve pressure on hospitals while supporting independence in the community for those needing support. The council specifically urges that community mental health home care be treated within primary health care and that support not be limited to a two-week period.

Managing wait times is a challenge for governments and providers. Efforts to manage placements through wait time measurement, monitoring, and management programs are showing promise.

Finally, I should draw members' attention to the wealth of comparative data, which shows how jurisdictions across Canada are beginning to move on various issues.

We have a full and challenging year ahead of us. Highlights will include: organizing the health human resources summit; hearing from stakeholders; producing a series of public reports highlighting innovative practices in primary health care, home care, pharmaceutical management, health human resources, planning, and reducing wait times; and gathering information to report on funds being spent on health care renewal to provide advice on the benefits that have been gained.

Let me conclude briefly. Our purpose is to shed light on what is working, resolve obstacles, urge that efforts be accelerated to make reform a reality, and improve accountability. We want to provide Canadians with information about reforms being implemented and the challenges of achieving change. We want to encourage the participation of Canadians in this process. If we are to achieve what Canadians really want, a sustainable, high-quality health care system, we need to move faster.

Our message, boiled down to two words, is “hurry up”; otherwise we risk losing the progress that is being made and the confidence of Canadians. We intend to work with governments, with health care providers, and with Canadians to push for accelerated change to modernize our health care system sooner.

On behalf of the Health Council of Canada, thank you for your attention today. I welcome your questions.

The Chair: Thank you, Mr. Decter.

We'll begin the question and answer session with Mr. Merrifield. I'll remind him the Conservative Party has ten minutes. He may use it all or he may share it.

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

First of all, Mr. Decter, I want to thank you for taking on this role. It seems that over the last decade particularly, health care has been more of a ping-pong ball used as a political tool rather than working in the best interests of Canadians. Provincial governments seem to blame the federal government and the federal government blames the provincial governments. It goes back and forth. You're the first glimmer of light that brings the two together in the council.

I'm hoping you'll be very productive. I couldn't agree with you more that we have to lay our swords on the table and start working in as expedient a way as we possibly can for the benefit of all Canadians.

That takes me to my first question, which is on the health human resources summit you're proposing. I'm intrigued with that, because obviously wait lists and human resources shortages are the number one and number two problems in the health care system. But we had that addressed in 2003 with a $90 million bill that was supposedly going to a collaborative plan, a plan to coordinate in partnership, I think are the exact words. It came out of the 2003 accord. For the $90 million, can you tell me what happened to that money in regard to what I expect would come out of the health summit? What do you expect to come out of the health summit, if it hasn't already been happening?

Mr. Michael Decter: There are a couple of questions. Let me try to pull them apart and answer them.

There is an awful lot under way in health human resources across the country. Every province is ramped up. Nurse education has increased numbers, but we're still hearing from the Canadian Nurses Association that it's well short of the mark. A number of provinces have expanded medical school enrollments or announced that they're going to do so. The Government of Canada has supported a number of planning initiatives that have dug in, and I think that's where some of the $90 million has gone.

● (1555)

Mr. Rob Merrifield: Has the $90 million been spent on this?

Mr. Michael Decter: I can't tell you that. I'm certainly aware that some of it has been spent. Where some of the specific money has gone is something we hope to report on in our second year .

The basic question that remains is this. When you put all of these efforts together with the best data we have, have we done enough or are we still short of what we're going to need going into the future? It's the considered view of the council that although progress has been made, we're still short of what we're going to need to deal with the twin issues of current shortages and the looming baby boomer retirement out of the health care sector.

We make no criticism of anything that's going on. The reality is that many of the levers are not held by health ministers or first ministers. Many of the levers in the training field rest with education ministers, college and university ministers, and in many cases with the training institutions themselves. The role that community colleges play, for example, is an underappreciated reality in Canada.

Our hope is to get the people who hold those levers around a table in June, first of all, to simply see what progress has been made, and, secondly, to see what other actions need to be taken.

Mr. Rob Merrifield: I'm a little nervous about sitting around and seeing what kind of progress is made. I think what we really need to do is find some definite solutions as to where the roadblocks are. Just look at doctors, for example. We know there are 2,200 doctors being trained in this country. We need 2,500 per year, is what they are saying. That's the minimum. We have a significant shortage at the present time. We not only need to train them, but we also need to have them stay in Canada once they're trained, and we have to have them practice their profession in areas where they are actually needed.

So it's a very significant problem. I wonder if you can answer this. Is the problem going to be on the provincial side, which is educating them, or is it on the federal side? Is there something the federal government could do with regard to, say, a student loan program? This is an example that is 100% federal.

Mr. Michael Decter: There are a myriad of levers that governments hold, and some that they don't that rest with the regulatory bodies, the colleges. There are certainly things the Government of Canada can do; there are things the Government of Canada is already doing.

What I think is lacking, although there are some very good people in Health Canada who are very knowledgeable on this, is a good overview of this. People have a fix on some of it. I think you accurately report that we're moving from 2,200 physician training spots a year up towards 2,500. There's still a great deal of uncertainty because what we're seeing in the medical schools is a real decline in the percentage of medical students who indicate they want to go into family practice.

To the extent that there are gaps in family practice, you may be running to stay in the same place. So we're really hoping we can shine a brighter light on what exactly the situation is.

I'd also note, having spent a year touring the country, chairing the Canadian Nursing Advisory Committee, that although the physician issue got probably more ink, the nursing issue was a much more dramatic downturn. We went from training somewhat over 10,000 nurses a year to, at the low point, about 4,000. We've come back, but there's a lively debate about whether we've come back far enough to deal with the whole scale of the problem.

Mr. Rob Merrifield: The numbers I've seen would certainly coincide with that. I think you're right. It's a serious problem. There are a lot of them.

The other one that I really wonder what you're doing with is with regard to a study that came out last June on the 24,000 deaths in Canada with regard to adverse events just within acute care hospitals. How are you going to proceed down this line? I'm wondering if a summit is perhaps due on this area that has had absolutely no attention in the past.

Mr. Michael Decter: I believe you're going to have the leadership of the Patient Safety Institute before this committee shortly. I think there's some excellent leadership there. Dr. John Wade, who's the board chair, has served in my old home province of Manitoba both as dean of medicine and as deputy minister of health, and he brings a wealth of experience and talent to that job. Phil Hassen, who's just stepped into the CEO role there, was deputy minister of health in this province, and before that, he was a real leader in the quality movement as a hospital CEO in Ontario and B.C.

● (1600)

Mr. Rob Merrifield: We'll be talking with them on Thursday.

Mr. Michael Decter: What I want to say on behalf of the council is because a handful of new important agencies have been created—the council itself, the Patient Safety Institute, the Public Health Agency, ten years ago the Canadian Institute for Health Information, which I had the privilege of chairing for six years—we've been having some informal meetings. One of our roles is to avoid duplicating what others are doing. So the chairs and CEOs of those organizations, and Dr. Fellegi from Statistics Canada, and a handful of others have been getting together just to make sure we know where we can work together.

I'll give you a very good example. Electronic prescribing, which is a priority for Canada Health Infoway, is a priority for us. It is probably one of the most concrete things that can be done to reduce errors in the health system and to reduce that 24,000 number, which is an astonishing number.

Mr. Rob Merrifield: It is.

Getting on to the electronic records, I supported Infoway and its intent, and I still do, in its ultimate goal, which is to have your medical records follow the patient in an attempt to make for safer medicine and practice in Canada. I am really disturbed about this. We have $1.4 billion in Infoway, and that's a lot of money. They've had it for four years and I've yet to see anything come out of it. I wonder if you could give us an update. It's outside of the Auditor General to take a look. It's outside of freedom of information.

Perhaps you could tell us how they're progressing on this.

Mr. Michael Decter: Well, we had them come and present to our council at our Halifax meeting. Their chief executive officer, Richard Alvarez, who's relatively new there, gave us a very compelling picture of both the progress being made in certain jurisdictions and the obstacles. The obstacles aren't simply some governments who maybe don't have their act together as well as some others do, but they include some amount of provider resistance. Not everyone on the front lines is as enamoured of new technology as they might be, so adoption rates in some areas haven't been as high as were hoped.

But having said that, this is a big, big challenge to do. Although the over $1 billion put up for Infoway is a staggering amount of money, Prime Minister Blair put up £15 million in the U.K. to accomplish the same task.

Mr. Rob Merrifield: So what's it going to cost us to get to your 2010 record, then?

Mr. Michael Decter: I couldn't put a number on it.

It's going to cost more than is allocated. But the spending comes from moving the general level of spending in the health system from about 1.5% to 2%, up into the 5% to 6% range. So it's not all going to flow through Infoway; Infoway is more the lever, I think.

Some have made this investment already, and we did highlight them: Group Health Centre in Sault Ste. Marie has had an electronic health record for six years; the University Health Network in Toronto has had one for the last couple of years; the Capital Health region in Edmonton, Alberta, has installed it. So a lot of delivery organizations are finding ways, sometimes with assistance from Infoway and sometimes with their own funds, to make these investments.

It's going to require a more determined effort than is going on. We think the benefits in saved lives and saved dollars and better care well justify it.

The Chair: Thank you, Mr. Merrifield.

Our next questioner will be Madame Demers.

[*Translation*]

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

Welcome again. Good afternoon, Mr. Decter. Please excuse my being late. I was at a meeting of the Canadian Center on Substance Abuse.

When I look at your report, I find some duplication between the various agencies. Do you think we have become too bureaucratic? Do you see some duplication too? The Health Council of Canada also deals with issues related to substance abuse. I find this represents a lot of money. In fact, 4.75 millions of dollars have been allocated to the council, but in a press release made public on May 21st 2004, it is mentioned that the council has also confirmed that all the Ministers of Health who attended the meeting had approved its budget of 6.1 millions dollars. Is it really 6.1 millions dollars?

● (1605)

[*English*]

Mr. Michael Decter: Yes, that is the correct sum.

[*Translation*]

Ms. Nicole Demers: How do you explain the difference between the first figure which was 4.75 millions dollars and that of 6.1 millions dollars? At first, we were told that the council had been allocated 4,75 millions dollars.

[*English*]

Mr. Michael Decter: The actual allocation for the council set by the Government of Canada through Health Canada at the time of the 2003 accord was $10 million a year. Our budget is approved every year by the members of the council, who are actually the participating ministers of health. The council took the view that we would ask for the amount of money we thought we needed to do the job in each coming year.

I believe in the first year we were under way that request was in the order of $4 million, because we were ramping up—but I don't have the figures in front of me. I believe for the year coming up the request will be in the order of $6 million. The budget is approved not only by the health minister for Canada, but also by the health ministers for each of the provinces and territories that are participating. That's where the accountability really lies for the budget. We request what we think is needed.

We're not a very large organization. At the staff level, we have a secretariat of about 16 people. The council itself is quite large. Ministers decided to have a 27-member council drawn from all parts of the country, so there is some expense in bringing a group of that size together.

I spent a great deal of my life in government as a deputy minister in Ontario and a cabinet secretary in Manitoba, and I would say this is probably the least bureaucratic organization I've ever been involved with—and it's kept that way, I think, by members of the council.

[*Translation*]

Ms. Nicole Demers: Mr. Decter, how are the councillors paid? You say some expenses are reimbursed. Are there other type of allocations?

[*English*]

Mr. Michael Decter: There are two types of councillors. There are government councillors, a number of whom were appointed by their governments and were deputy ministers of health. The government councillors are not paid a per diem, but their travel expenses are reimbursed. The non-government councillors—that is, the citizens who are on the council—receive a small per diem for the times when they attend council meetings. I myself declined the per diem; a donation that would have been my per diem is made to the Stephen Lewis Foundation.

When I took on chairing this, my condition was that I wouldn't take any money; I would do it as a volunteer, because we have so much volunteer governance in the Canadian health system, and I value it. The second condition was that I would not move to the nation's capital. Fond as I am of the nation's capital, my day job is in Toronto. Those conditions were agreed to by the health ministers.

[*Translation*]

Ms. Nicole Demers: We have known for some time that the health status of aboriginal groups is very poor and you mention that in your report. Why doesn't the council propose some practical recommendations to change this situation? I see you talk about drafting recommendations but you have not announced any practical recommendation yet.

[*English*]

Mr. Michael Decter: Our main recommendation is very concrete and flows from our experience. I should say that on the council we're blessed to have some of the country's most prominent and most thoughtful aboriginal first nations and Inuit leaders: Jose Kusugak, from the Inuit Tapirisat; Chief Roberta Jamieson; and a number of others. We have a group that has good insight.

Our single most important recommendation was that we have to embark on training a workforce in health that is from the very communities that are suffering very poor access to health care. We went into Nunavut. We met there and we went into some of the smaller communities. I can tell you that when you are sitting in the airport in Kimmirut, a community of about 500, and the one nurse in the nursing station—now called the community health centre, which is supposed to have a staff of three nurses—is sitting at the airport literally praying that the flight coming in is going to bring another nurse because she has been working 24/7 for way too long, you also realize that nearly every health encounter in Nunavut requires an interpreter because the providers are almost entirely from the south and don't speak Inuktituk.

Our single recommendation, which I think is probably the most important contribution we could make, is to accelerate the effort to train the Inuit to become nurses, nurse practitioners, physicians, pharmacists. Let's do the same in the aboriginal and first nations and Métis communities. I think that's the only way we change that dynamic. People who are there with big incentives and big costs for short periods of time are never going to be able to understand the communities or deliver the quality of care that's needed.

So you're right, we are going to put out a longer report on this subject over the next few months, but our very clear and central recommendation is that we need to train a workforce that's of the communities.

● (1610)

The Chair: Thank you, Madame Demers.

Mr. Thibault.

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

Thank you very much for appearing, and congratulations on your first year in operation. I join all members in doing this on behalf of Canadians.

I appreciate your great gesture of turning over your per diem to charitable organizations. I stop just short of commending you for doing that, because I wouldn't want positions like yours to go to the lowest tender. I think it's important that we have people of your calibre and that they be remunerated accordingly to get them there and cover their expenses. But I do understand the spirit in which you do it and I do appreciate that. I think too often we worry more about the cost of our services to the public than the results. It's the results I'm interested in, and I thank you for accepting that position. You bring a lot of professionalism to the council.

I think the presentation you made is quite self-explanatory. It raises very important points and some difficult questions for all providers, whether, as you mentioned, it be the federal government or the provincial governments—federal in the case of aboriginals and northern affairs. Other responsibilities are the provinces—the universities, community colleges.

You mentioned the question of the difficulties in health human resources. There have been some improvements. You point those out. There are two new medical schools opening, some improvements in nurse training, and some improvements in the technologies, but they're not meeting all the demands and it's difficult to see how that will happen.

There are three things that are very important to me that I'd like you to comment on. One is I was very pleased with what you said about training the Inuit and the first nations, training people from those communities who can best serve those communities. But there's also the question of people who have trained in foreign countries—foreign credentials, the protectionism or control by the professional organizations and the difficulty of getting credentials accepted in Canada—the nurse practitioners; the physicians' assistants; the other health providers—because you did talk about the holistic approach or the multidisciplinary team—the question of dental within that; the question of chiropractic, for example, or other professions.

Could you elaborate on how you see these things evolving and if you're seeing any change out there?

Mr. Michael Decter: I had the privilege of speaking at a forum at George Brown College in Toronto on Thursday night. I was on a panel that was trying to address this question. What I said there I'll repeat briefly here. This morning approximately one million Canadians got out of bed and went to work in the health system. Out of those one million Canadians, some 62,000 are physicians and some 300,000 are nurses. But the majority of those people are neither doctors nor nurses. For a long time we had the category "other". When I was board chair at the Canadian Institute for Health Information, I said it's a little embarrassing if the "other" category is bigger. We need to actually unbundle that and say who the others are. The others are a really diverse range of very important providers —dentists, dental hygienists, physiotherapists, the people who actually operate the technologies, the informatics people, and nurse practitioners, which is a small but growing category, as are midwives in a number of provinces. The fact is this is a very diverse, and growing more diverse, team.

We talk, often glibly, about multidisciplinary teams, but there are still a lot of barriers to having these teams work. For one—and this is the issue we were trying to address at George Brown the other night —we train people narrowly in their disciplines. There's now quite a push to say that if we expect them to work together when they're out there delivering health care, we need to put them together during the training period to a greater degree than we do at the moment. I think a lot of educators are looking at that. There are some pioneering places. McMaster University has for a long time done some of that across the health disciplines. It's fair to say that if you don't teach team work in the training process, it's a lot harder to get team work out in the actual system.

When you actually look at the best of what we do, such as the operating rooms where remarkable surgeries are performed at our leading hospitals, you'll see that it isn't just the surgeon. It's the nurse specialist, the anesthetist, all of the people who end up making that work as a team. I think what we're really saying is we need to do the same in primary care.

A remarkably good example is the diabetic program at the group health centre in the Soo, where the patients with diabetes meet with a nutritionist, a nurse, an educator, as well as their physician. One of the things I like about their approach is the nurse has them take off their shoes and socks before the doctor sees them to see if there are any ulcers, whereas in an undifferentiated family practice, a busy physician might not have the time to do that and could easily miss it. It seems like a simple thing, but it can save a lot of disease.

One of the issues we do want to take on at the summit we're planning is foreign-trained doctors and other providers to find out exactly what that situation is. Efforts are under way to have exams, counselling, etc., so that people trained other than in Canada can gain entry to practise. Again, we have some questions about all of those things and whether our immigration policies actually fit with the requirements of our colleges.

This came up during the CNAC work. We have a situation where people are admitted to Canada on the basis that they're nurses. But they don't pass the nursing exam, so they're not working as nurses but rather as nurse's aides and in other jobs, often at two or three different locations, because a lot of that workforce is part time. I think this became a particularly important issue during the SARS situation, when you start asking how a disease moves from one hospital to another. If staff are working at several hospitals, you're increasing your risk. And there are some real human issues when they eventually do qualify as nurses. A lot of those foreign-trained nurses are not able to credit all that time they worked for pension and other purposes.

● (1615)

It's as though they've just started when they've qualified.

We think there are a lot of good things being done, but we think there's more to be done in really looking at the whole team. I think it's very important. It's sometimes easier to see the shortages at the high end, but if we don't have the people to run the MRI machines, then we can put more of them out there, but we won't actually get more images. And if we don't have the nurse practitioners in the northern communities, then we're going to be sending far more people south for care than we should. The story goes on and on.

Sorry to give such a long answer, but it's an important question.

The Chair: Thank you, Mr. Thibault.

Ms. Crowder.

Ms. Jean Crowder (Nanaimo—Cowichan, NDP): I also want to thank you for your presentation today.

I know you've acknowledged in your presentation and in the report that gathering information on funding will be done in the future in more detail. But I have some concerns about that, given that in your own report you indicate that Canadians want to know whether money is being spent on health care renewal, they want information on current programs and expenditures, and they want some description of how the money is actually being spent.

I guess the reason I'm concerned about the fact that you won't be looking at this for awhile is that we're going to be a couple of years into this next ten-year plan before we actually have a handle on how money is spent. Under the minister's own report, which he tables annually, there was a recent court decision that talked about the failure to report on any number of areas in that health report.

Given that the mandate of the Canada Health Council is to report to the public, and it's not a report to Parliament or to the government, how can we ensure that the report and the information, given the inadequacy of the information that's coming forward, is actually even going to be acted on by the various levels of government?

● (1620)

Mr. Michael Decter: Well, we don't have any formal power. We can't order anything. We're not a tribunal or a court. We purely have the power to persuade. The first point I'd make is we can't make anything happen unless the decision-makers think it's a good idea and unless we have the public onside.

The second point I'd make is on this whole issue of value for money. Being able to follow the money is I think a very serious issue with the public. I think one of the reasons this council was created in 2003 was that, if you go back to the year 2000, there was a health agreement. It was a kind of down payment on reform in advance of the Romanow commission or the royal commission. And two years after, on one of the elements—because there's been great concern in the country about the adequacy of diagnostic imaging, particularly the MRI issue—there was $1 billion committed in 2000 for what was called new medical technologies.

Then two years later, in the run-up to the accord that created us, there was a newspaper story, I believe in *The Globe and Mail*, written by Lisa Priest that suggested that some of the money in New Brunswick had flowed to lawn mowers for hospitals. I think that caused a great disquiet. I certainly know that some of the first ministers were very concerned about it and said the money hadn't been put up for that reason.

But we have a very complex health system. When you put up money nationally, which flows to the provinces and then out to the provider system, there's a lot of room for things that look like apples at the top to become oranges or something else by the time they hit the ground. That, I think, erodes public confidence.

We're looking at how we can best describe where the money went, and we are somewhat dependent—well, wholly dependent—on governments giving us information, and that's been uneven to date, but we're hoping it's going to improve.

We also need to work with other people who have far deeper resources than we do. I had breakfast this morning with the Auditor General for Ontario and with Graham Scott, who's the chair of the Canadian Institute for Health Information. I asked, how do we work together? The auditor in Ontario has been given a broader value-for-money mandate to look at hospitals, to look at universities, to look at school boards, and he's quite rightly thinking, how do I do this, how do I get the information? We're thinking if we can work with that accountability community, if I can put it that way, it may help us do our job.

We're not an auditor general. We're not really a watchdog, but we are in the accountability business. We need to work closely with the people who do have some legislative mandate to be able to get at some of these issues.

Ms. Jean Crowder: I'm not sure Canadians have a degree of confidence that the kind of reporting that's been done in the past demonstrates the accountability in the public health system. Canadians want to know that the publicly funded services are also publicly delivered. I know that with a number of the reports that currently come out of the provincial governments, the data just isn't available. I notice that both Quebec and Alberta have refused to sign on to the Canada Health Council, so we don't have a nationwide mechanism to report on accountability.

I'm wondering how you think Canadians will have confidence in whatever funding reporting you're going to be doing when you don't have all provinces signed on.

● (1625)

Mr. Michael Decter: Let me address that issue very directly because I think it's an important one. We hope eventually we will have all provinces signed on, but that's up to them, and we respect their decision. As chair of the Canadian Institute for Health Information for six years, it took us the full ten years to get Quebec to join. Quebec was the province that was the last to join, but it did before I left, which I was very pleased about. We're only going to win those two provinces over by good deeds. We're not going to win them by any other thing than them seeing that it would be helpful to them and to their citizens to join.

Alberta has its own Health Quality Council, and I actually received just on Friday its 2004 report, which I think is an excellent report. Dr. Cowell, its chief executive officer, is going to come and meet with us and discuss how we might work together.

The first point I'd make is that just because a jurisdiction isn't participating doesn't mean we lack access to their data, because all governments have committed to putting more data into the public domain.

The second point I'd make, which is a testimony against inference, is just because a jurisdiction is participating doesn't mean it is as forthcoming with information as we'd like. I think it would be fair to say that people are in favour of transparency and accountability but a little timid about how much accountability and transparency they want and how quickly.

Quebec is going through an interesting process. It had a council, but that is being replaced with a commissioner. I believe its legislation has become stalled in the national assembly because there's an issue about whether the commissioner should report to the minister or to the assembly itself. I have had discussions with Minister Couillard, and his advice was to wait until they had a commissioner and then see if there's some common ground. That's not to suggest that Quebec in any way is planning to join, but there might be a way of working together, as existed with CIHI before there was a formal joining.

We did take the step of reporting on the whole country in the report. We took what we could get where we could get it and we fed it back to all jurisdictions to ensure its accuracy. So our view is that we're the Health Council of Canada and we're going to report on the whole country, and we will do it to the best of our ability.

The Chair: Mr. Savage.

Mr. Michael Savage (Dartmouth—Cole Harbour, Lib.): Thank you, Madam Chair. It's nice to have you back with us and looking so healthy.

Mr. Decter, it's nice to have you with us.

The first note I would make is that I'm looking at your list of councillors and it's pretty impressive, speaking from the point of view of a Nova Scotian who has seen Dr. Tom Ward and then Alec Gillis, who I assume took over when Tom left. It speaks very highly of that.

I note that one of your last points is that your goal is to achieve a sustainable high-quality health care system. My first question is around the issue of health promotion as opposed to dealing with people once they're sick. To be a sustainable system you should only have to address the health promotion side. I wonder to what extent you've considered that.

Mr. Michael Decter: We structured ourselves into a series of working groups. One is the Healthy Canadians working group that Chief Roberta Jamieson chaired. They put their first attention on the disparity issue, those Canadians with the worst health status. They are equally determined to focus on health promotion as we go forward.

We intend to make common cause with Dr. David Butler-Jones, the head of the Public Health Agency. We actually did him a mild disservice in the report, and I should correct it on the public record. We said there was not a national immunization strategy in place and in fact there is. Now it's not as consistent from coast to coast, as we'd like. He was very generous in not knee-capping us on our way to the first report. I said I would correct the record at the first opportunity I had. This is it.

We think there's enormous common ground for the council, with a broad mandate on the health status of Canadians, and the Public Health Agency, which has some very specific things it can do, not only bringing jurisdictions together so that all Canadian children get the immunizations they should have, but really educating Canadians about what they can do to stay healthy.

There is no doubt we face an enormous challenge. We've made huge progress. If you go back to the Lalonde report in 1974, you may ask what we have done over 30 years. Well, we've reduced smoking in the country by about 50%, from over 30% to 20%, which is huge. We've reduced drinking and driving dramatically. We've made our vehicles and roads safer.

Then you look at some things that are going the other way. We have a lot of unhealthy behaviour in our children and teenagers, to the point where childhood and teenage obesity is becoming a genuine problem. We may give back some of the gains we've made.

We have particular populations, in the first nations, Inuit, and Métis areas, and in some other areas, who have very poor health status. That goes to broader determinants. It is an issue that we think is very important.

I think one of the best investments the country made, although we haven't thoroughly evaluated it, was the money, the $2.2 billion, that went into early childhood development in the 2000 agreement. Dr. Fraser Mustard campaigned very hard for that and made the point to the whole country that what we essentially do in those early years affects health throughout life. The council is very supportive of that. I think you'll hear more from us on this front.

● (1630)

Mr. Michael Savage: Am I done?

The Chair: You could maybe ask a very quick one, if we could have a quick answer.

Mr. Michael Savage: Yes, only a quick one.

We have made a lot of strides on things like tobacco, but in healthy living, nutrition, physical activity in schools, and things like that, we haven't.

I'm delighted to see that you'll be pairing up with Dr. Butler-Jones, who I think Canadians can have great faith in, and Dr. Sylvie Stachenko, who's also at the Public Health Agency. I would also say there are other non-profit organizations, heart and stroke, cancer, and diabetes, that are involved in the health care system, although they may not be at the top of some people's minds.

Thank you very much.

The Chair: Okay. Did you want an answer?

Mr. Michael Savage: No. Thanks.

The Chair: Thank you very much, Mr. Savage.

Next is Mr. Fletcher.

Mr. Steven Fletcher: Thank you, Madam Chair.

Welcome to the committee today, Mr. Decter.

In the council's report, appendix 5A provides a detailed summary of all the provincial and territorial drug plans but does not cover the six federal drug benefit programs that were recently assessed by the Auditor General of Canada.

Why has the Health Council chosen to focus only on provincial and territorial government activities and exclude the federal responsibility? As we know, the federal government is the fourth largest player for prescription drug benefits in Canada.

Mr. Michael Decter: Well, given that you caught me off guard on this, I think I'd have to say this is not an omission that I was aware of or that had been brought to my attention, which means it's one of two things. It's either simply an omission that the page isn't there or...it's certainly not intentional. We intended to report on all jurisdictions. I'm frankly a little taken aback that the federal jurisdiction isn't in here, which may be bad proofreading on my part.

I guess all I can do to answer your question is to say it would be our intention to include the federal jurisdiction when we report further on drug programs, which we intend to do. I don't know why it's not here. It should be.

Mr. Steven Fletcher: Okay. Do I gather, then, that the information does exist?

Mr. Michael Decter: I think the Auditor General did a thorough job of looking at those drug programs. There were some very pointed comments made by the Auditor General. That's in the public domain, so I don't think we should have any trouble obtaining it.

Mr. Steven Fletcher: Thank you.

The federal government is the fifth largest provider of health services, serving almost a million people at about $4 billion, and you produced a couple of reports dealing with this jurisdiction. The federal government also has a responsibility for delivering health care services to first nations and Inuit, veterans, military personnel, inmates of federal penitentiaries, RCMP, and so on. The 2004 federal report indicates there was no data available for most of these populations. As a result it doesn't provide substantive analysis of its performance in health care delivery with respect to comparative indicators.

Has the Health Council examined the federal government's comparable indicator reports and how performance can be improved?

● (1635)

Mr. Michael Decter: We've looked at the reports each jurisdiction published towards the end of November or the beginning of December. We were already into production of our report by then, so the timing wasn't optimal for us to include the information. I met with the Conference of Deputy Ministers of Health in December and commented to them that we were concerned that we were getting a less than full flow of information from some jurisdictions, that some jurisdictions had been extremely good and others hadn't.

We've had some subsequent meetings with the Government of Canada. Representatives from the council have met with officials of Health Canada, and I'm assured we're going to get a much improved flow of information going forward

That is our lifeblood. If governments don't share information with us, we really can't report to Canadians very effectively. There has been, I think, a general improvement year over year in the reporting, but there are still some pretty important gaps in it.

Mr. Steven Fletcher: That's very intriguing. Which jurisdictions haven't met the standards we would expect? Names, sir, names.

Mr. Michael Decter: I'm reluctant. I tend to a positive point of view. We highlighted that the Government of Saskatchewan had not only met all of our requests but had met them in a thoughtful and full way. We suggested to other jurisdictions that if they were to come up to the Saskatchewan standard we would be very pleased.

I want to be careful, because we scrambled a little bit in the first six months before we got our funding approval and our secretariat to come together. We had working groups, and the working groups hired some consultants and went at the task of gathering information. Some governments were very good with our working groups and a little less forthcoming in the second round. So I don't want to penalize anybody. I think—

Mr. Steven Fletcher: Mr. Decter, has the federal government met the standard?

The Chair: Mr. Fletcher, your time is up. You're well over five minutes. We'll move on to Mr. Lunney, please.

Mr. Lunney.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you. First of all, in terms of organization, you mentioned you meet about four or five times a year. Is that right? That's a physical meeting, then, is it? It's not teleconferencing. You're all physically in the same place?

Mr. Michael Decter: Yes. We had five meetings in our first year and we're planning four in the year we're in. Those are physical meetings of the council in one place. Between meetings we have six working groups and a finance and audit committee, and they meet frequently—or more frequently—by teleconference.

Mr. James Lunney: Those six working groups are made up of members of the council, not staff. How many staff do you have working for you?

Mr. Michael Decter: I think we're up to 15 or 16 now, which is our full complement.

Mr. James Lunney: I wanted to pick up on a couple of your objectives: the “Strengthening of health human resources management so that we have the health care work force we need throughout Canada” and “Accelerating the creation of multidisciplinary teams...”. That was mentioned numerous times in your report under primary health care. You talked about the difficulty of integrating primary care providers, nurse practitioners, and pharmacists. There's further talk about multidisciplinary teams of providers reducing clinical error and increasing the power of satisfaction, and so on.

Mr. Thibault mentioned this a minute ago, the list of others that you talked about briefly. One of the largest of those groups of “others” in terms of primary contact is chiropractors. There are about 7,000 primary contact practitioners, the third largest primary contact profession in the country after medical doctors and dentists. I wonder why with your group we still have a sense that chiropractors are not part of the discussion; when you went on to talk about dentists and physiotherapists and technicians, chiropractors were again dropped from the discussion. Is there any vision for including chiropractic?

I just draw your attention, in case you weren't aware of it, to a major study in the *Archives of Internal Medicine*, where we're dealing with one million people under regular managed medical care and another 700,000 who had the same care plus chiropractic coverage, but with 12% lower health costs overall. I would think that's something your organization would be interested in examining. I'm just wondering if there's any forum for discussion with chiropractors on how they can be included as part of these multidisciplinary teams, especially since you're looking for resources that are already within your communities. Perhaps if we looked and opened the envelope a bit, we'd find that actually the shortage we're concerned about is not as big as you imagine. There are a lot of practitioners already in the area who are perhaps underutilized.

● (1640)

Mr. Michael Decter: Let me take the general point first on the scope of practice, because I totally agree with it. If we look at the regulated scope of practice, there's much work that could be done by nurses or that could be done by nurse practitioners that's currently being done by physicians, and equally, there's work being done by specialists that could be done by general practitioners. So the whole scope of practice issue is one of the areas that we think you can, in a team setting, move work around in. In the current setting, when you move work around, you also move dollars around, and that often makes it very difficult to get agreement.

Specifically on the point of chiropractors, let me say very directly to you, being the son of an orthopedic surgeon, that it took me a long time to overcome some childhood prejudices on this subject. There are some very strongly held negative views about chiropractors, and orthopedic surgeons are sometimes the ones who hold them the most strongly. I've had occasion over the years both to speak to chiropractors and to their college and have actually come to understand a great deal more about what they do.

I think we're looking for a more inclusive health workforce, and I think your point's a good one. It was not a deliberate omission on my part; I just didn't want to chew up the whole of the members' question period by listing the whole range of providers, because it's a very long list. Provinces have provided some coverage, unevenly, for chiropractic services across the country, and I think chiropractors are part of the broad health care team. As we move forward, I think we have to be looking for what each of the professions can do to contribute to solving the shortfalls we have.

Mr. James Lunney: I'm basically just asking, if it isn't within your mandate at the new health commission to look at effectiveness and cost-effectiveness on behalf of Canadians, then whose is it really? And is there any effort to look at effectiveness and cost-effectiveness in terms of other clinical applications? Perhaps the commission could work with CIHR in terms of advancing research objectives that would demonstrate efficiencies that are perhaps right in front of us but are underutilized.

Mr. Michael Decter: Yes, it's a good point. The 2003 accord didn't speak to outcomes; the 2004 accord did, and we were kind of caught in the middle. We were running on our original mandate and we then had the 2004 agreement come to us, which in some areas expanded our role. It gave us much more clearly the health outcomes issue, and we're wrestling with how to tackle that, but we will.

A lot of good work has been done at a provincial level in Canada by groups like the Institute for Clinical Evaluative Sciences in Ontario, the Manitoba Centre for Health Policy in Manitoba, and so on across the country. We're looking at how we can take some of that work and move it to a national level. I did meet with Dr. Bernstein and his scientific directors at CIHR, and we're looking at how we can tap into the work they're doing.

The other area in which we gained a clearer mandate was health status. In 2004 we did have our mandate at least clarified, and in some ways reduced, in the wait times area. As we move toward our second report, we're grappling with how we take on board these changes to our mandate while we're still very much in the early days, but CIHR is a huge resource for the country in understanding better what we get for various health interventions and what we can know about them. That's hugely important. We talk frequently about our pride in the health system, but we're still debating inputs. We're debating dollars and numbers of providers. We really have to shift to debating outcomes. What is it getting us? What is this intervention achieving for patients and for the population?

● (1645)

The Chair: Thank you, Mr. Lunney.

Mr. Carrie will complete the first round, and then Mr. Savage.

Mr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

I want to follow up on my colleague's question. You mentioned that there are some very good accounting templates developed by the Governments of Saskatchewan and Ontario. Given that the federal government is the fifth largest provider of health services, serving almost a million people at a cost of $4 billion, does the Health Council of Canada expect an annual report on federal government spending?

Mr. Michael Decter: We certainly view the federal government as one of the participating jurisdictions. My simple answer would be yes. Although the federal government has some other clear regulatory and policy roles, it has a delivery role. It is a role that is larger than those of a number of the provinces, in terms of the actual number of Canadians who get their health care through the Government of Canada's direct provision.

Mr. Colin Carrie: Are other provinces starting to use accountability issues too?

Mr. Michael Decter: Yes. It is fair to say that every jurisdiction is working on it, sometimes with a different emphasis. For example, Ontario is the last remaining jurisdiction that has no regional structure; although they are moving in that direction, they are still looking more at the accountability of hospitals for the money they receive. That is the role that has been given to the provincial auditor in Ontario.

In a number of the other provinces, the regional health authorities are now the main delivery organizations, and they have accountability provisions and performance agreements. We're really into a world that's changing somewhat from the old days, when government's role was primarily as funder, to an era in which there's much more interest in accountability, and there are much better data than there used to be.

Mr. Colin Carrie: To change my line of questioning a little and to follow up what my other colleague mentioned about manpower issues, in my own jurisdiction of Oshawa I know of two foreign-trained medical doctors who are working in a convenience store and living in a basement apartment. Are you actively looking at different programs that would be provided by the federal government to perhaps give student loans, or starting some type of apprenticeship program, so that we can start utilizing professionals in the community as soon as possible?

Mr. Michael Decter: We want to look carefully at what's already under way. Ontario is running, I believe, its first exam for foreign graduates—I don't know if that is today or this week—and looking at having a number of them write to qualify.

I have to tell you, for many years we had that access tightened down to an extreme degree. I believe, in my time at the Ministry of Health, 25 per year was the number of those looked at and allowed in. I think we're now looking at several hundred coming through a process.

But there's a balancing act. Again, to come back to the complexity of this, the federal government can certainly assist those new Canadians in terms of student loans, and so on, but you have two hurdles: you have the regulatory colleges, which actually have to pass judgment on the qualifications and the licensure; and you have provincial governments, which bear the primary brunt of people entering the system, from a financial standpoint, and where they practise, and so on, and where the needs are. So you do need those three forces pulling in the same direction, and that does make it a more difficult issue, but the simple answer is yes, we want to look very hard at that resource and what the realities are of moving the foreign-trained into qualified Canadian practice.

Mr. Colin Carrie: If the federal government is working, though, independently to supply health services to almost a million Canadians, can they not independently regulate some of these professionals or decide who's in and who's out?

You mentioned the multidisciplinary model. I would think the federal government has a great opportunity, through the Health Council, to show a leadership role in the aboriginal communities, which are so drastically underserved. What is being looked at in that regard?

● (1650)

Mr. Michael Decter: The Government of Canada certainly has and is working with a number of the Inuit, first nations, and Métis organizations, and with the territorial governments. The Nunavut government, for example, has a very big effort under way, called Closer to Home, to try to staff the community health centres and to wire them with telehealth, which actually got done in the last month or so and will be a big boost.

I think you are right that the Government of Canada can show leadership in how it provides care. There's a model to the south of us, the veterans administration in the United States, which for many years had probably the worst quality of care in the United States. It was truly dreadful. It had an inspired leader by the name of Dr. Ken Kizer, who was put in charge of it and has made the VA in the States a leading model for quality, and particularly for quality in primary care.

He shifted a lot of the resources into primary care—I've heard him speak now a few times—and I think there are some lessons from that. He said we had high-tech hospitals, but we had homeless veterans living on the street. They didn't need high-tech hospitals; they needed basic primary care.

When you go up into the northern communities, you see there are a lot of very basic things that people need. I think there's a lot of running room for the Government of Canada to do a better job there with the organizations that represent those communities. I don't think they can do it solo, but they can show leadership.

The licensure issue rests with the independent body. So who actually gets to practise as a nurse or a doctor is subject to a professional regulatory body, jurisdiction by jurisdiction. But who gets hired, who's part of the team, is really up to the funders, so governments can shape, and I believe they do.

In Ontario, the movement to family health networks and family health teams are broadening the team.

Mr. Colin Carrie: I just notice—

The Chair: Mr. Carrie, the time is up.

We'll move on to Mr. Savage.

Mr. Michael Savage: Thank you, Madam Chair.

I think we would all agree that Canada's first nations, Inuit, and Métis need special attention. It's an area that has not had the attention it requires.

Even leaving that aside, there are great disparities in our health care system. I come from Atlantic Canada, which has the highest incidence, outside of those communities I mentioned, of chronic disease, of cardiovascular disease, of cancers. Diabetes is out of control in Atlantic Canada. There's great disparity within our health system in terms of waiting lists, home care, palliative care, and drug coverage among the provinces. In fact, we hear about two-tier medicine, which is a concern, but one might say that even within the publicly run system we have two-tier medicine, comparing one province to another.

I wonder if it's possible that we will ever actually close the gap between the provinces in terms of health care. I think it's important that we fund more, as we did agree to in the fall, but is it realistic to expect that we'll ever close the gap between the provinces in terms of some of those key programs?

Mr. Michael Decter: When you look at the gaps in the two services that have been insured for the longest period of time—hospitals, since the hospitals acts in the late fifties, and physician services, really from the late sixties, early seventies—the gaps are much narrower. There are gaps, but I would say they're probably larger within jurisdictions than across them. That is, the difference between your access to hospitals and doctor care in downtown Halifax versus what it might be in some parts of Cape Breton parallels the differences between downtown Toronto and northern Ontario.

When you get into home care and drug coverage there are significant gaps among the provinces, but I believe that in both 2003 and 2004 there were serious commitments made to narrow those gaps. The minimum standards for home care, as they're implemented, should pull the floor up. The last time I looked at the numbers was a year or so ago, and the disparity was such that some provinces were spending $130 per capita on home care and some were spending as little as $30. So you have a differential of four times.

When you look at something like hospital care there are differences, but they're based somewhat on costs and would probably be in the 30% range rather than the 300% or 400% range.

On drug coverage, we have a population that resides in Atlantic Canada that does not have catastrophic drug coverage. That was on the first ministers' agenda. There's now a task force co-chaired, I believe, by the federal health minister and the British Columbia health minister, which is due to report in June 2006. The council intends to contribute to that task force process and make a report on the things that we think could be done to make affordable coverage a reality for everyone in the country.

As you know, in the last round the premiers pitched for the federal government to take over that whole jurisdiction. The federal government basically declined. They reached agreement that they would work toward closing the gap.

I'm an optimist, or I probably wouldn't have taken this job on. I think we'll get there, because if we don't it will have consequences well beyond those for individuals. When your drug coverage and your nursing coverage are insured in a hospital and not insured when you go home, it becomes very sticky. Practitioners, physicians, and others don't want to discharge someone home if they know that's going to strip away their access to medications. So we end up using our most expensive resource in the system, our hospital, to do things that it really shouldn't be used to do, because the coverage doesn't follow the patient home.

I'm optimistic that we'll get there. I think it will take a few years. There are some real issues, in the medications area, of appropriate prescribing, appropriate dispensing, and compliance. So it's not just a matter of having coverage; we have to convince people to use medications appropriately.

● (1655)

The Chair: Thank you, Mr. Savage. Mr. Savage was the first speaker in round two. I have several names on the list.

I see that it's almost 5 o'clock. There is another committee coming in at 5:30 p.m., and you know how unpleasant it is to wait while people pack up their papers. So I'm going to try to draw the meeting to a close at 5:25 p.m. so we have time to get out and leave the room for the next group. I believe they will probably have some interactivity with these machines. There could be somebody waiting in England to come on and talk to them.

With that in mind, I'll ask you to please make your questions and answers as brief as possible so we can get through these names.

The next speaker is Madam Demers.

[*Translation*]

Ms. Nicole Demers: Thank you, Madam Chair.

I would first like to say that I am pleased to have heard my colleague Mr. Thibault say that in the area of health, results are what count not the money spent to get them. This will be very helpful for our future work. Thank you very much.

Hon. Robert Thibault: This is completely false. This is not what I said.

[*English*]

Ms. Nicole Demers: That's what you said before.

Mr. Decter, is that okay?

[*Translation*]

You said that drug coverage was very expensive and that you had studied some measures that could lower the cost of such insurance. Could you tell us about those measures?

[*English*]

Mr. Michael Decter: Certainly. The pharmaceuticals are now the second largest item within health care spending. As a nation we now spend more on drugs than we do on doctors, and that's been a dramatic change over 20 years.

We have a very good working group on pharmaceuticals headed by Bob Nakagawa from British Columbia, who's a real national leader in this field.

When we look across the provinces at all the things they've done to try to manage drug costs—and we will be putting out a stand-alone report on this—we think it's hugely important—and we say it in our report—that physicians and pharmacists have access to an independent source of information, a source of information that isn't from and of the people who are manufacturing and promoting the drugs.

We think it's also hugely important that the public get good access to information about the medications that are being prescribed and what their benefits are. We've had some fairly disturbing events around some very widely taken medications recently; the data are coming out. It's an area we really want to drill down in, and because we have different approaches across the country, there's lots of ability to share positive lessons. But we did highlight the PharmaNet program in British Columbia, which is essentially an electronic record of all medication.

Dr. Vertesi, an emergency room doctor in British Columbia who is a member of our council, appears in the video and just points out the obvious benefit of knowing, when someone's there and you're about to treat them, what medications they're taking. These days many of our seniors are taking multiple medications and with consequence.

I'm looking at the chair and realizing brevity may not be my best strength here.

Some hon. members: Oh, oh!

● (1700)

[*Translation*]

Ms. Nicole Demers: Mr. Decter, we know that seniors take a lot of natural drugs on top of prescription drugs. Will your study on drug taking as weel as your education and awareness campaign also deal with that?

[*English*]

Mr. Michael Decter: I think we're going to have our hands full just with the prescription side of this, but I think there is a growing awareness. I know Health Canada has been looking broadly at some of the other substances, natural and herbal and other.

The area where there may be some good room is really with the disease-specific groups. I know, for example, that the Arthritis Society has a terrific website. They have 10,000 pages of peer-reviewed material, and it may fall to some of those groups to help patients know more about those consequences. There are both good and bad stories that emerge about combinations of things and the effects.

If I could, I'll make a broad point here. What sometimes gets lost in our focus on interventions in the system is the reality that we're moving from a health care system that was, because we wanted to live longer, really focused on acute care. The acute care hospital system and health system focused on dealing with heart attacks; dealing with episodes of acute illness was what we put our resources into. We have that victory. People are living longer, but they're living longer with a burden of chronic disease—with diabetes, with arthritis, and with asthma—and we're really in the process of building a system to support people with those diseases in the home and community. Now, a lot of that support is going to be around information about how they can manage their disease.

[*Translation*]

Ms. Nicole Demers: Thank you.

[*English*]

The Chair: Thank you, Madam Demers.

Mr. Fletcher.

Mr. Steven Fletcher: Thank you, Madam Chair.

Mr. Decter, I'm going to pick up on my earlier theme on the comparative indicator reports from the various jurisdictions. You mentioned that Saskatchewan has done a good job. For us to be able to accurately assess how the health care system is going, it's important for us to know who's not doing a good job, who could improve. I'm going to ask you straight out: how is the federal government doing according to these reports?

Mr. Michael Decter: The federal government and I don't agree at this particular moment on that subject. The federal government feels in the personage of Health Canada that it has been very forthcoming with us and has provided a great deal of information. That was certainly not my view in December.

The reason I want to be a little careful here is there have been some very constructive meetings, and I don't want to fight the last war. So I think we're getting the cooperation going forward that we need, and I believe, to be very candid with you, that there's always been good support at senior levels for the council. Where the reluctance sets in is sometimes in the middle of the organization, people who worry that too much transparency might not make them look particularly good. So I know the tendency is to go at the minister or, when you can get at them, the deputy minister. I'm on my third federal health minister in a year. Turnover is a little stiff. But there has been good support from each of the three of them. And I'm on my second federal deputy minister in a year, and Mr. Rosenberg and I had a very fruitful meeting.

So I'm feeling quite good about going forward. If I had to tell you it was rosy all the way through, I couldn't tell you that.

● (1705)

Mr. Steven Fletcher: Well, you may be going on to your fourth minister.

By the way, Mr. Decter, you may look at it as fighting the last war, but you may still be in the war. And we on the opposition side will help you go to peaceful, sunlit uplands, if you allow us.

My question to you is this. Is it hypocritical for the federal government to ask for the province to provide accountability when they themselves cannot be accountable for their own actions?

Mr. Michael Decter: I think the idea was there was no willingness on the part of the provinces to be more accountable to the Government of Canada for how they spend their health dollars or what results they get. There did seem to be in both 2003 and again in 2004 a genuine agreement to make what everyone did in delivering health care services more accountable to the public. And there I'd have to say that we've covered some significant ground over the last number of years. I had six years at CIHI to observe it, and the federal government... I can't say enough about Dr. Fellegi as an enormous ally on this.

Statistics Canada have really moved the yardsticks in giving information, making information exist that didn't exist. Their access survey—and let me say here that I think it is terrific—is only being done every two years. It would be really good if it were done every one year.

There is a limit to how much information any jurisdiction is going to supply to a third party if it worries that this third party's work is going to cast it in a bad light. We're all human. It's why newspapers don't get to report their own circulation and TV stations don't get to report their own ratings. There's a very human tendency to put your thumb on the scale if you're both being measured and doing the counting.

The example I often give is the labour force survey. Think about if we said everyone could report on their own unemployment rate. My guess is unemployment would be a lot lower than it is now. We have an independent survey that does that. We can comment and we can take data and we can do our best, but I have a high degree of confidence in that data when it comes from Statistics Canada. When it comes from some other sources it's subject to some challenges.

The Chair: Thank you, Mr. Fletcher.

Next we'll have Mr. Thibault.

Hon. Robert Thibault: Thank you, Madam Chair.

There are just a couple of quick points I'd like to make, and I'd like to ask you a question.

One is the question of accountability. In Nova Scotia I attended a meeting where the premier was meeting the health care community prior to coming to the first ministers' meeting, and he indicated that accountability was not a problem for them. Perhaps you're right—depending on the way of accounting for some provinces it might be more difficult, but everybody had the same goals. It's getting the solutions.

The question of information technology is very interesting, but before I get to that, one of the other service providers that might have some input is the physician's assistant. I wasn't aware of that category until lately. A lot of them are retiring from the military and want to continue working. I believe it's the University of Manitoba or a community college in Manitoba that has a course graduating them that is recognized by the Canadian Medical Association. They are a possibility. When I finish you perhaps might be able to make a point on that.

I live in rural Nova Scotia. I see you have Simone Comeau Geddry, who is from my community, on your board. I live in a rural community, three hours' drive for the major hospitals. At our small hospital in Yarmouth, which is one of the smaller or more isolated regional health centres, we have a new MRI machine coming in. We have a new CAT scan in there now, a new digital X-ray machine that's going in there—all of those are funded with the federal money that came through the agreement. But what I think is the most important thing is that they're all connected.

When we saw Dr. Isra Levycoming here to tell us that a lot of doctors weren't connected to the Internet, that was a concern, but this hospital now is connected with that machinery through which a specialist anywhere in the world is able to give a second opinion. It gives a lot of confidence to the doctors practising out of that regional health centre in the area to know they are not as isolated. That is an important part of the technology, which is very expensive. The amount of money and Infoway, and all that was mentioned earlier is very expensive, but it's an important initial investment that we have to make as a country to bring top-notch service to our isolated and rural areas.

● (1710)

Mr. Michael Decter: I totally agree. We are in an era when we can do a lot more. We can know a lot more. I mentioned earlier that my late father was an orthopedic surgeon. Sadly, he passed away before we moved from X-ray to some of these newer, much better modalities for imaging. He did surgery literally based on shadows on X-rays. As a child, I trailed him around and watched that process.

In the fifties we did enormous amounts of what we called exploratory surgery. Our surgeons did surgery because they knew there was something wrong, but they didn't know what it was. Now, with MRI and CT and better X-ray, very few surgeons pick up a scalpel without knowing exactly what they're going to see. With the kind of connection we're talking about, someone very far away, someone half way around the world, can look at a particular set of images and can give some advice to the surgeon, which may be advice about whether this is a patient that needs to travel, or it could be advice about how something needs to be done. Yes, it is expensive to put in the infrastructure, but it is hugely more expensive to have cases misdiagnosed or not diagnosed or to have a kind of collapsing of some of the health infrastructure, because if people don't have the modern tools, they don't want to be in Yarmouth. They've been trained in our big cities using modern tools and technologies, and they want to put those to work. They don't want to be delivering a kind of second class of service to patients.

I do believe these are very important investments and the payback is there. In our video, Matthew Anderson, who runs this program at the University Health Network in Toronto, said, “When we moved to digital we got rid of 40,000 square feet of storage space”, which, for those who still think in square foot terms—and I'm old enough to do that—that is a good sized building. That was just paper records. How many of us have been there when someone we care about is getting re-X-rayed or having their blood work done again because no one can lay their hands on the previous test? We do many things over and over again in the system because we don't have it wired together in the way it should be.

These are important investments. I think we are making them. As a council, all we're saying is let's see if we can speed that process up somewhat.

The Chair: Mr. Merrifield.

Mr. Rob Merrifield: I want to go back to close this off. This whole idea of the accountability of the federal government has been gnawing at us a little bit. Who is it that you directly talk to in the federal government? When your council is unsatisfied with the information that's coming, how far down do you go, or do you talk directly to the minister?

Mr. Michael Decter: I was invited to meet with a group of health ministers at their meeting in Vancouver, which I think was in November. I was also invited to appear with my executive director at the conference of deputy ministers in December. So we've had those formal opportunities to say how things are going and where we could use some help. Contractually, because our funding flows through Health Canada, my executive director, Cathy Fooks, works with that particular part of Health Canada that's responsible for our funding agreement.

The issue really is we have to work with multiple people because information doesn't sit neatly in one place. It sits in various branches and divisions. We had asked each government to designate a single person who we could work with on information requests, and governments did that. So we do work with Ian Shugart, who is one of the assistant deputy ministers, and with Meena Ballantyne, who is our contact in terms of the formality of the agreement and flow of funds.

But if I have a problem I take it up at the minister and deputy minister levels. The council formally reports to Canadians through health ministers. So in terms of the formality of it, my reporting relationship is to the group of health ministers who actually ask me to take this on.

● (1715)

Mr. Rob Merrifield: So it's actually to the minister, the deputy minister, is what you're really saying. That's appropriate. If there's a problem with a department not functioning properly, it should be the head of the department who deals with that, and ultimately it's the minister's responsibility. Fair enough.

Perhaps even as a health committee we should make note of that and send a letter on to the minister helping out on that one.

I want to get on to your report as well. Is this report, before it's published, gone through and agreed to, looked over by the ministers of each of the provinces and the health minister federally?

Mr. Michael Decter: There's a two-stage process. What we did—if you look at the back of the document—is we shared with each government what we were going to say about them, for accuracy. If we said, for example, Nova Scotia has contracted Dalhousie University to do such and such... We fed each province in December at a working level what we were going to include in the report, not about anybody else, and not our comments; we did that as a fact checking exercise. Under the agreement that existed that created us, ministers got the report ten days ahead of the public. They got it so that they weren't blindsided by it and they could be properly briefed by their staff.

Mr. Rob Merrifield: Did they have an opportunity to change it at that time?

Mr. Michael Decter: No changes resulted to the report because we have to put it into translation well before ten days. So no situation of that sort arose pertaining to the report.

Mr. Rob Merrifield: It's interesting to know how it got to be published and the process behind that. It would be interesting to know on further ones when they come forward so we'll understand that process.

I have a question on drugs and catastrophic drug coverage. You talked about it a little bit earlier. It was in the 2003 accord. Actually there was a commitment that we would have something together, not just a report to be tabled in 2006, and we challenged the minister on this. That report now may only come after 2007 and 2008, and it may even be beyond that before we actually see catastrophic drug coverage. That's quite a bit different from 2003 to 2004. I wonder if you could comment on where you are with that as far as the council and recommendations are concerned.

Mr. Michael Decter: We're guided by what first ministers have agreed to. We're essentially reporting progress on what was agreed. The 2004 agreement changed some of the 2003 agreements. You point very squarely at the agreement on catastrophic drug coverage, which changed from a commitment with a date to a process to get to a program. In addition to noting that, we can really only report progress on what is the current agreement, and the current agreement is to have the ministerial task force report by June 2006.

Mr. Rob Merrifield: But you had agreed that it's backed off 2000?

Mr. Michael Decter: There's certainly a very clear change there. There were other changes between 2003 and 2004, going in different directions. But in the case of the catastrophic drug coverage, it did change from being a hard commitment to being a process with a commitment attached to it.

Mr. Rob Merrifield: Madam Chair is preoccupied. I should keep going here.

Home care is another issue in the same way. Regarding implementation, I'm a little unclear as to what's coming out of the 2004 accord on home care. I see your recommendations here, but there was supposed to be a national strategy coming forward in 2003, according to this—

Mr. Michael Decter: Yes. In the 2003 accord, first ministers directed their health ministers to agree by, I believe, October 2003 on a minimum basket of services that would be included. The governments failed to come to an agreement. So in a sense the logjam was broken in the 2004 agreement where first ministers actually did come to a substantive agreement on the two weeks of coverage, and so on. So you had a situation where, in essence, the first ministers had to get back together to reach an agreement that they'd hoped would have been reached by their health ministers.

● (1720)

The Chair: Thank you very much. We just have a few minutes left and we have Mr. Carrie and Mr. Lunney. I'm going to give each of them two minutes for the question and the answer.

Mr. Colin Carrie: Okay, a quick question. The health council report states that there is a target that by 2011, 50% of the population will have access to appropriate health care. I commend you on that target—that's wonderful—but my concern is that the process is going to be very much patient-oriented. Instead of a top-down, it's a bottom-up thing. I was wondering, who actually is going to decide questions like access to appropriate health care treatments? Do you have something in place for that to occur?

Mr. Michael Decter: This is really a commitment of first ministers—and we will certainly be monitoring and reporting on it—but the provinces are the ones that are going to have to give this definition. I think a phrase like “appropriate provider” is open to provincial interpretation. For example, the College of Family Physicians says every Canadian should have a family doctor. You have other realities. It's very clear to us from our visit to Nunavut that in those communities the chances of people having a family doctor anytime in this decade are remote. The communities themselves would see a nurse practitioner as an appropriate provider. So this is going to be given meaning by what provinces do, which we will report.

Mr. Colin Carrie: From a federal standpoint?

Mr. Michael Decter: I think the Government of Canada will decide within its area of delivery what it views as an “appropriate provider”.

The Chair: Thank you, Mr. Carrie.

Mr. Lunney.

Mr. James Lunney: Thank you, Madam Chair.

Given the huge costs associated with drugs—as you mentioned, they've now exceeded the costs for physician services, etc.—but also the significant failures, some very well publicized and catastrophic, with Vioxx, Celebrex, and C. difficile, for example, with gastric acid inhibitors, a 250% increase in death... We know there are natural health products that actually work better for many of these conditions that these prescription drugs purport to treat. We had some discussion about chiropractic earlier, but there's also a naturopathic community out there. There are other herbalists. Given the great advances you've made with information gathering through Infoway and so on, is anybody contemplating creating a forum for working collaboratively and discussing alternative strategies where you'd see the naturopath, the chiropractor, perhaps a herbalist, and the medical people working in the same environment and collecting data on alternatives that might work far better than what we're currently using?

Mr. Michael Decter: I'd make two brief comments, respecting the chair's admonition that I should be brief.

One is that individual Canadians are voting with their feet, in a sense. Many Canadians are consulting a broader team than the formal health system. You will encounter a significant and growing number of Canadians who in a survey will say they have a naturopath or a chiropractor, not to the exclusion of a family doctor or pharmacist, but as part of the team. Much of this is self-organized at the level of the individual, the patient.

There are some places, and Vancouver comes to mind, where there have been some formal organizations of institutes or centres trying to do exactly this. I have not had the opportunity to follow their progress in great detail.

I think a statistic that was reported in the United States was that last year there were more visits to, if you like, non-traditional providers—everyone from massage therapists to herbalists to aromatherapists—than to the traditional system. I think there really is a quest on the part of the public for things that work. Then what's going to come at us, I think, in the measurement and evaluation field is what can we tell the public about what works and what doesn't work?

This can be very controversial. The Americans set up an agency to evaluate health outcomes, and its first report indicated—it was published about 8 or 10 years ago—that for lower back pain, you got roughly equal results from seeing an orthopedic surgeon, a family doctor, doing nothing, seeing a chiropractor, or taking drugs. The results, when they were published, were so controversial that Congress came within a few votes of abolishing the agency because it created such a firestorm among the various provider interests.

This is just to say to you that I think this is important work, but we're going to have to approach it somewhat cautiously.

● (1725)

The Chair: Thank you, Mr. Lunney.

On behalf of the committee, it's my pleasure to thank you, Mr. Decter, for the work you've done, the responsibility you have assumed, and your presentation to us today in answer to our questions, particularly.

Thank you for your generosity, and don't be surprised if you become one of our frequent guests.

Mr. Michael Decter: Thank you. I'm going to work on the brevity so that more people can get more questions in.

The Chair: Oh, good. Thanks very much.

Now, to my colleagues on the committee, I will remind you that despite the clerk's best efforts to get us a Thursday morning slot, she was unable to for the next few weeks. When we get to March, I believe, we are going to win on that front.

However, early on we had decided to try for Thursday from 11 to 1, and now that Ms. Crowder has replaced Mr. Blaikie, and since she already has a meeting from 11 to 1, we're going to try for 9 to 11.

Ms. Jean Crowder: Actually, Madam Chair, our committee met on Thursday night. From 11 to 1 doesn't work for the other committee, so I'm available from 11 to 1.

The Chair: Okay. So we will try for 11 to 1 on Thursday.

On Wednesday we have the Canadian Patient Safety Institute and the Canadian Adverse Events Study. Those of us who studied prescription drugs and heard all about adverse reactions will hear some fascinating testimony, I think, and will probably ask some piercing questions.

We have a hangover issue from the meeting at which I was not present, chaired by Mr. Merrifield, and it has to do with the Access to Information Act and the release of information that has something to do with tobacco regulations.

Then we have another paper that you asked for around tobacco regulations. I'm going to ask you each to pick up one of those and review it. Then in the first meeting that we can end about 15 or 20 minutes early, I'm going to ask Mr. Merrifield to come back and take the chair to finish up the committee's deliberations on those two subjects. But there are two papers you can take with you today in preparation for that moment.

I have a feeling, Mr. Merrifield, that Wednesday will be sufficiently interesting that we won't want to take 15 or 20 minutes off the end.

Mr. Rob Merrifield: It's going to be really full, yes.

The Chair: I'm thinking about the following week, the following Wednesday. We have the Internet pharmacy on February 14, the Monday, and then again on February 15. We have the Canadian International Pharmacy Association and the Pharmacy Association of B.C. I think that will have enough information in about an hour and 10 minutes or an hour and a half so that we can use the last half hour for this.

So I'd ask you to review these papers and then bring them with you to the next few meetings, because we're not sure when we actually might get to them. If you're prepared, the minute there's an opening we'll get Mr. Merrifield back in the chair to deal with it.

Any questions? Seeing none, I will ask not only my colleagues on the committee but also all visitors to our meeting to clear the room as quickly as possible because the other meeting is about to begin.

Thank you.

The meeting is adjourned.

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