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Chair

Ms. Bonnie Brown

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● (1110)

[*English*]

The Chair (Ms. Bonnie Brown (Oakville, Lib.)): Good morning, ladies and gentlemen. Welcome to the 34th meeting of the Standing Committee on Health.

It is my pleasure this morning, on your behalf, to welcome the Minister of Health, the Honourable Ujjal Dosanjh.

Before the minister begins his remarks, I have to say this official phrase, which is that I call for vote 1 under Health.

I want to remind my colleagues that our procedural rules have a different set of times and order of speakers when the minister is present. We start with the official opposition, which has 15 minutes, and there can be one person, two persons, or three persons sharing that time. I'll wait for Mr. Merrifield to tell me what they're going to do. Then it's 10 minutes for the Bloc Québécois, 10 minutes for the NDP, and 10 minutes for the Liberals. After that it will be five minutes, alternating between opposition and Liberals. It's a little bit longer this morning, and the Liberals have to wait a little bit longer to get in.

With that in mind and with that review of the rules, I will now offer the floor to the Honourable Ujjal Dosanjh, our Minister of Health.

Hon. Ujjal Dosanjh (Minister of Health): Thank you, Madam Chair.

I am pleased to be here today to discuss the estimates for the health portfolio for this fiscal year.

I will introduce Dr. David Butler-Jones, the chief public health officer, and Morris Rosenberg, the deputy minister. We also have Ian Shugart and Chantale Cousineau-Mahoney.

I will discuss with you the entire scope of the work of the health portfolio. I will read my initial remarks into the record, and then of course we will have fun having questions and answers.

The portfolio is made up of Health Canada, the Public Health Agency, CIHR, the Hazardous Materials Information Review Commission, and the Patented Medicine Prices Review Board.

Let me first talk about the CIHR. The figure for CIHR's main estimates in 2005-06 is approximately $777 million. We are already seeing the payoffs of our investment in CIHR. Canadian researchers have made breakthroughs in areas such as heart disease and diabetes. CIHR investments are being made right across the country, in all regions of the country. As a result of the CIHR investments, what you see across the country are in fact clusters of research in different parts of the country blossoming and actually leading the research. We're on the cutting edge of research in many areas in the world.

In terms of the Public Health Agency of Canada, Dr. Butler-Jones was appointed as the Chief Public Health Officer of Canada in September. The agency is relatively new, and I'm very proud of their early successes.

Three key examples show how the agency will work to protect or improve the health of Canadians. The agency's Canadian pandemic influenza plan has been lauded by the WHO as a model for other nations. We renewed our focus on HIV/AIDS. In fact, the healthy living and prevention of chronic disease plan is the third important aspect of where we are working very hard.

I was in China with my colleague the parliamentary secretary, Robert Thibault, and Dr. Butler-Jones, discussing pandemic preparedness with them, as we have ongoing traffic and increasing traffic with that part of the world. I want to tell you that we had some useful discussions on that issue.

I'd now like to draw the attention of the committee to the Department of Health. The departmental estimates cover almost $2.9 billion in expenditures. This doesn't count the substantial impacts on health that are the result of Government of Canada transfers that are covered in the Department of Finance's estimates, particularly the Canada health transfer.

This committee is one of the many partners who help deliver our mandate. That's the reason I recently wrote to you to explore issues related to the safety of drugs in Canada.

I recently spoke in Vancouver to the Canadian Therapeutic Congress on these very issues in a very comprehensive fashion, which I thought was a bit of a nerdy speech, but an important one. We needed to lay out all of the work that we're doing, and we needed to lay it out before the experts who deal with these issues every day. My remarks focused on various areas where we would advance the transparency agenda, such as the new Regional Adverse Reaction Centres, a new Office of Pediatrics, and a new Office of the Ombudsman, to name a few.

I have stated numerous times before, including early on in my tenure as Minister of Health, that I have a principle I work with, which is the public have a right to know. I have a fundamental bias towards transparency and openness. Canadians have a right to know the good, the bad, and the ugly of the entire process of drug approval and post-market surveillance.

That said, I want to return to the focus of this hearing, which is Health Canada's plans for the current fiscal year.

Quite simply, Madam Chair, Health Canada's plans are driven by the fact that Prime Minister Martin and our government are firmly committed to the partnership for a healthy Canada. This vision was set out in the two Speeches from the Throne during 2004, and reinforced in each of the last two budgets.

● (1115)

At the base of this is our deep belief in the Canada Health Act and the values it embodies. This act sets the foundations for our health care system, foundations that have the profound support of Canadians, as you well know. That's why one of the pillars of my work is to defend the fundamental values of medicare. That commitment to defend medicare is providing an excellent basis for me to collaborate with my provincial and territorial colleagues.

An excellent example of this collaboration was the first ministers process leading up to their meeting in September 2004. In all, first ministers committed to predictable and growing funding totalling $41.3 billion over ten years. I am pleased to report that the consensus that led to the FMM deal is strong and that FMM money is already flowing. Provinces are making the necessary investments in their respective systems, the agenda is being advanced, and we are already seeing progress.

Let me use just one example: wait times. Budget 2005 provides $15 million over four years in direct federal funding for wait times initiatives, in addition to the $5.5 billion wait times reduction fund over ten years. Work has been mobilized to meet the target of December 31, 2005, for the establishment of evidence-based pan-Canadian benchmarks in priority areas.

Then there is the shared effort to develop a pharmaceutical strategy under the auspices of a ministerial task force. There is work taking place on home care and primary care reform and on an aboriginal blueprint. We also continue to work together to accelerate the telehealth initiatives. We're also at work on health human resource initiatives. An example is the $75 million from the 2005 budget that will be used to assess and integrate internationally educated health care professionals among the health care providers in Canada.

I'll focus my remaining comments on the key items in the estimates for 2005-06, specifically on instances where expenditures are changing significantly in comparison to the last year. Before I do, I should point out that these estimates do not include the financial commitments affecting Health Canada that were made in the 2005 budget. Those commitments would normally be incorporated in the supplementary estimates later in the fiscal year.

An initial point that I should draw to your attention is that Health Canada's main estimates have decreased by $310.6 million over last year. That's $310.6 million over last year. The major reason is that $358.6 million worth of resources have been transferred to the new Public Health Agency of Canada. The overall decrease is less than what was transferred to the agency, as we've projected some important new expenditures. The largest share of them relates to our responsibilities for a health care system serving first nations and Inuit people. These estimates include almost $20 million in new funding to support action on health human resource needs and an extra $12.2 million for the primary health care transition fund.

A final item I want to mention is that we're also providing $10 million to the Health Council of Canada. The council is playing a critical role in building accountability to Canadians for all governments.

I'm keenly aware that Canadians care deeply about their own health and the health of their families. They cherish the health care system that we have built in Canada, a system that focuses on our medical needs, not on our ability to pay. The challenge they have placed before governments is to make that system work better to ensure a sustainable and accessible system for many years to come. The ten-year plan responds to that challenge. The choices among expenditures that are set out in the estimates reflect the desire to put our resources where they will achieve the best results for Canadians and be accountable for those resources.

Thank you. I'd be happy to take questions.

● (1120)

The Chair: Thank you.

Mr. Merrifield, can you inform me as to how your party is going to use its first 15 minutes?

Mr. Rob Merrifield (Yellowhead, CPC): Sure. Mr. Fletcher will start with ten minutes and I'll take five.

The Chair: Thank you very much.

Mr. Fletcher, I'll remind you when you're coming close to ten minutes.

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

Mr. Minister, my first question is a simple question about the Canada Health Act. It just requires a yes or no. Does the Canada Health Act permit the private delivery of publicly funded health services?

Hon. Ujjal Dosanjh: Far be it from me to give you a legal opinion, although I used to be a lawyer in my previous life—

Mr. Steven Fletcher: A yes or no would be fine.

Hon. Ujjal Dosanjh: I don't have to answer yes or no. I'll give you the answer that I think fits your question.

Mr. Steven Fletcher: Well, we probably won't get an answer, then.

Hon. Ujjal Dosanjh: Then carry on. You ask the next question if you don't want the answer.

Mr. Steven Fletcher: Yes or no, does it allow public—

Hon. Ujjal Dosanjh: I'm sorry, I will answer the question as I see fit.

Mr. Steven Fletcher: Okay, well, we'll see how that goes.

Hon. Ujjal Dosanjh: All right.

Look, the Canada Health Act is an act that is the foundation of the medicare system, in a sense, that captured the foundation of the medicare system in Canada as it was in 1984. That enshrines the five principles that we all know. That also enshrines prohibitions against user fees and queue jumping. Those are the confines of that system.

Lawyers may argue and say yes, private delivery is up to the provinces to deal with, and the federal government really, legally, has no jurisdiction to deal with private or public delivery, but let me just tell you, as opposed to your plan, sir, which says you support private delivery—

Mr. Steven Fletcher: Mr. Dosanjh—

Hon. Ujjal Dosanjh: —we support public health care and public delivery.

Mr. Steven Fletcher: Madam Chair, for the record, the minister has not answered the question, but I think the record shows that there is indeed private delivery of publicly funded health care.

Mr. Minister, are you willing to acknowledge that? Can you acknowledge that this exists in Canada?

Hon. Ujjal Dosanjh: Let me first say that all of our practitioners, most of them, are private practitioners. That has been the case from the moment that medicare was established in Canada. So you would be a fool to even in fact contemplate answering that question in the negative. The fact is that 30% of our health care is provided by those practitioners, most of whom are in the private domain.

Mr. Steven Fletcher: Actually, when I raised that issue the last time, Mr. Minister, you did try to answer it in the negative, when I brought up the fact that most of our family doctors are indeed publicly funded but private administrators of the delivery of health care.

So I think it's safe to say there is indeed publicly funded private delivery of health care throughout Canada, and that is exactly what the Conservative Party stands for. We stand for and support the Canada Health Act.

Now, along—

Hon. Ujjal Dosanjh: Let me just tell you what you stand for. You raised the question.

Mr. Steven Fletcher: No, Mr. Minister, I made the statement.

Mr. Minister, was it a good idea when your government, the Liberal government, cut $25 billion out of the health care system in 1995? Was that a good idea?

● (1125)

Hon. Ujjal Dosanjh: Let me first tell you, we had a royal commission into health care, Roy Romanow's commission, that in fact indicated the levels of support—

Mr. Steven Fletcher: In 1995—

Hon. Ujjal Dosanjh: Sir, would you let me answer the question?

The Chair: Mr. Fletcher, you can ask the questions, but you have to let the minister answer—

Hon. Ujjal Dosanjh: You cannot interrupt me. If you continue to interrupt me, I shall stop answering the questions.

The Chair: And he's usually quite succinct.

Go ahead, Minister.

Hon. Ujjal Dosanjh: We had a commission into health care, the Roy Romanow commission, and that provided a comprehensive report on health care. It indicated the levels of support the federal government should provide as of today. When the ten-year plan was put together and agreed to by first ministers in September of last year, Roy Romanow went public and said that in fact the support that's embedded and provided in that health care accord far exceeds the levels he had recommended.

Let me now come to your commentary about where the Conservatives stand.

Mr. Steven Fletcher: Madam Chair, my question was, and I'd like to remind the minister: was cutting $25 billion out of the health care system in 1995 a good idea? The minister has not answered the question.

The Chair: Mr. Fletcher, the minister is here to address the estimates for this fiscal year, not to comment on things that are ancient history.

Mr. Steven Fletcher: He already indicated that he was going to answer the question. Now he's not going to answer the question. He can't have it both ways.

The Chair: He answered the question as he deemed fit, which he's entitled to do, just as you are entitled to ask questions. However, I would remind you that the parameters of this meeting are the estimates for this fiscal year, and to go back ten years or so seems to me to be beyond the purview of this meeting.

Mr. Steven Fletcher: Madam Chair, with all due respect, I disagree. It was the $25 billion that was cut that caused the health care crisis in the first place, and any moneys that are being put into the system today are as a direct result of this current government's neglect of the health care system in the past. So I'm not sure that—

Hon. Ujjal Dosanjh: But sir, that is because.... Let me answer that question for you.

Mr. Steven Fletcher: Mr. Minister, that was a statement; it wasn't a question.

Hon. Ujjal Dosanjh: Well, stop making statements unless you want me to respond to them.

Mr. Steven Fletcher: The issue—

Hon. Ujjal Dosanjh: You made a statement, sir; you said....

Look, the Mulroney government brought this country to the brink of financial disaster. We were ready to be a banana republic. We had to do something about it.

Mr. Steven Fletcher: Madam Chair, the minister is not letting me finish the preamble of my next question. The minister would, I think, for the diginity of his post, be well advised to allow me to finish.

The fact is that the $25 billion the Liberal government cut from the health care system has caused the health care crisis. My question was simply whether that was a good idea. The minister has refused to answer that question, so I will go on.

Will the minister agree, then, that it was the Conservative Party platform, which was double what the Liberals promised in the last election, that the Liberals have taken and tried to implement through the health accord?? It was the Conservative Party that brought the $41 billion to the table in the first place.

Hon. Ujjal Dosanjh: Sir, let me respond to you about your platform.

The platform of your current leader in 2002 was, and I quote, "our health care will continue"—

Mr. Steven Fletcher: Madam Chair.

The Chair: You asked the question, Mr. Fletcher. The floor is not yours at the moment. The minister has a chance to respond to your statement and question.

You can't talk all the time, Mr. Fletcher.

Minister, the floor is yours.

Hon. Ujjal Dosanjh: Let me quote. Your current leader of the Conservative Party, in 2002, on his website, says: "...our health care will continue to deteriorate unless Ottawa overhauls the Canada Health Act to allow the provinces to experiment with market reforms"—my friends, I underline, market reforms in health care—"and private health care deliver options."

In fact, your current leader wants to commodify health care and not have health care within the current confines of the Canada Health Act.

Mr. Steven Fletcher: Madam Chair, the minister would be well advised, again, to be concerned- -

The Chair: It is not your role, Mr. Fletcher, to advise the minister.

Mr. Steven Fletcher: That will change, I'm sure, in the short term.

If we were going to talk about positions of the Liberal Party, a former minister of this government and the current minister said on April 20, 2004, "we know the public administration principle of the CHA already provides flexibility on private delivery...". That was Pierre Pettigrew.

Your government has already acknowledged that private delivery is something that is amenable under the CHA, yet you continue to mislead the Canadian public and suggest somehow that private delivery of health care is evil, even though most of the family doctors are private delivery models.

● (1130)

Hon. Ujjal Dosanjh: Sir, with the utmost respect, let me just say to you that in fact it is your party that continues to say one thing in its public policy platform and has said many other things prior to the public policy platform.

Mr. Steven Fletcher: Madam Chair, it is the Liberal Party that has the hidden agenda on health.

Hon. Ujjal Dosanjh: In fact, I'm happy to repeat those lines for you if you've forgotten

Mr. Steven Fletcher: We could take this outside. I'd be happy to.

Hon. Ujjal Dosanjh: I'm not a physical kind of guy.

Mr. Steven Fletcher: Neither am I, but don't be shocked if you have tire marks over your shoes.

The Chair: That's it, Mr. Fletcher.

Mr. Merrifield.

Mr. Rob Merrifield: That would be be an unfair advantage, because he has strong batteries in his machine.

I do want to follow up. Let's call a spade a spade. I believe the minister agrees with the Canada Health Act, and so does our party. If you agree with the Canada Health Act, then you understand that the provinces have the ability to determine who delivers health care and that delivery options are a part of the act. That's just the way it is. Whether the minister likes it or not, that's the reality of it.

The issue of our policy.... I want to correct the minister, and right here on the record have him understand clearly what our policy says, because there actually is a part in there that we refer to as a kind of special Liberal adaptation to the Canada Health Act, which is accountability. That's the sixth principle that we have said, campaign after campaign, election after election, we would add to the Canada Health Act. That is only there because it's this party that destroyed health care in the middle of the nineties by taking $25 billion out of it and leaving it in the state it is in now.

You talked about waiting lists a few minutes ago. Under the Liberal regime you've doubled waiting lists in this country since 1993. That's just the reality. We can talk about what may happen in the future—the $41 billion—but that you can't argue with. That's just the fact of what has happened in the state of health care in this country.

So would the minister argue with me about the fact that the Canada Health Act allows the provinces that jurisdiction, where close to 32% of our system right now is private delivery? Is that true or not?

Hon. Ujjal Dosanjh: I've already said 30% of our system is private delivery. I won't argue the Constitution with you, but what I will argue with you is that your professed public policy is that you support public pay for private delivery. We support public pay and public delivery.

Mr. Rob Merrifield: The Canada Health Act—

Hon. Ujjal Dosanjh: That's the difference, sir.

Mr. Rob Merrifield: I disagree with that.

Hon. Ujjal Dosanjh: Your leader, in 2002, said he supports market reforms to health care, to make health care a commodity, to give the provinces the flexibility by overhauling the Canada Health Act. Why did he want to overhaul the Canada Health Act? Can you tell me?

Mr. Rob Merrifield: Because we need some accountability in the Canada Health Act. Never again should we allow a prime minister of this country to destroy health care the way they did in the 1990s. The man who did that is the man who was the finance minister at that time and the Prime Minister today. That has never happened in any province since that time or has any federal government ever proposed it.

Why do we need accountability? It's so that unilaterally you cannot destroy health care, as has been done in the last decade.

Hon. Ujjal Dosanjh: Sir, why—

Mr. Rob Merrifield: That is why you need accountability in the Canada Health Act. It's not there today, and that has to be changed if you're going to sustain health care into the 21st century.

Hon. Ujjal Dosanjh: I guess that's the kind of accountability that would lead to market reforms. That's the only thing your leader mentions. There's nothing about accountability in 2002.

Mr. Rob Merrifield: Listen, we have—

Hon. Ujjal Dosanjh: You've changed, have you?

Mr. Rob Merrifield: No, no, that's there.

I don't know if you were at the Montreal conference. Maybe you should have been there to see exactly what our policy is. It seems as though in public you've been more knowledgeable about the policy of the Conservative Party than you have been about your own.

I'd have to challenge you that the Canada Health Act actually does allow that, and you have acknowledged that. We both agree. We say that we agree with the Canada Health, and I believe Canadians support that. Our party supports it; your party supports it. Let's just call a spade a spade and understand clearly what that act allows.

● (1135)

Hon. Ujjal Dosanjh: I have always said that constitutionally the provinces are the masters in terms of the mode of delivery.

Mr. Rob Merrifield: Exactly.

Hon. Ujjal Dosanjh: That is not changed by the Canada Health Act. That's part of the Constitution.

Mr. Rob Merrifield: Exactly.

Hon. Ujjal Dosanjh: You say you support private delivery. I say we support public pay and public delivery.

Mr. Rob Merrifield: We support public pay—

Hon. Ujjal Dosanjh: That is the difference.

Mr. Rob Merrifield: No, there is no difference there.

Hon. Ujjal Dosanjh: There is absolutely a difference. We don't support an extension of private delivery. You do, sir.

Mr. Rob Merrifield: No.

Hon. Ujjal Dosanjh: Yes, you do.

Mr. Rob Merrifield: What we support is what is allowed under the Canada Health Act. If you agree with the Canada Health Act, then you agree with that.

Hon. Ujjal Dosanjh: We're not talking about laws. Now we're talking about policy, sir. Your policy says you support private delivery. That means an extension over what exists in terms of private delivery. I say to you that we don't.

Mr. Rob Merrifield: That's an interesting interpretation of what you suggest we believe.

Hon. Ujjal Dosanjh: It is the absolute truth.

Mr. Rob Merrifield: I would suggest to the minister that he concern himself more with what he believes than what he thinks we believe. I think that would be a much wiser way to move into this next 21st century with regard to health care.

If you, sir, and the Liberal Party do not lay your sword on the table with regard to health care...because Canadians aren't interested in a debate between what nuances of the Canada Health Act are important or are not important. What they're really concerned about is their health and sustaining health care into the 21st century. We don't have time to play politics with it. This government has played politics with it for a decade and has left it in the shape it's in right now.

Hon. Ujjal Dosanjh: Sir, I—

The Chair: Thank you, Mr. Merrifield. That's 15 minutes for the Conservatives.

Mr. Rob Merrifield: I'm sorry, my time has gone and so has yours.

Hon. Ujjal Dosanjh: No, it's not. Mine isn't gone.

I'm actually somewhat shocked that you would think that euphemisms such as “maximum flexibility” to the provinces, which you want to allow, and that words such as “market reform”—

Mr. Rob Merrifield: That does not challenge the Canada Health Act, and that is the issue.

Hon. Ujjal Dosanjh: The words—

Mr. Rob Merrifield: If you respect the Canada Health Act, then you respect that jurisdiction of the province.

The Chair: Mr. Merrifield, let him in.

Hon. Ujjal Dosanjh: The words such as “market reform” that your leader is so fond of talking about in terms of health care, and he only did so last in 2002—

Mr. Rob Merrifield: Do you not support the Canada Health Act?

Hon. Ujjal Dosanjh: It is important to remember that there is a huge distinction. Where do you want to go, sir?

Mr. Rob Merrifield: Do you not support the Canada Health Act?

Hon. Ujjal Dosanjh: You want to go into private health care. We don't.

The Chair: Madame Demers is next—thank heavens.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): Thank you, Madam Chair. The minister will be pleased to hear that our party neither wants to nor shall ever be in power.

I am going to ask you some questions which I hope you will be able to answer. I would like you to explain something to me, Mr. Dosanjh.

On Monday we met with the Patented Medicine Prices Review Board. It was explained to us that where pharmaceutical companies had sold a product, for example Remicade, at too high a price, they had to reimburse the amount by which they had overcharged to the Receiver General, who recommended that the money be returned to the provinces.

This year, we are talking about $7.8 million in the case of Remicade, and $3.8 million in the case of EVRA, for a total of just under $11 million. Do you plan to do what was done in the past, in other words to return this money to provincial and territorial departments of health?

[*English*]

Hon. Ujjal Dosanjh: I'm sorry, I didn't get the full gist of your question.

Ian, do you know the issue?

Mr. Ian Shugart (Assistant Deputy Minister, Health Policy Branch, Department of Health): Thank you, Minister.

There is a process.

[*Translation*]

A discussion process between federal and provincial governments is under way.

Ms. Nicole Demers: Yes.

Mr. Ian Shugart: There was a fairly complex formula which had to be followed, and, furthermore, as far as I understand, the provinces are not in agreement as to how the fund should be distributed. However, discussions are continuing, and we could provide the committee with follow-up if additional information would be helpful.

Ms. Nicole Demers: Thank you very much.

I have been reading through the magazine entitled *The Epoch Times*. I am very interested in and concerned by the health of aboriginal women and children. On reading this magazine, I learned that your budget entailed a certain number of cutbacks. For example, $27 million are to be severed from the Non-Insured Health Benefits Program over the next three years. The magazine also reveals that the budget for the first nations health information system is also to be cut by $36 million over three years. Furthermore, there has been no guarantee that funding for first nations' health will be indexed at 10 to 12 per cent.

Could you explain why such cuts were made at a time when aboriginal health is a growing concern? We know that suicide rates are highest among young aboriginal people. Their quality of life is low, as is their life expectancy, and, once again, aboriginals women are the principal victims.

Given the current context, could you explain to me why such budget cuts were made?

● (1140)

[*English*]

Hon. Ujjal Dosanjh: Let me just briefly say that there is an additional $700 million provided for aboriginal health over the next five years.

I'll let Ian Potter, one of our officials, answer the question about the cuts.

Mr. Ian Potter (Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health): The member has identified a number of items that were part of the government's overall efforts to streamline delivery and make it more efficient. Within that process there were two issues you've identified. One was reductions in non-insured health benefits. These are reductions from a growth level. The impact will mean that the funding for non-insured health benefits will continue to increase year after year but that Health Canada will make efficiency gains in the way it manages that program so as to reduce the expenditure we would have had if we hadn't.

[*Translation*]

Ms. Nicole Demers: [*Editor's Note: Inaudible*]

[*English*]

Mr. Ian Potter: How? There are a number of efficiencies in managing transportation, for example, and issues the Auditor General has identified where we can negotiate more effective collective agreements with service providers in dealing with pharmaceutical provisions, dealing with—

[*Translation*]

Ms. Nicole Demers: You are talking about what would ideally happen, not things which have been accomplished. You are talking about what you would like to achieve, although you have not yet done so, and it is not by reducing funding for communities that you will meet your objectives.

[*English*]

Mr. Ian Potter: That's right.

[*Translation*]

Ms. Nicole Demers: Fine.

I would like to know why aboriginal people do not have access to certain drugs, for example drugs for treating Alzheimer's disease such as Aricept, Exelon and Reminyl. These drugs are not available to aboriginal peoples. When we asked the Department of Health to explain why this was so, we were referred to their website and asked to look for the answers ourselves. I found it most unsatisfactory that I and other people should be answered in such a way when looking for information.

These medications have a very positive effect on patients suffering from Alzheimer's disease, because they allow them to enjoy a good quality of life when they are at the initial stages of the illness. Why are aboriginal people being refused these drugs? Once again, women are the ones who really suffer as a result of this.

Why are these medications not available for First Nations people and the Inuit?

[*English*]

Mr. Ian Potter: The program we manage, called non-insured health benefits, has a formulary. It identifies those drugs it will cover. The list of drugs we will cover is the result of something called the common drug review. This is a review that is conducted by all provinces and territories by medical specialists, physicians, and pharmacists who look at the efficacy of the drug, and they recommend whether the drug should be listed as part of a funded program or not.

We have in addition an advisory group that follows that and provides us with advice. Our group includes physicians, specialists, and scientists, plus people who are aware of the particular circumstances of the first nations and Inuit clientele. They recommend to us the items that should go on that list. This is done in a scientific way. If there is a drug you've identified you believe should be covered, there is an appeal process to go back to that scientific panel and ask them to review it to see whether it should be provided.

[*Translation*]

Ms. Nicole Demers: Are you telling me that members of the military, as well as all other people looked after by Health Canada, do not have access to these drugs? When the group recommends that some drugs not be used, does that mean that none of the institutions under the purview of Health Canada have access to them?

● (1145)

[*English*]

Mr. Ian Potter: There are some differences among the national drug plans for the first nations, the Inuit, veterans, and the RCMP and DND. This was remarked on by the Auditor General, who recommended that all of the federal drug plans should develop a common formulary and that we have similar basic core drugs. All departments are committed to moving in that direction, with the recognition there may be certain differences. For example, combat situations might require a particular drug our plan would not need to have listed. The intent is to have a common formulary so all the federal programs list drugs that have been recommended by the scientific panel as having efficacy.

[*Translation*]

Ms. Nicole Demers: Is this the same group of specialists who, in 1997, recommended that you approve Depo-Provera, a drug which is very dangerous for women? It was asked that the drug not be approved. It was being used primarily by women in third world countries, women to whom, in my view, little attention was paid. It is a drug which weakens bones, causes vision problems, weight gain, and both an absence of menstruation and heavy bleeding. It can also have very serious consequences for women who are anemic or undernourished, yet in spite of this, it is still on sale.

Is it the same group that recommended that you approve Depo-Provera that is recommending that you not approve Aricept?

[*English*]

Hon. Ujjal Dosanjh: I appreciate the concern the member raises. In fact, we will take a look at the drugs you mentioned and see if they can be processed through the Canada drug review and made part of the formularies if there is a certain degree of efficacy.

[*Translation*]

Ms. Nicole Demers: Have you taken notes this time? The last time we spoke was when the House met as a committee of the whole to discuss the budget in November. On that occasion, I asked you questions on specific drugs, and you were supposed to provide me with a detailed response.

However, you have not done so, and nor have your deputy ministers or assistant deputy ministers. Some of them have already been replaced by others, which perhaps explains why I have not had an answer. I would greatly appreciate it if this time you would follow up on the notes that you have taken.

[*English*]

Hon. Ujjal Dosanjh: What I would like to tell the honourable member is that we will go through the undertakings we accepted at the last hearing as well as the undertakings we accept here and come back to the committee and provide the information.

The Chair: Thank you, Madame Demers.

[*Translation*]

Ms. Nicole Demers: Thank you, Madam Chair.

[*English*]

The Chair: Mrs. Crowder is next.

Ms. Jean Crowder (Nanaimo—Cowichan, NDP): Thank you.

I have a question that arose out of the CMA's pre-budget submission. They were specifically talking about something they called the Naylor gap; they believe additional funds should be made available for public health as a result of the SARS crisis and the Naylor report. They indicated the $1 billion that had been recommended should be provided, and I see it is half of that. I wonder if you could comment on the fact that this process happened and that there doesn't seem to be the money assigned to that.

Hon. Ujjal Dosanjh: I think if you look at the budget, you will find about $300 million on the integrated chronic disease strategy and you will see other money in public health. It may not be exactly what Naylor said it ought to be, but there is significantly more money in this current budget for public health than before, and that includes the issue around avian flu and the like.

Mr. Shugart.

Mr. Ian Shugart: I would just add that in the 2004 budget, there was also funding provided directly to provinces through trust arrangements in support of immunization and so on. I would have to check, but I don't know that the CMA, in their number, has taken into account that support to provinces, which had been called for in the Naylor report.

● (1150)

Ms. Jean Crowder: Is there some reporting-out mechanism so that we have some assurance that this money is actually being spent by the provinces in public health?

Mr. Ian Shugart: As I recall, provinces committed at the time to report on their use of those funds.

Ms. Jean Crowder: Okay.

So if we're talking about reporting, let's talk about accountability. When Bill C-39 came before the House, there were no provisions in it for accountability. I understand that the estimates do talk about improving accountability, but when I look at the recommendations from organizations like the Health Council of Canada, they talk about very specific mechanisms around accountability. That includes a reporting-out mechanism that talks about where the money is spent, and how it's spent, so that the Canadian taxpayer has some assurance that the money is actually going into the principles and the values that Canadians think are important around health care. Bill C-39 didn't address it, so there's no legislative framework for that.

In the CMA presentation, as well, they strongly encourage Parliament to put in legislation around making sure that the dollars came forward. They also strongly urge that the framework include some accountability and some commitments by governments to report on access indicators and so on. I wonder if you could comment on that.

The other issue, of course, is that when we look at the Canada Health Act report that comes out, I'm not sure it gives people the confidence that the money is going where it's intended. For example, under British Columbia, they list insured hospital services “with own province or territory”, and then under payments, for things like acute care, chronic care, rehabilitative care, and so on, it says “not available”. There's a whole series of not available data. This is in my own province of British Columbia.

So I'm not sure that people trust that the money is actually going where we think it's going.

Hon. Ujjal Dosanjh: Let me deal broadly with your questions around accountability.

I think Canadians want more accountability from all governments in terms of health care delivery. The health care accord actually commits all governments to a higher level of accountability than ever before. It's unprecedented. We have deadlines as to when we need to establish benchmarks and indicators by; we have deadlines by which time we have to have expanded home care as per the accord; we have deadlines by which time we have to have the national pharmaceutical strategy all figured out collaboratively across the country; we have March 31, 2007, as the first date when all provinces and territories have to report significant reductions in wait times for their own populations; and then you have accountability, the ultimate form of accountability, with the parliamentary review. That happens, I believe, in three years' time. That parliamentary review—that's you, and some of us, if we're still around here—will then be able to judge whether or not the provinces and in fact the federal government, in terms of our own aboriginal health care responsibility, are living up to the obligations embedded and undertaken in that health care accord.

Ultimately, an even more important aspect of that accountability is the population of each of the jurisdictions. I think the members of the public, the electorate, have enough information to be able pass judgment, and have the occasion to pass judgment on each of the jurisdictions of this country, including the federal jurisdiction, as to whether or not we're living up to these obligations.

From my perspective, we need to move away from always having the federal government police the provinces. We are a federation, we need to work together. Yes, the provinces need to be policed in some situations—

Ms. Jean Crowder: Thanks, Mr. Minister. I don't want to interrupt, but I have only ten minutes.

Hon. Ujjal Dosanjh: Okay.

Ms. Jean Crowder: I have a question for Mr. Potter. Madam Demers mentioned that the aboriginal communities have expressed some concern about the reductions in the dollars going to aboriginal health. In my area, some of the aboriginal communities have expressed grave concerns about the renegotiation of those health agreements, because they have apparently not taken into account the enormous population growth in our community. It's the aboriginal youth who are contributing to population growth, and this doesn't appear to be reflected in the renegotiation of these agreements.

Madam Demers also talked about drugs. We have a case before us of a young native child by the name of MacKenzie Olsen, who was on a pilot drug. I understand the rationale around orphan drugs. But where is the compassion when we've had a child on a pilot drug who is now going to have to come off that drug, waiting for the regulatory process to unfold? The quality of this child's life is being destroyed by the lack of a mechanism for funding of the drug.

● (1155)

Hon. Ujjal Dosanjh: Let me deal with the issue of the drug for this child. This is a very difficult situation. Questions about it are hard to ask and even harder to answer. We have a scientific process in this country that we all agreed on called the common drug review.

Ms. Jean Crowder: We let the kid take the drug for the pilot. Couldn't we find a mechanism to keep him on it while we figure out the regulations?

Hon. Ujjal Dosanjh: We need to take a look at how these kinds of drugs come onto the market. We need to look at our whole strategy of allowing companies to market drugs. They create a dependency and then suddenly they pull out. These are issues we need to deal with. They are sometimes reluctant, less than cooperative, or cooperative in a tardy fashion with the common drug review. This particular company has only reluctantly submitted to the Canadian common drug review. This drug review is currently being undertaken, and I've asked my officials to talk to the drug review people to have it expedited.

I think you would agree that, as politicians, one can't pick and choose between drugs. One can't substitute oneself for science. It is a scientific review, a review about efficacy. It is a very difficult issue.

Ms. Jean Crowder: Maybe we should meet with the child and discuss what his life looks like. Why do we raise the hope for him and then take the drug away? If we're saying that the drug isn't suitable, why do we let him get on it in the first place?

I'm sorry, this is outside of the estimates, and I apologize.

The Chair: Thank you, Ms. Crowder.

Mr. Savage.

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

Mr. Minister, welcome to the first health committee meeting of the 2005 election campaign.

We've heard a lot of preambles here, so allow me to add my own. I honestly am not sure that we'd have a publicly funded health care system if we had continued with the reckless $40-billion deficits of the Conservative government. I'm glad we have a publicly funded system. I'm glad that we reinvested in it last year, and I'm proud of that record.

I want to ask you about autism. Currently, autism is not a core-covered service under the Canada Health Act. Do you think this should be changed?

Hon. Ujjal Dosanjh: This is an issue of therapies—what therapies ought to be covered. I was in politics in British Columbia when this issue arose there. It is a difficult issue that needs to be decided through institutions such as the common drug review, or perhaps a common therapy review. We need to make sure that we get a common understanding across the country, so that we are able to provide similar, good-quality care nationwide.

Far be it from me to say whether a particular therapy ought to be available. I'm not a doctor or a scientist.

Mr. Michael Savage: I understand that. I think it would be a very worthwhile issue for parliamentarians to support.. I think it is a gap in the system that we need to adjust with the extra money we put into health care.

I want to talk a little bit about health human resources and, in the larger context, what I consider to be the second threatening two-tier aspect of health care, which I've referred to before as not just private and public, and that is the fact that we have differing standards of health care across the country now.

In my province of Nova Scotia, our home care is very inadequate. We have no pediatric home care to speak of. Drug plans across the country are scattered back and forth.

I met this week with some representatives of brain tumour associations. In some provinces there's a new type of chemotherapy—an oral chemotherapy—that is very effective in assisting people who have brain tumours. In some provinces it's covered. In Nova Scotia, in most cases, it's not; it's done on a piece-by-piece basis. That's the type of situation I'm concerned about.

I recall going to meetings before when I was involved in the Heart and Stroke Foundation and hearing that my Alberta colleagues were very happy because they had a new expert coming in—a cardiologist or a cardiac surgeon—and then I'd found out they were coming from Nova Scotia.

So it's the pan-Canadian necessity of this health human resource strategy that I'm hoping we'll be able to get at, in part, through the first ministers' accord. I wonder if you or your officials might be able to speak to how we accomplish that.

● (1200)

Hon. Ujjal Dosanjh: First of all, let me just add to what you said. The federal government provided more resources for health care in the 2000 accord. I was there as premier. I can tell you in the 2003 accord more resources were provided, and then in the 2004 accord more resources were provided. And in all of those accords, particularly in the 2004 accord, there is a significant amount of money for training of health human resources in the $5.5 billion. For the wait-time reductions there is a significant element of the money that's there for health human resources.

We also have $75 million provided to Health Canada in this budget that we're going to use to deal with foreign credentials recognition, and integration of internationally trained medical professionals into our workforce so that people like the one who was featured on the *Globe and Mail* don't have to go to the U.S.; they can stay here and start working here where they're needed.

Mr. Michael Savage: I think Madam Dhalla might want to speak to you about that. She's been very involved in the foreign credentialing issue.

Do I have time for my—

The Chair: You have time for one quick one.

Mr. Michael Savage: I just want to ask Dr. Butler-Jones—because this is my favourite topic—how you would say we're doing in terms of preventing chronic disease and promoting the issue of health among Canadians. Aboriginal people in the first nations are very important. Atlantic Canada has a very high incidence of chronic disease. Diabetes, for instance, is out of control there, and there are many others. Do you see us making progress on that front?

Dr. David Butler-Jones (Chief Public Health Officer, Public Health Agency of Canada): While I would never say we're there yet, I think we are making significant progress in terms of both last year's and this year's budget. But it's not just a budget item.

The $300 million will certainly go a long way to support the integrated strategies. The very fact that various voluntary sector organizations are working together around integrated strategies, so that in fact whether it's heart disease or cancer or lung disease or others—there are many underlying factors they have in common—focusing our collective resources, and planning the provincial strategies and others really is, I think, allowing us to move much more quickly than the course of a couple of years I would have hoped it would take, and I'm anticipating continuing in that direction.

The Chair: Thank you, Mr. Savage.

Ms. Dhalla, go ahead, please.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): Thank you very much to the minister and all of the department for coming today.

I want to speak to you, Mr. Minister, about two issues that are very important and near and dear to me, not only due to my background as a health care provider, but also on behalf of my constituents of Brampton—Springdale.

On the first one, I think I'll have to agree with Mr. Fletcher and Mr. Merrifield when they mention that Canadians do not want to play politics with the Canada Health Act, and I really wish that some members of the Conservative Party would stop doing that.

I've had a number of constituents who have called my office with some grave concerns. And I would like you to elaborate, perhaps, on some comments that were made by our Conservative leader, Stephen Harper, in regard to market reforms taking place on the Canada Health Act. Two other well-known Conservative people I think all of us know, Mr. Manning and Mike Harris, discussed substantially amending or replacing the Canada Health Act and transferring responsibility for health care delivery and financing, including transferring federal tax points entirely to the provinces, and also discussed the fact of possible private delivery of health care services.

I know you mentioned earlier that you're a big promoter of public pay and public delivery. Can you perhaps comment on how having a two-tiered system, one for the rich and one for the poor, would affect Canadians across this country?

● (1205)

Hon. Ujjal Dosanjh: The Manning-Harris report talks about in fact either eliminating the Canada Health Act or altering it fundamentally. It also talks about using private capital, non-government provider, and market-based pricing mechanisms, which is the same kind of language that the current leader of the Conservatives, or Reform-Alliance, used in 2002 on his own website about—

The Chair: Excuse me, Minister. On a point of order, Madame Demers wants to make an intervention.

[*Translation*]

Ms. Nicole Demers: Excuse me, Madam Chair, but I would like to raise a point of order, please.

The minister is here so that we have an opportunity to ask him questions on the current health care system. I am not interested in what will happen further down the road. At the moment, people are behaving as if this were an election campaign, and everybody is getting wound up speaking about their election platform. I think that this is repugnant.

We have important questions to ask the Minister of Health, there are important things to discuss. We should not be spending our time saying that so and so is no good, and so and so is no better. We are doing our best to get answers to the questions. Could we please apply ourselves to the task at hand?

[*English*]

The Chair: I agree with you, Madame Demers—

Ms. Ruby Dhalla: Madam Chair—

The Chair: —in the sense that this meeting is supposed to be about estimates. I must say, when I first came to this House, people who were asking questions were actually referring to page number such-and-such in the blue book, and line number such-and-such, and asked a specific question, as did you, Madame Demers, and I must compliment you. You did ask specific questions about specific items, as did Ms. Crowder.

Some people have insisted, over the past couple of years, in going off the estimates and talking about what I call general theories of politics and governance. I really would like to ask people to come back to the purpose of this meeting, which is to question the minister and his aides on the estimates that are before us and what that means for Health Canada, the Government of Canada's activities in this fiscal year, which we're just into. There's all kinds of time. We have to decide as a group whether or not we're going to vote for this set of estimates. That's why the questions should stay on the estimates.

Thank you very much, Madame Demers, for reminding us all.

Ms. Dhalla.

Ms. Ruby Dhalla: It's unfortunate that our meeting started off this way—

The Chair: Yes.

Ms. Ruby Dhalla: —because I don't think that was the intention of anybody here. We're here to talk about the great work that the Minister of Health, under his leadership, has done with the department. So perhaps he can continue to comment on some of the priorities the Department of Health has.

Hon. Ujjal Dosanjh: We obviously have as the topmost priority to ensure that the health care accord is implemented and we are able to establish pan-Canadian benchmarks and indicators. Work is under way at the provincial and territorial levels. The work is under way federally.

In fact, the Prime Minister and I met with the Wait Time Alliance a couple of weeks ago, if I remember correctly, and congratulated them on their work. There is the Western Canada Waiting List Project and there are other projects in Ontario that have indicated their views as to benchmarks in the five priority areas indicated in the election, or highlighted in the election.

As part of the accord, we have the national pharmaceutical strategy that's under way. As part of the general reforms within Health Canada, we've taken very vigorously to dealing with issues around the drug review process, the clinical trials, the approval process, and the post-market surveillance. All of those we want to throw open to the public and to others so that we know what kinds of drugs we're getting and what kinds of clinical trials are being run—the good, the bad, and the ugly of all of the information that's possible to be given to the public.

The Chair: Thank you, Ms. Dhalla. The ten minutes for your side is up.

We'll now move to Mr. Carrie.

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

I appreciate not getting too partisan here, but, Minister, we've been throwing a lot of numbers around. Every single week I take calls from constituents. I had one last week from a senior in Oshawa who's been waiting a year and a half to get a family doctor.

Canadians aren't really concerned with just the numbers. They want to see results, and not just how much money we're putting into the system but where the accountability is, where we're getting the bang for the buck.

To quote you, on November 23, 2004, you said that the real problem is wait times.

In an area such as mine in Oshawa, we're 40 physicians short. We've had a net loss of two in the past year. With all the money flowing into the system, constituents are asking me, "How many new doctors are we getting for this money? How many more services are we going to have access to?"

With your estimates, how much money are you actually putting into enforcing that the province ensure that money is being spent on what it's supposed to be spent on, and how much money is going to enforcing the comprehensive clause of the Canada Health Act?

● (1210)

Hon. Ujjal Dosanjh: In terms of health human resources, I would not be wrong if I told you that right across the country, with the kinds of resources that are available under the new accord, and in fact with the increased funding the provinces are providing themselves, we're probably looking at incorporating over 1,000 new doctors and about 800 new nurses and others into health care delivery. They're not going to come tomorrow.

Rather than blaming somebody in the past, we need to understand that there was a time in Canada when all the medical schools across the country—because the people with the pointy heads, the experts, said we had an abundance of doctors, an oversupply of doctors—decided to reduce the number of medical students they were taking. Now the demographics are changing, the population is increasing as well, and we need more doctors and we need more nurses.

We are all actually working together. We were at the meeting in October of all the health ministers. We agreed to work together on the issue of integrating foreign graduates into our system and to expand and enhance the medical schools and nursing schools.

Mr. Colin Carrie: My constituents are saying we're out of touch. I have a press release here from Lakeridge Health in Oshawa dated March 31 saying there are 308 layoffs there. Patient care is being jeopardized. We're in a crisis. And here in Ontario we have a provincial Liberal government that just increased the health tax, which I believe has brought in $2.2 billion, but they're only giving $46 million to the hospitals. It seems that the province is directing all the money to be gobbled up in wages.

I'd just like to ask you, with numbers like that, are you trying to say to the people of Oshawa and the people of Ontario and the people of Canada that you feel the system is working? Where do we have the accountability measures that have been promised?

Hon. Ujjal Dosanjh: Let me say to you that I think the system is, by far, one of the best systems in the world. It is not perfect. Obviously, we're all struggling with these issues. I would just ask you to look within and perhaps you can look at the Harris effect. I remember Mike Harris, who just issued a report with—

Mr. Colin Carrie: You just asked us not to look back ten years—

Hon. Ujjal Dosanjh: No, but—

Mr. Colin Carrie: —at your record or at Mr. Harris'—

Hon. Ujjal Dosanjh: But—

Mr. Colin Carrie: —or Mr. Manning's. We're trying not to get partisan here, Minister.

Hon. Ujjal Dosanjh: You're telling me. That's wonderful news.

Mr. Colin Carrie: You know what, though?

Hon. Ujjal Dosanjh: Let's not be partisan.

Mr. Colin Carrie: You're the top minister in Canada, and if you're saying to me.... You're trying to shirk your responsibility to the provinces here—

Hon. Ujjal Dosanjh: I'm not shirking responsibility.

Mr. Colin Carrie: Isn't it part of your job to enforce accountability with the provinces? If they're not spending the money on publicly delivered health care, isn't that what you're supposed to be doing?

Hon. Ujjal Dosanjh: If a particular province doesn't do a good job and isn't using the resources it needs to use to do the right thing, that province will, of course, face the electorate at some point. Are you suggesting that we should be the big brothers in Ottawa and tell the provinces how to manage their own health care?

Mr. Colin Carrie: Sir, isn't that part of your job—

Hon. Ujjal Dosanjh: Are you—

Mr. Colin Carrie: —to ensure that you enforce the Canada Health Act?

Hon. Ujjal Dosanjh: Yes, we are enforcing the Canada Health Act. It's you guys who want to actually abandon it, demolish it, dismantle it.

Mr. Colin Carrie: That's not true.

Hon. Ujjal Dosanjh: Well, if you look at your own leader's remarks in 2002, that's exactly what it is, sir.

Mr. Colin Carrie: Sir, don't put words in his mouth.

Hon. Ujjal Dosanjh: I don't have to try at all.

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

We'll go to Mr. Thibault.

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

I appreciate your concern that the committee return to the tradition of asking questions solely on the estimates. I remember that the minister appeared in the House at the committee of the whole, at what's often regarded as the iron-kidney marathon, where he did five hours of questioning. I don't think there was one question on the numbers. I've appeared at the committee as a witness on estimates and supplementary estimates on six occasions, and I don't remember one question on the numbers. I remember them all being on policy. So this longstanding tradition of asking questions on the numbers has yet to begin, I believe.

● (1215)

The Chair: Excuse me,but Madam Demers set the proper tone. We should have the wisdom to follow her.

Hon. Robert Thibault: I agree. I think what's important is to look at policy and how we're being prepared in Canada now and how we're preparing in Canada for the future, but also to examine risks. And I think the minister is right to bring forward the subject of risk and changes in public policy. I think that's fair.

The minister, in his opening remarks, referred to having visited China, and I was pleased to be invited along. It was very informative for me. The minister was accompanied by Dr. David Butler-Jones. The purpose was to see how that part of the world, specifically China, where we had the early SARS incidents, had reacted to that and had prepared for the potential emergence of new diseases, and to look at the question of pandemic preparedness.

Could you discuss how we are prepared in Canada and how our trading partners are prepared, and the work that is being done in partnership with organizations like the World Health Organization? For example, we're worried now about Marburg and avian flu, and others. Perhaps you and Dr. Butler-Jones could comment.

Hon. Ujjal Dosanjh: I think I'll have Dr. Butler-Jones give you the details. Let me repeat what I said in my opening remarks.

The WHO made the comment some time ago, after looking at the level of preparation in different countries, that we're by far the best prepared in the world. That's not to say that we are perfect. We still need to do more work.

I'll let Dr. Butler-Jones give you the details.

Dr. David Butler-Jones: I guess there are a couple of things to add to the minister's remarks.

We are in a fortunate position, compared to many countries, in having a plan in place. The provinces and territories have their own plans, as well as regional plans, that all link together. It is an area where we had good collaboration with the provinces and territories.

In particular, a couple of examples are the ongoing committee that we share that continues to review the planning, as well as the purchase of antivirals that the provinces participated in, which are part of that plan. Hopefully, if this budget goes through, some money will go towards the development of a "mock" vaccine and the continued development of preparations.

We work very closely with the WHO and with our counterparts in other countries. Clearly, one of the things from China is that they have taken this seriously, post-SARS, which is very gratifying. There is a level of openness that had not been seen previously and a willingness and interest in collaborating with other countries to ensure that. We have scientists working in Angola, helping with the Marburg outbreak, as well as in North Vietnam in terms of the avian flu outbreak. It is an area where collaboration is increasingly the rule, and people are learning the lessons from SARS.

Hon. Ujjal Dosanjh: I would add that I understand Dr. Butler-Jones has to leave by 12:30, so if anybody has questions for Dr. Butler-Jones directly, perhaps the chair could allow that to happen.

Hon. Robert Thibault: Like all Canadian doctors, he has a busy schedule.

The Chair: That has not been indicated to me. Seeing as all the members will want to have a turn, I think I have to proceed with the speaking order.

Mr. Thibault, you have about two minutes left.

Hon. Robert Thibault: David Butler-Jones, like all other Canadian doctors, has a busy schedule and lots of appointments, I'm sure.

I'd like to return to a question that was asked by Madam Demers. I think there might have been some confusion in the answer. It's on the distinction between the drug formulary and the drug approval, and that it is two separate systems.

I'd like to explain that for the drugs that we underwrite for use by the people we have insured, the drugs might be approved for use in Canada and prescribed by physicians but not be on the formulary. Madam Demers' answer might have led to some confusion. I'd appreciate it if you could clarify that.

Mr. Ian Shugart: Madam Chair, the parliamentary secretary is right. Although this is one area within the national pharmaceutical strategy that was developed as part of the first ministers health care accord, it could well use some change and perhaps adaptation.

The criteria for making decisions about market access for drugs is on their safety, first and foremost, and then the question is on whether they do what they claim to do, their efficacy.

The question of their effectiveness in the real world population once these drugs are being used by patients, and then the cost-effectiveness of a medicine and how one particular therapy does compared to other therapies—or for that matter, no therapy at all—are among the criteria that are used for deciding what public systems will pay for on drug formularies.

I think it is widely recognized that we can do a better job of bringing to bear some of the decision-making and the evidence that go into both of those processes. Ideally, in Canada we should be moving to a situation where the evidence drives not only the decisions on access of new medicines to the market, but on the ones that are actually used in the clinical context and those that are supported by public funds on public drug plans.

● (1220)

The Chair: Thank you, Mr. Shugart.

Thank you, Mr. Thibault.

We'll move on. On your behalf, I would welcome Madam Bonsant, who is visiting our committee today.

[*Translation*]

Ms. France Bonsant (Compton—Stanstead): Thank you, Madam Chair.

Good morning, Mr. Minister. Sixty per cent of my riding, Compton—Stanstead, is rural. I have visited farms, and have been told by farmers that Quebec has a process for tracing animals. However, when we send our animal carcasses to a processing plant, they are mixed with animal carcasses from other countries.

I want to know whether Health Canada is aware of what is happening in the United States as regards mad cow disease. Inspectors lost their jobs over what happened.

I would like to know whether Health Canada carries out tests on animal carcasses from Uruguay, Brazil or the United States, because mixing beef from abroad with Quebec or Canadian beef may well result in the spread of certain diseases. I therefore want to know whether you carry out tests. If not, does your budget provide for you to employ inspectors to examine meat which comes from other countries in the world where the standards are perhaps different from those in Quebec and Canada?

[*English*]

Hon. Ujjal Dosanjh: I'll ask Diane Gorman, our ADM, to answer that question for you.

Ms. Diane Gorman (Assistant Deputy Minister, Health Products and Food Branch, Department of Health): Thank you very much.

I'm Diane Gorman, Assistant Deputy Minister of the Health Products and Food Branch.

The organization that does the work you've described is the Canadian Food Inspection Agency, and it does have a responsibility to track the animals and also to inspect products that are coming into the country.

In addition to that—and I shouldn't answer on their behalf—they also have a responsibility for monitoring the practices of other countries internationally: a product coming to the border is inspected at the level of the individual product, but they also know what the practices are in terms of how they handle animals in countries internationally. It's the responsibility of the CFIA.

[*Translation*]

Ms. France Bonsant: Are the tests carried out on live animals, or only on the frozen meat which arrives in Canada?

[*English*]

Ms. Diane Gorman: Products coming into Canada would be inspected in different ways, and again, I shouldn't answer on their behalf. Live products would be looked at differently from products that have already been slaughtered in other countries.

Your question goes much more to practices—how you would know about the health of the animal, which would be also monitored by them.

[*Translation*]

Ms. France Bonsant: It is absolutely shocking to read in the papers that American inspectors have lost their jobs because they found evidence of disease in American cattle. How can I be sure that this beef has not wound up in my fridge?

Ms. Diane Gorman: Once again, that would be a question for the Canadian Food Inspection Agency.

Ms. France Bonsant: In my case, I have some concerns, because diseased cattle may have got through, without our knowledge.

[*English*]

Hon. Ujjal Dosanjh: May I suggest to the honourable member that you put those questions to the CFIA, which is in the Department of Agriculture, or to the Minister of Agriculture, if he is before a committee?

[*Translation*]

Ms. France Bonsant: We were discussing health earlier, and food and health are closely related.

[*English*]

Hon. Ujjal Dosanjh: I appreciate that.

[*Translation*]

Ms. France Bonsant: Thank you.

Do I still have some time?

[*English*]

The Chair: You have two minutes.

[*Translation*]

Ms. France Bonsant: I'll hand over the floor to my colleague.

Ms. Nicole Demers: Thank you, Madam Chair.

My question is for Mr. Shugart. You said earlier that there may be changes in the licensing of certain drugs. I'd like to know if you're taking into account, in the case of drugs such as Aricept, Reminyl and Exelon, research carried out using a test called the Mini Mental, which quickly allows for an assessment of the deterioration and loss of independence of a person with Alzheimer's. As it stands, the test hasn't been approved. However, if people were to use the drugs I referred to earlier, their lifestyles would deteriorate half as quickly as without.

I personally know people who were on Aricept. Before taking it, they were no longer able to function. Two weeks after having started to take the drug, they were able to start living normally again. Tests such as the Mini Mental are very appropriate in determining whether or not to take the drugs. Do you intend to look into this as well?

● (1225)

Mr. Ian Shugart: Thank you, Madam Chair.

The question that is raised is technical and scientific in nature. In theory, within the department as well as under the regular process used to examine drugs, we use all available data, so as to be able to do a full assessment.

However, I cannot comment on any specific test. As Mr. Potter mentioned, we have access to a vast array of experts who contribute their expertise and up-to-date knowledge on new developments in the field of drugs. Everything is included in these two assessments.

Ms. Nicole Demers: Unfortunately, that doesn't seem to be enough. I don't believe we are strictly talking about scientific knowledge here. Other considerations should be factored in.

Thank you, Madam Chair.

[*English*]

The Chair: Thank you, Madame Bonsant and Madame Demers.

We'll now go to Ms. Dhalla.

Ms. Ruby Dhalla: I want to speak about another issue, which I think is incredibly important to a number of new Canadians and to Canadians who've been born and raised here but who go away to medical school and find, upon completing their education and becoming doctors, that they are unable to get back into the country. I have a number of constituents and friends just in the Brampton—Springdale area who face this type of challenge.

I think it was great that for the first time we had money allocated in our budget towards this. Could you please comment on what moneys will be utilized in terms of foreign credentials recognition and on what the department is doing to ensure that Canadians get access to doctors? There's a tremendous shortage in the country right now, and I think foreign credentials recognition is going to be a solution to that.

Hon. Ujjal Dosanjh: First of all, let me acknowledge the fact that you and the Honourable Hedy Fry and others have been working very, very hard on this issue to try to put together a program that brings all of the jurisdictions to work together.

As you know, much of the jurisdiction with respect to entry into these professions rests with the provincial governments, and we need to work with them. We have $75 million that we're going to be working with on these issues over the next five years to make sure that we have, if not a one-stop shop, at least shops where some of these newcomers are able to be integrated, whether they be Canadian young men and women abroad getting medical or nursing degrees or other technical skills in this field, or new immigrants coming with these skills from abroad.

I am sure that within the next week or so we will be unveiling the details of some of this work that you've been doing. Stay tuned.

Ms. Ruby Dhalla: Have there been discussions between the federal government and the CMA and the various other regulatory bodies in this regard? Perhaps the department could comment, or....

Hon. Ujjal Dosanjh: Well, there are several departments working together. The HRSDC, Citizenship and Immigration, and the Department of Health, or at least these three departments, have been working together on these issues. I am certain that individual departments have been talking to provincial and territorial jurisdictions within their own domains to determine what level of cooperation can be obtained.

● (1230)

Ms. Ruby Dhalla: The second question was in regard to the $42 billion deal for the health care accord signed with the provinces and the federal government. I think some months back, or when you spoke last year, they were in the process of establishing benchmarks and objective targets to achieve. Where are you in that process right now?

Hon. Ujjal Dosanjh: Wait Times Alliance, the Western Canada Waiting List, the ICES evaluation—all three have issued what they see to be appropriate benchmarks for wait times in cardiac, cancer, diagnostic imaging, sight restoration, and joint replacements. So the work is under way.

The provinces and territories, the Canadian Institute of Health Information, and CIHR are all working together to make sure that by December 31, 2005, we have the benchmarks in place across the country. Science is the same across the country. By March 31, 2007, we want to be in a position to provide a report about the progress we've made in reducing wait times.

I can tell you that provinces like Ontario, British Columbia, Alberta, Saskatchewan, and others have already made significant investments in reducing wait times and are succeeding to a certain extent.

Ms. Jean Crowder: With respect to the safety of our food and drugs, I was pleased to hear the minister say that he was looking towards more transparency. There's a lack of confidence out there, given what happened with the silicon breast implants. It was only after a public outcry brought this to the minister's attention that it was made a more public process.

On page 20 of the report on plans and priorities, it says that a number of novel foods such as genetically modified animals and plants will be submitted to Health Canada for review, authorization, and release to the Canadian market. On Bill C-27, a number of people came to the committee expressing concerns about the lack of attention to precautionary principles.

The forecast spending in 2004-2005 was $258.8 million as net expenditures. The planned spending in 2005-2006 is $234 million. It continues to decrease. Canadians are increasingly more concerned about the safety of their food supply and the drug approval process, given drugs like Vioxx, and Celebrex, and any number of others.

There are expected re-spendable revenues of $41.2 million projected for each year. I want to know specifically what's included in those revenues.

Hon. Ujjal Dosanjh: Diane, what's included in those revenues?

Ms. Diane Gorman: Let me start with your concerns about safety and the assurances that Canadians want to have. These numbers don't include some of our recent investments. This year the government invested $170 million in safety through the federal budget.

Ms. Jean Crowder: Where else, then, will those show up in the estimates?

Ms. Diane Gorman: Supplementary estimates. We have also gone to cabinet at various times seeking additional funds. About two years ago, we went to cabinet and received funding for something called the therapeutic access strategy, which had elements of safety in it. At that time, the minister offered to go back to cabinet to demonstrate how these early investments had resulted in improvements to our drug regulatory system. They declined, but that does not mean there is not a commitment to go back and demonstrate what we have done with the funds and how we plan to improve safety.

● (1235)

Ms. Jean Crowder: You talk about improvements in the process, but I think that flies in the face of people's perception. Last year the Canadian journalist association gave Health Canada the award for being the most secretive department in Canada.

If you're talking about improvements in process, I'd like to know if they include access and transparency. We've seen under the regulations under the pesticide act...I can't remember the proper name for it. The act was changed in 2002 and the regulations were developed, but they've never been implemented. Some of the commitments that were made around that process, for example, the public reading room, have never been put in place, so there's a bit of a challenge with what's on paper and the reality of what's happening.

Hon. Ujjal Dosanjh: May I just make some general comments about transparency? Then I'll let Diane answer this piece.

Ms. Jean Crowder: I want to ask another question on revenue.

Hon. Ujjal Dosanjh: Well, why don't you put that question in? Then we can answer them together.

Ms. Jean Crowder: Could you just explain what the incoming revenue is? There's $41.2 million shown in every year as expected re-spendable revenues, and I want to know where that money is coming from. Where are the revenues being generated?

Ms. Diane Gorman: In the mid-nineties—1995 in fact—the branch was given the ability to have cost recovery, as it was called at the time, directly from the industry. Fees were set at that time but for such things as where, if an industry wants to have what we call an establishment licence in Canada in order to manufacture pharmaceuticals, we inspect them and ensure they meet the standards that are required in Canada. Then they must, as a part of the licensing, provide funds to us.

Ms. Jean Crowder: So those are licensing fees?

Ms. Diane Gorman: That's one element of it. When a drug submission is made to Health Canada—and this is the practice internationally—it comes with a certain fee, which, as you can see, in no way covers our entire cost, but the fees were established in 1995.

Ms. Jean Crowder: Thank you.

Hon. Ujjal Dosanjh: Perhaps I'll make some general comments about our department-wide campaign to be more open and transparent. A long time ago, when I came eight months ago, I said we wanted this department to be an agent of change and to be activist, transparent, and more open. We've been trying very hard in all of the issues to be so, and I would urge the members to keep our feet to the fire on that score. I think the public has a right to know; that's the first principle, but if there is any information that needs to be confidential for commercial or proprietary purposes, so be it.

Ms. Jean Crowder: Then we'd really appreciate finding out if there's actually a Health Canada study on estradiol in the veterinary branch.

Hon. Ujjal Dosanjh: Absolutely.

Ms. Jean Crowder: Thank you.

The Chair: Thank you, Ms. Crowder.

Mr. Thibault.

Hon. Robert Thibault: I have a brief comment and then a question for the minister.

Madam Dhalla was talking about foreign credentials, and it's a problem across the country. There's the lack of doctors and health professionals generally, technicians, nursing staff, etc., a very big problem across the country. The rural areas suffer more, the outlying areas. It's much more difficult to encourage immigrants to go to those outlying areas, and it's much more difficult to bring the students who go away to study back to those areas.

For a lot of the problems the communities have found solutions in the community. I had the opportunity to sit the other day with a member of the hospital foundation in the Yarmouth area, and I learned they've come up with an imaginative solution. They are working on providing, for people who have had foreign training but don't have Canadian certification yet, space to be able to practise under the mentorship of Canadian medical professionals. It's not a very expensive proposal but I thought it a very elegant one, a very good way for those people to be part of the solution while they're getting accreditation so they can earn a good livelihood and continue to provide a service.

I would ask the minister that when he is doing his work with the other departments, with Madam Dhalla and her group and Madam Fry, they consider the possibility of giving financial assistance to projects like that, ones that might not necessarily fit into a mould but that are very good.

Another example of a solution being found in the community is also in Nova Scotia. Of all the categories that have wait times and that have been targeted as being in need of assistance in Nova Scotia, one where they were able to significantly reduce the wait times with a very limited amount of money was the area of cardiac surgery. They already had a lot of the elements of the solution. They had to realign them and I believe build one more operating theatre, and they have brought the wait times down substantially in Nova Scotia.

As I understand it, they can target the money that is being transferred to them towards other areas of wait time on the list, so it's not a cookie-cutter approach.

● (1240)

Hon. Ujjal Dosanjh: That's true.

Let me answer the latter question first. There are five priority areas we all agreed to work on, but we also acknowledged the fact that if those aren't the areas that are most troubling in any particular jurisdiction, they can work in other areas. So it's absolutely wonderful that they're already succeeding.

We need to find creative solutions to these kinds of issues. Sometimes the solutions are just there and you need to be able to think and visualize them. We are in fact always supportive of, through pilot projects, trying to find creative solutions to the integration of medical professionals or any other area of health care. I think the suggestion you make is wonderful.

In terms of the rural health and general health care, part of the goals and objectives established in this accord is the undertaking that by 2011, I believe, if I remember correctly, or 2009, we have to have 50% of the population in this country cared for by multidisciplinary teams under one roof so that they don't always have to end up in a hospital. If one doctor isn't available, there's another doctor or a nurse practitioner, or someone else who is available. I think that would be a great way of easing burdens in areas where we need to ease them. I think all of the jurisdictions are working towards that.

Hon. Robert Thibault: I have a last question for the minister.

In the last two budget speeches we found $170 million being invested to expedite the approval process for new drugs coming on the market to try to improve that. That was a few budgets ago. Now we see $170 million to create transparency and give confidence that the system is working appropriately. A cynic could say that it's money working against money. I'm sure it isn't. Could you please explain what the purpose of these announcements is?

Hon. Ujjal Dosanjh: There is always a push on the part of Canadians to have easy and quick access to newer drugs as they come on the market. So we needed to deal with the access to those drugs. We needed to put some resources in that part of the spectrum.

I think what we now are doing is putting money into other parts of the spectrum—the post-market surveillance, the adverse drug reactions, and whether or not there ought to be conditional approvals—and that there ought to be more transparency in the total spectrum from the beginning to the time the drug is on the market and continues to be on the market or is taken off the market. All of that should be covered by huge transparency and openness. Canadians need to know why we're approving drugs, what information we have, what the good, bad, and the ugly are of the clinical trials, and then Canadians need to know how the drugs are performing once they're on the market.

Hon. Robert Thibault: Thank you very much.

The Chair: Thank you, Mr. Thibault.

All members of committee have spoken with the exception of Mr. Lunney, who has ceded his time slot to Mr. Merrifield.

Mr. Rob Merrifield: Thank you.

I want to clear something up, Mr. Minister, and actually put your mind at ease a little bit with regard to dollars in health care. We've always supported more dollars in health care. We supported that in the 2003 accord and the 2004 accord, so I hope that gives you some comfort as far as sustaining health care in the long run is concerned.

We're a little concerned about some of the accountability, or lack of it, that we've seen out of the 2003 accord. I'd like to go back to what Mr. Thibault was talking about with regard to human resources. I believe Ms. Dhalla was concerned about it as well. In the 2003 accord, $90 million was to be applied for human resources. Of that—and I actually put this on the order paper trying to find the information out—only $10 million has actually been spent on it. There's another $8 million over a five-year period, and only $5.2 million of that was actually spent. But we asked the question: before you even get into how you're going to spend it, and deal with human resource shortages, you should have an idea of how many doctors and how many nurses we're actually short in the system over the next five years, over the next ten years, over the next twenty years, how many we're going to need. I couldn't believe it when the answer came back: you don't know.

You have enough people around the table—I wonder if you could clear that up for us.

● (1245)

Hon. Ujjal Dosanjh: I think that in terms of the numbers of how many more doctors or nurses we need across the country, the CMA in fact have those numbers. Whether or not those numbers in themselves are reliable.... I don't recall the numbers, but there are numbers available for experts and others.

Mr. Rob Merrifield: Well, I know they have their numbers, and the nurses have their numbers, but I would think your department should know what you're at least targeting for the next five, ten, twenty years. I couldn't believe my answer coming back saying there's no answer.

Mr. Ian Shugart: Well, I don't think it would be quite no answer, but the truth, Mr. Merrifield—

Mr. Rob Merrifield: I didn't get—

Mr. Ian Shugart: —is that we don't know the details we need to know if were going to have the health human resource planning and decision-making in the future that is required, which is why we are using some of that $90 million...it's $85 million, actually, as a result of some reductions in the 2004 budget.

There is a very substantial exercise going on with the provinces to bring everyone to the table to do the data development, the forecasting of needs that will allow us to assess needs in the future. We know some of the areas where there are very concrete numbers—planned retirements, for example—in each of the professions, but we don't know the out-migration, for example, in any given year. There is a very substantial piece of work going on to improve the data development, the data gathering, so we will be able to forecast further.

Mr. Rob Merrifield: So you don't know now. It's a bit of a guess, but I would think at least the answer would have come back that you were projecting this, you're projecting that, you're projecting it. Those numbers of projections, based on demographics and normal trends of when people retire and so on, but—

Mr. Ian Shugart: And we're working to develop those now.

Mr. Rob Merrifield: I'm amazed we don't know that at this present time.

Anyway, let's get on to another subject. Very quickly—and I'm very concerned about this one—we've talked about smallpox vaccine here in this committee. We have six million doses in Canada, and I guess the game plan is to be able to divide that five ways, if a smallpox outbreak happened here in Canada. This is old vaccine. My information tells us two things: one, we don't know if the vaccine's going to work; two, we don't know what timeline it's going to take to be able to split them. My question to the minister is why would we go with the old vaccine, when we're the only one of the G-7 countries taking this approach?

Hon. Ujjal Dosanjh: I understand there was scientific work done on that and an assessment made on that. In fact, this vaccine is true and tested and tried. The new vaccine is not.

Mr. Rob Merrifield: You have guaranteed that this old vaccine will work?

Hon. Ujjal Dosanjh: This is the old vaccine and—

Mr. Rob Merrifield: Do you have clinical trials to show it will work?

Hon. Ujjal Dosanjh: Well, the clinical trials are going to be under way—

Mr. Rob Merrifield: Going to be under way?

Hon. Ujjal Dosanjh: Yes.

Dr. Butler-Jones will have all the details. That's why I was suggesting that if there were any questions in his area, he is fully familiar with all the facts. I'm only familiar with part of the facts. We'll be happy to get back to you, but we've gone through an assessment and reassessment of that issue. I can tell you, from all of what I have read, I am confident our plans are very good—at par with, if not better than, the other jurisdictions.

Mr. Rob Merrifield: We're talking about estimates. I know you're just doing clinical trials, starting to do clinical trials, on that vaccine.

Hon. Ujjal Dosanjh: You know that.

Mr. Rob Merrifield: Yes, I know that.

How many dollars?

Hon. Ujjal Dosanjh: There you are.

We'll be happy to get back to you. I'll get Dr. Butler-Jones to get back to you.

Mr. Rob Merrifield: But you don't have a number—you don't have a projection, a budget, to know how much?

Hon. Ujjal Dosanjh: No, I don't have.

Mr. Rob Merrifield: Well, okay. It's amazing we would take this approach. I wish you would put my mind at ease a little bit by giving us some information that would clarify why we'd take this approach when the United States is looking at the new vaccines, not the 30-year-old stuff—and the price of it. I don't know why we'd take that approach. That's not a decision for Mr. Jones, that's a steering direction from the minister.

● (1250)

Hon. Ujjal Dosanjh: Let me disagree with you a little bit, with respect.

These decisions are based on science. Science comes to the minister and to the DMs and tells them what is feasible and what is not feasible. Based on that, they make recommendations. Invariably, you accept those recommendations because they're based on science. The information we have is that our assessment is sound, and that we can multiply the 6 million into 30 million.

The clinical trials are going to be under way. In fact, if I remember correctly—it was some time ago I was made aware of all these issues—the shelf life of the vaccine that you're suggesting is very short. You have to replace it every few years. Now, you're into science. I'm not a scientist. You may be. I think those are the kinds of issues that Dr. Butler-Jones can address for you.

Mr. Rob Merrifield: Okay. If I can get into that—

Hon. Ujjal Dosanjh: If you want those in the public domain, in terms of a letter written to you, he'd be happy to write a letter and put them in writing.

Mr. Rob Merrifield: I would appreciate that.

The Chair: Thank you, Minister, and thank you, Mr. Merrifield.

Everyone has had a chance to speak, so on behalf of members, I would like to thank Ms. Gorman, Mr. Potter, Ms. Cousineau-Mahoney, Mr. Shugart, Mr. Rosenberg, and of course the Minister of Health for coming to us today and answering our questions, enhancing our knowledge of the spending plans of the department.

In a minute we're going to proceed to our responsibility to vote on the estimates. The minister's team is welcome to stay, if they choose, but we would understand if they have to leave.

That would be your choice, Minister.

Hon. Ujjal Dosanjh: I'll leave, thank you.

The Chair: Okay.

We'll take a break while the minister and his team leave the room, and then we'll proceed to the votes.

● (1252)

(Pause)

● (1254)

The Chair: Order, ladies and gentlemen.

I would refer you to the document that is very simply called, on the front, “Health”, page 14. The overleaf, 14-2, lists the votes.

It's page 27 in French, Madame Demers. Do you have it?

[*Translation*]

Ms. Nicole Demers: Yes.

[*English*]

The Chair: Good.

Now, we need seven people and we have seven people. Thank you.

We have a series of votes: votes 1, 5, 10, 15, 20, 25, 30, and 35. I am at your pleasure. We can do each one as a separate vote or we can do them en bloc.

● (1255)

Mr. Steven Fletcher: Madam Chair, just do them en bloc.

The Chair: Mr. Fletcher is suggesting that we do them as a package. Is there any disagreement with that?

Mr. Rob Merrifield: Actually, there is one that catches my eye—the minister's salary and motor car allowance. I'm wondering if he should really walk for a while.

The Chair: I think, Mr. Merrifield, if your party has its way, he'll probably have a lot of walking to do; I don't think we need to accommodate it.

Mr. Rob Merrifield: And he should walk with us.

The Chair: I need unanimous consent to do this as a package.

Some hon. members: Agreed.

The Chair: Shall votes 1, 5, 10, 15, 20, 25, 30, and 35, minus the amounts that have already been approved in interim supply, carry?

HEALTH

Health Department

Vote 1—Operating expenditures.....$1,552,618,000

Vote 5—Grants and contributions.....$1,201,794,000

Canadian Institutes of Health Research

Vote 10—Operating expenditures.....$37,910,000

Vote 15—Grants.....$734,660,000

Hazardous Materials Information Review Commission

Vote 20—Program expenditures.....$2,897,000

Patented Medicine Prices Review Board

Vote 25—Program expenditures.....$3,848,000

Public Health Agency of Canada

Vote 30—Operating expenditures.....$234,719,000

Vote 35—Grants and contributions.....$164,009,000

(Votes 1, 5, 10, 15, 20, 25, 30, and 35 agreed to)

The Chair: Shall I report main estimates 2005-06 to the House?

Some hon. members: Agreed.

The Chair: Thank you very much.

I have only one question for my colleagues, and that is about our schedule. It seems we have a great number of witnesses wanting to come on Bill C-420. I've asked the clerk to add another meeting on another Wednesday.

Are you agreeable? Because I don't see how we can do it—

Mr. Rob Merrifield: Is that a whole day?

The Chair: No, no, just a regular meeting, 3:30 to 5:30. Otherwise, I would have to get rid of the meeting on the report we wanted to hear about, on assisted human reproduction. Remember, that was put in on one Wednesday. The following Wednesday, we'll add another one for Bill C-420.

Mr. Steven Fletcher: When would that be? What date were you looking at?

The Chair: We have witnesses on Bill C-420 starting on May 2; all day on May 3; on Monday, May 9; on Thursday, May 12; and on Monday, May 16. That would mean clause-by-clause on Tuesday, May 17.

Mr. Steven Fletcher: What about May 20?

Ms. Ruby Dhalla: What about May 19?

The Chair: May 19 has been reserved for the scientists from Health Canada.

May 20 is a Friday. Did you want to stay?

Mr. Steven Fletcher: Yes, I'm very keen.

The Chair: I think I have not seen any protest to that suggestion of flight rearrangement....

Mr. Lunney.

Mr. James Lunney (Nanaimo—Alberni, CPC): Rather than just consider an extra reading of two hours, we need to consider the number of witnesses who are asking to come, and the practicality of seeing them even in that amount of time. It seems to me we're going to need a couple more days.

Actually, if you want to give more than five minutes for the witnesses to speak, some of them.... For instance, Dr. Hoffer is coming from Victoria. He's 88 years old, but he is one of the deans of orthomolecular medicine in Canada.

We need to give these witnesses due time if we're going to do this. Whether we actually end up being here is another question.

The Chair: Let's see how we do in the early going.

Mr. Steven Fletcher: Is there time in June?

The Chair: There's lots of time in June. We hope to do a good job on Bill C-420. I think we should see how we do. Suppose we have a meeting on a Wednesday at 3:30 and we find out we have half a dozen witnesses. We may have to bring in dinner and go into the evening. That's a possible solution.

Mr. Steven Fletcher: Can we schedule to June?

The Chair: There are a lot of possibilities. We're having a week's break. I think we should reassess when we come back.

Thank you, ladies and gentlemen.

This meeting is adjourned.

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