House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 030 • 2nd SESSION • 39th PARLIAMENT

EVIDENCE

Thursday, May 15, 2008

Chair

Mrs. Joy Smith

Standing Committee on Health

Thursday, May 15, 2008

● (1130)

[*English*]

The Vice-Chair (Mr. Lui Temelkovski (Oak Ridges—Markham, Lib.)): I now call the meeting to order.

Pursuant to Standing Order 81(4), we are considering main estimates 2008-2009, votes 1, 5, 10, 15, 20, 25, 30, 35, 40, and 45 under Health, referred to the committee on Thursday, February 28, 2008.

Today we have the minister with us. Minister, you've been here before. We'll have you give us a statement and then we'll go through the questions. It's a pleasure to have you with us.

Hon. Tony Clement (Minister of Health): Thank you very much, Chair, and welcome as well to members of the committee. It's always nice to be here.

I'm addressing the health portfolio's main estimates for 2008-2009, of course, and I have with me and am pleased to introduce our deputy minister of Health Canada, Morris Rosenberg; Alfred Tsang, who's the chief financial officer for Health Canada; and on the Public Health Agency of Canada side we have Dr. David Butler-Jones, who's the chief public health officer, and James Libbey, who is our chief financial officer. I may from to time, if it pleases the committee, turn to them to assist me with any technical matters that might arise in answering your questions.

[*Translation*]

To begin, I'm happy to be appearing before this committee during what has been a very active time for the portfolio.

We're taking action and making good on commitments for a healthier environment, safer communities, safer food, health and consumer products, along with more patient-centred health care. In doing so, we're building from the expertise of our officials as well as provinces and territories, health care stakeholders, first nations and Inuit community leaders, patients and industries.

[*English*]

Our range of partners needs to be broad because our policy spectrum is wide. Health policy is not only about working with doctors and nurses on dealing with illness, but working with all sectors of society on promoting health.

As written in the Ottawa charter, signed at the first international conference on health promotion on November 21, 1986,

> Health promotion goes beyond health care.
>
> Health promotion policy combines diverse but complementary approaches including legislation....

It is characterized by action that

> ...contributes to ensuring safer and healthier goods and services, healthier public services and cleaner, more enjoyable environments.

Mr. Chair, as you can see, those words do well at defining and explaining the approach of today's federal health portfolio, and therefore, I would put it to you and the committee, these main estimates.

For instance, we know that more than two-thirds of deaths in Canada are the result of chronic diseases. These estimates thus contain an incremental funding increase of $8.6 million, for instance, for our integrated strategy on healthy living and chronic disease, which encourages healthy living and includes disease-specific strategies for diabetes, for cancer, and for cardiovascular disease.

These estimates also include an increase of $2.7 million for new and ongoing public health information programs, including our healthy pregnancy initiative and the children's fitness tax credit campaign, which of course raises awareness of the credit and encourages families with children under the age of 16 to be more active.

In addition, I want to highlight that these estimates refer to $10.65 million annually to renew our response to hepatitis C. This will be spearheaded by the Public Health Agency as it works closely with community and provincial and territorial partners to implement a renewed prevention, support, and research program.

Planning our preparedness and response to a pandemic also remains a priority. We are implementing a balanced, multi-faceted approach that includes securing a domestic vaccine supply, as well as a comprehensive pandemic influenza plan. Stockpiling of antivirals, of course, and other public health measures are included to minimize the impact of a pandemic. Indeed, we have now reached our target for the purchase of 55.7 million doses of antivirals for the national antiviral stockpile, the number of doses estimated to treat all Canadians who become ill in a pandemic and who require and seek medical attention.

On top of this, the main estimates contain a $28.3 million increase for a cleaner, healthier environment. This includes a $17.4 million increase for the chemicals management plan. Through this plan we've committed to assessing chemical substances used by industry that are of potential concern. We are challenging industry to show they're using them safely and we're taking decisive action to protect the public.

Health Canada's assessment of bisphenol A is a great example of how we have moved forward, because as long as no new compelling information arises during the current public comment period, we will be moving to ban the importing, selling, and advertising of polycarbonate baby bottles. The assessment found that when it comes to its use of producing items like hockey helmets and DVDs, BPA is not a concern, but when it comes to polycarbonate baby bottles, there is a risk that very hot liquids may cause the chemical to leach into the formula, be ingested by newborns and infants, and possibly have negative effects on their development. As a result, we're acting promptly on our knowledge and taking action to best protect our kids' health.

Mr. Chair, our estimates also include a very important investment to protect the health and safety of our youth and communities. On April 29 I had the pleasure of joining the Minister of Justice and Minister of Public Safety in announcing $111 million for critical drug treatment and prevention initiatives for provinces and territories under the national anti-drug strategy.

● (1135)

[*Translation*]

Under this strategy, we're strengthening enforcement as well as treatment—and providing help to parents in talking to their kids and protecting them against the threat of illicit drugs.

[*English*]

I'm proud to say that these main estimates also include a contribution of more than $27 million to support our awareness-building efforts and implement our treatment actions. With the recent announcement of a $230 million investment over five years, our government is investing more than any previous government in order to safeguard Canadian families from illicit drugs.

Alongside this unprecedented action for safer communities, we're also moving forward with action for safer products. As you know, the Prime Minister announced Canada's food and consumer safety action plan last December. Although it is not covered in the main estimates and will be discussed later this year during supplementary estimates, budget 2008 backed this plan with a two-year investment of $113 million. On April 8 we moved this plan forward by tabling Bill C-51 and Bill C-52.

[*Translation*]

Respectively, they seek to modernize the Food and Drugs Act, which has not been upgraded for some 40 years, and replace Part I of the Hazardous Products Act, which was written in the late 60s.

Together, they propose important tools to strengthen Canada's approach to safety.

[*English*]

These bills represent important action—the important action we need to take to better protect Canadians in a modern world. I look forward to discussing them in greater depth with you in the weeks to come, as those bills come before committee.

However, right now I want to address our proposed approach to strengthening drug safety under Bill C-51. There are some who are maintaining that this bill will in some way weaken our drug approval process. I want to say right here and now that this is not the case—in fact far from it. The current process calls for a vigorous assessment of health products before they gain access to market, and under Bill C-51 that won't change.

Hon. Carolyn Bennett (St. Paul's, Lib.): On a point of order, Mr. Chair, Bill C-51 will come to this committee at another time. This is about the estimates.

The Vice-Chair (Mr. Lui Temelkovski): I'm sure the minister doesn't have much to say about Bill C-51 right now.

● (1140)

Hon. Tony Clement: That's quite true, Chair. Let me just say that this government is for more safety, not less, and when these bills come to committee we'll have an opportunity to thoroughly debate those.

I want to emphasize that we know full well of the immense importance of strong support for health research and health care. Our main estimates back this assertion with action. For example, we know very well that health research is the backbone of effective health policy. As a result, our main estimates include an increase of more than $59 million to the Canadian Institutes of Health Research. With this funding CIHR will support excellent health research and turn the knowledge into concrete benefits for Canadians, including better health, a stronger health care system, and a stronger economy.

In addition, the estimates contain increases for quality health care. For example, there's an additional $60 million to address the health needs of the growing first nations and Inuit populations and to improve health care delivery through greater integration with provincial and territorial health systems.

There's also support for the commitment we made to working with provinces and territories to develop patient wait-time guarantees.

[*Translation*]

In March 2007, each province and territory agreed to develop and implement a guarantee by 2010, in either: cardiac surgery, cancer care, joint replacement, sight restoration or diagnostic imaging.

Budget 2007 provided more than $1 billion to support their efforts.

[*English*]

One key component of this investment, which is included in our main estimates, is funding for interested provinces and territories for pilot projects to test innovative approaches to establishing guarantees. So far I've had the pleasure of announcing projects in Nova Scotia, Manitoba, and P.E.I.

In closing, Chair, I'm very confident that the actions we're taking today within Health Canada, in research settings throughout Canadian society, and within these main estimates, along with the steps we're taking through legislation and regulation, are getting results for Canadian families. I want to assure you that our government is dedicated to building a safer, better Canada. The actions of the health portfolio are strongly supporting this objective.

With that, I want to thank you again for the opportunity to provide my comments. I would be pleased to take any questions that might crop up at committee.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much, Mr. Minister.

I am advised by my very capable adviser, the clerk, that this will be in discussion of vote number 100, the Health Act.

Dr. Bennett, you have 15 minutes of questions and answers.

Hon. Carolyn Bennett: Excellent. Thanks very much.

Thank you very much for coming. It is always a pleasure to be able to look at whether we're putting our money where our mouth is in terms of the most cherished program of Canadians. My questions will probably deal with three areas, more around partnerships and relationships than actually around the money. I think a laudable new goal for the Public Health Agency is around health disparities.

I'd like to just begin in terms of the rather lofty phrase at the beginning of your page 9, on “Health Canada: A Partner in an Interwoven Community of Stakeholders”. The number one bullet says:

> provinces and territories—who bear primary responsibility for health care administration...and have their own roles in health protection and promotion. A strong relationship with provincial and territorial counterparts is a critical factor in achieving our mandate;

I guess I would first like to ask the minister why, then, he cancelled the meeting with the other provincial counterparts in December and has again refused to meet with them this spring at all, particularly in view of the rather damning report of the Auditor General in terms of being able to get agreements with the provinces on the reporting of particularly infectious diseases, such that you wouldn't be able to report in a timely fashion to the WHO. She has identified the fundamental weaknesses in the surveillance system and is saying that this has not made satisfactory progress on strategic direction, data quality, due to gaps. You're not—particularly at the Public Health Agency—receiving timely, accurate, and complete information. It's impossible to get a consistent national picture on infectious diseases, and therefore you are unable to obtain the information necessary to prevent and respond to a disease outbreak.

So I'm very concerned that we can't meet around a table and negotiate this important next step, particularly when the public health network has been cited as one of the most important things in 30 years in Canada.

Out of the 10-year plan, things like being able to set goals and targets for improving the health status of Canadians through a collaborative process, all of these things that require partnerships you seem not to have done.

Sadly, at the committee, as we're doing the post-market surveillance, it seems that the national pharmaceutical strategy has ground to a halt in terms of even the federal co-chair not being named.

Tell me about how you're going to have a partnership with the provinces when they think they have no partner with you.

● (1145)

Hon. Tony Clement: Thank you for your questions. I appreciate that very much.

First of all, it was unfortunate that the last federal-provincial-territorial meeting was cancelled. It wasn't cancelled by me. Unfortunately the co-chair was Saskatchewan. They were having the election, and then the post-election period in Saskatchewan, with the change in government. The collective decision of all of the partners, including the provinces and territories, was that this was not an ideal time. In fact, many health ministers cancelled out of the meeting before a decision was made by the co-chairs to not go forward.

I am very much looking forward to having our meeting this fall instead. In fact, I can assure this committee that I've had many successful bilateral meetings with ministers of health. Just recently, this week, I met with the Minister of Heath from Nunavut. Last week I met with the Minister of Health for Alberta. I could go through the list—the Minister of Health for P.E.I., and so forth.

That has been a priority of mine, to at least have these bilateral discussions as much as possible, in the absence of a multilateral meeting.

On infectious diseases, perhaps I might just defer very quickly. I know you want to preserve your time, but if Dr. Butler-Jones can talk about the Auditor General's report, I think that would be helpful to the committee.

Dr. David Butler-Jones (Chief Public Health Officer, Public Health Agency of Canada): Certainly from our perspective the AG's report was actually a good-news story in the sense that she recognized that we have made tremendous progress since the formation of the agency. The areas she focused on for further work were around formal agreements, for instance, for routine information. There was the concern or the question of the possibility in an outbreak—she didn't say it was happening, because it isn't happening, we are getting the information we need—that we might not get that information.

The reality is—as we saw with the people on the train in northern Ontario last Friday—the system does work. We do get the information we need, we do coordinate and collaborate very effectively with the provinces and territories, and we have the processes and protocols in place. I expect shortly we'll have those formal agreements for routine information-sharing as well. We do actually have an agreement for information-sharing that all ministers have agreed to. We're just finalizing some final wording, but they have agreed to it, in principle, across all jurisdictions for the sharing of information in emergencies.

Finally, the WHO tells us that 40% of all their reports from around the around come from us first. Our surveillance system actually identifies things before the countries themselves know about them, and most countries look to us as a model for how we do that work with provinces and territories.

Thank you.

Hon. Carolyn Bennett: Mr. Chair, I would like to focus on the money now, in that it seems disappointing, with the aging demographics and the challenges that the summary information shows, that by 2010-2011 the ministry will have less money than they will have this year.

I don't know how one explains that the budget for the whole health portfolio goes down, but particularly in terms of the main estimates for the Public Health Agency that it would go down from $658.3 million to $590.5 million. I think it is extraordinary that in things like health promotion, the planned spending can go down to $197 million by 2010. The money for public health capacity goes down, the money for infectious disease goes down. Emergency preparedness is the only thing that seems to stay. Is that not embarrassing?

And the one thing I'm sure the minister expected us to ask, and which every day we're being asked by community organizations: what is going to be the funding on HIV/AIDS? I wonder if the minister would like to tell me how many new HIV/AIDS infections there are per year and how he can justify cutting community funding and not even letting them know how much money they will have so they are able to plan.

These organizations want long-term, medium-term.... They don't even know the short-term funding now, and it's not clear in the estimates. I'd like to know whether the money for the vaccine initiative has been used. And when was the last time you met with the ministerial council on HIV/AIDS in terms of what I think is their concern?

So the community is furious, as you know. They don't know what to spend, and yet cases of HIV/AIDS are still climbing in this country.

● (1150)

Hon. Tony Clement: Thank you for your comments.

Certainly I wish committee members to know that this year in the 2008-2009 budget we're putting more than $84 million toward HIV/AIDS, which is more than has ever been spent by the Government of Canada in our country's history.

The budget cuts the member is referring to are those that were found in the 2005 Liberal budget, which of course, despite the Conservative Party's position, was passed by Parliament, and we have an obligation to implement those cuts as a result of the 2005 Liberal budget.

Hon. Carolyn Bennett: Minister, with due respect, you have choices to make every year, and those were Treasury Board allocations, as you know, so don't go there.

But explain to me why your overall budget is down for all of health, and for all of public health in your projections. It seems to be very difficult for you to go downtown and get the money.

Hon. Tony Clement: Part of it is because sunset funding requirements are found as a result of Treasury Board requirements.

You might want to say something, Mr. Tsang.

Mr. Alfred Tsang (Chief Financial Officer, Department of Health): Mr. Chair, there are indeed some sunset programs there during that intervening period. The flip side of that is that incremental funding has been announced, for example in budget 2008, that has not shown up in the main estimates only because of a timing issue.

And equally, as I was saying, there are some sunset programs during that intervening three-year period for which Health Canada may wish to seek incremental funding from the government too. So there's a timing issue related to that trend.

Hon. Tony Clement: And there was a final thing—

Hon. Carolyn Bennett: Sunset is a passive activity. You can choose not to sunset programs, and things like the primary health care transition fund, which people had thought was doing good work, you chose to let sunset. These are ministerial decisions, and I don't think the bureaucratese is very helpful to Canadians as to why this government would be choosing to reduce the budget for health and health care for Canadians over the next five years in what they are able to do within the whole of the health portfolio, but particularly in the area of public health in terms of what we know is the number one goal of medicare, which is to keep people well, and not to patch them up once they get sick. This is a shared responsibility. How on earth can you defend the money going down?

Hon. Tony Clement: Sure. As I said, there are sunsets, there are one-time expenditures where the budget goes up and down, depending on the one-time expenditures. But to say we're spending less on health care is false.

When you look at the ten-year accord on health care renewal that was signed, which we have implemented, that means extra transfers to the tune of $1.2 billion to the provinces this year alone, extra, for health care.

You mentioned the primary health care transition fund, but that was part of the 2004 deal. You were a member of the government that signed that deal, which wound down that program. So I certainly feel no need to defend your decision.

Hon. Carolyn Bennett: In the Public Health Agency, on page 9, the notable change was that healthier Canadians reduced health disparities in a stronger public health capacity. Now, we've already dealt with the fact that the budget for public health capacity is going down—which I don't really understand at all. But I guess I'm most disturbed, in terms of the program activity for first nations and Inuit health, that the planned spending for 2010-2011 is dramatically reduced, in terms of gross expenditures, as is even the number of people doing it.

In terms of what we've known about equity and the things that work best, the health human resources of our aboriginal people—this is the $100 million that I've asked you about many times—how many more aboriginal physicians and aboriginal nurses are we able to show for the $100 million that was put into the health accord? Not just cultural sensitivity and nice things that we want all Canadians to do, but how many more aboriginal nurses and how many more aboriginal doctors do we have in this country?

How on earth can you be reducing the money in the program activity on first nations and Inuit health at the same time as you are saying that you want to reduce health disparities? We know this is the biggest embarrassment for our country: the gap in health status of our aboriginal peoples.

● (1155)

Hon. Tony Clement: Thank you for that.

I'll just give you some raw statistics.

Through the aboriginal health human resources initiative—which, as you say, has been funded, and we support that—we have been able to more than triple the number of aboriginal health care students receiving support. So there are over 1,100 bursaries and scholarships that have been awarded in the program, and over 60 aboriginal medical students are part of that funding. So I believe that we are being helpful to the needs in the community; there's no doubt about that. As these estimates show, we have in fact injected many tens of millions of dollars more into the first nations and Inuit health branch for the provision of services.

We know that the populations are rapidly increasing to a greater extent than the population as a whole, so we have more people who need more medical services. We're certainly trying, at the same time, to transform the system, because I have a great deal of concern about the sustainability of the system for first nations and Inuit health. That's why we're working with the leadership—and the provincial leadership—to try to get to some better health models and some better health results. So I think we're on the same page on that.

Hon. Carolyn Bennett: Except that on page 66 the gross expenditure for first nations and Inuit health programming and services goes down.

Hon. Tony Clement: In each budget there's a one-time expenditure that seems to be added on to this budget. We have a one-time expenditure this year that goes towards meeting the services but also goes towards this transformational funding that is designed to help us get to a better place when it comes to the long-term sustainability of the program. So as the program gets transformed, then of course you don't need the transitional funding for that transformation.

Hon. Carolyn Bennett: And that explains the 150 fewer staff.

Hon. Tony Clement: No, but—

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much, Minister.

Thank you, Dr. Bennett.

We'll move on to Madame Gagnon, *pour dix minutes*.

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): Thank you, Mr. Chairman.

I'd like to continue the discussion on the aboriginal clientele, for which the federal government is the first level responsible in health. This week, the committee heard from representatives of the Wait Time Alliance, the organization that is supposed to provide information on the evaluation that was done on the achievement of the objectives of the 10-Year Plan to Strengthen Health Care.

As regards aboriginal people, no one had any information to submit to us on follow-up to the five priorities of the wait plans or on operations. On a number of occasions, I tried to question various witnesses who appeared before the committee regarding the 10-Year Plan to Strengthen Health Care so that they could show the government is serious. Earlier you told my colleague, Ms. Bennett, that you wanted to revolutionize the health system, but one witness said it is quite hard to revolutionize it when you don't have any data.

I particularly emphasize the case of aboriginal people, since you are responsible for their health and that is not a provincial jurisdiction. What are you doing to correct this lack of data? Do they need more support? We're talking about cuts to the main estimates. Are you able to help them more than you are doing now? Could there be a new plan in three or four years without you having achieved the desired objectives?

● (1200)

Hon. Tony Clement: I can certainly say a few words on that subject.

First of all, most of the time, the funding intended to improve aboriginal access to hospitals and health care is the responsibility of the provinces and territories. It is not direct funding.

The same is true of wait time guarantees. When we announced those guarantees to all the provinces and territories, each one promised to implement them. Those guarantees will benefit both the first nations and the general public.

As regards aboriginal people living on reserves, we have announced pilot projects offering guarantees, in particular a maternity program. That program is mainly intended for aboriginal people living on reserves.

All the programs will help to improve the situation. This is not a program or a system, but a strategy that embraces all our investments.

Ms. Christiane Gagnon: With all due respect, minister, allow me to doubt the human resource and funding efforts made to give a real hand to one of the clienteles that is a federal responsibility.

On a number of occasions, I have asked that the Standing Committee on Health conduct a survey on aboriginal health. We will definitely be hearing from witnesses. I'm sure we will hear another story regarding aboriginal people's demands to improve their health and the support that could be given to them in that area. Then the committee can hear from you again and provide you with a completely different report, a much more pessimistic and less optimistic report than yours.

You also announced a grant of $59 million to the Canadian Institutes of Health Research. I met a number of health researchers, and some told us that research demand had increased. However, as a result of a shortage of available funding, they had the impression that a number of research projects had been rejected in spite of the fact that they met the criteria.

How is it that a number of types of research projects are rejected and that the funding is lacking? Research laboratories often have to cut back their activities, even stop research, in some cases, for lack of money.

You say you're increasing the budget of the Canadian Institutes of Health Research. That means it's possible the money is being distributed less effectively.

Hon. Tony Clement: Today the government supports more than 11,000 health researchers in Canada. Our country of course has a lot of world renowned researchers.

[*English*]

There's a lot of competition for these grants, there's no question about it. But we think that by adding to our totals and creating....

There are a number of measures. There's a new Canada global excellence research chair fund, which I think will be helpful in a lot of these. We're putting more money into Genome Canada. I know we're funding stem cell research directly as well. There's a lot of very exciting world-class things that our researchers are involved in. The Government of Canada has certainly proven that we can be part of the solution.

● (1205)

[*Translation*]

We now have a new science and technology policy, which we call the Science and Technology Strategy. That strategy is important in ensuring the economy's future success.

[*English*]

It's not just for health care; it's for the economy as well. We will continue to support our researchers in health care as well as in many other areas.

[*Translation*]

Ms. Christiane Gagnon: Some researchers have told us that the funding application success rate fell from 30% in 2004 to 21% in 2007. That means a drop of 8.9 percentage points, a net reduction. These figures clearly illustrate the situation of many researchers.

Researchers are asking that the success rate of applications be restored to 25% because it has really dropped. They're not asking that it be restored to 30%, but at least to 25%. They're asking that there be a reinvestment because research in certain fields deserves to be pursued and researchers currently cannot continue.

I visited a number of small research centres, and you often see that small teams are conducting research on a shoestring.

Hon. Tony Clement: Yes, we've planned a change in leadership for that agency.

[*English*]

CIHR has a new leader. You probably know him as a result of his leadership in Quebec over the last few years.

[*Translation*]

I have every hope that, with this new leadership, we'll be able to work together to meet that challenge. Of course, there are challenges.

[*English*]

When one looks at the situation from a worldwide perspective, Canada is doing very well. We're considered a world leader in medical research. It's something we want to continue. Medical research has been identified as one of the top—

[*Translation*]

Ms. Christiane Gagnon: We must—

[*English*]

Hon. Tony Clement: —priorities in the science and technology strategy, so we will continue to make efforts for sure.

[*Translation*]

Ms. Christiane Gagnon: Some researchers are leaving Canada to go elsewhere because they can't continue their research. We have another vision of things.

Minister, you say you want to invest $111 million in the prevention and treatment of substance abuse associated with illicit drugs. I wouldn't want to quote you out of context, but you say you have a firm strategy.

We were quite concerned recently because you withdrew from the market a book that was designed to help fight drug dependence and address prevention. In Quebec, there was an outcry of protest from a number of sectors, the police and various observers in the field, such as university professors.

[*English*]

The Vice-Chair (Mr. Lui Temelkovski): Madame Gagnon, could you just ask your question?

[*Translation*]

Ms. Christiane Gagnon: It's been said that you want to exercise your veto on a matter of principle or out of a closed attitude toward this matter, which is important. That's a step backwards in view of the situation.

Hon. Tony Clement: We've announced a new national drug strategy. It's important that there be prevention and treatment strategies, and we've announced investments. I don't think the old strategies are suited to future situations. That's our decision, but it's supported by the public.

● (1210)

[*English*]

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much.

Madame Gagnon, thank you.

We'll have Mr. Fletcher, since Madame Wasylycia-Leis will be absent for a few minutes.

Don't get excited, Minister—she is coming back.

Mr. Fletcher.

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

I'd like to thank the minister and his officials for coming to the committee today.

I think I'll follow up on some of the themes that the Bloc brought up.

Minister, our government has announced the Mental Health Commission and a national anti-drug strategy, and they seem to have some crossover at some level. As you know, we committed $110 million over five years to the Mental Health Commission to study the most effective ways to address mental health and homelessness. The commission was set up to research projects on housing and other types of supports in major centres like Vancouver, Winnipeg, Toronto, Montreal, and Moncton.

My first question is what does the government hope will be achieved by the Mental Health Commission as they undertake their research in areas of homelessness, mental health, and addiction? I'd also like to ask how it fits in with the national drug strategy. Our government announced $64.3 million over two years, and that strategy is designed to reduce and prevent the use of illicit drugs, particularly among youth and aboriginal peoples, treating those drug dependencies and combatting the illicit production and distribution of drugs.

As you are aware, Minister, there have been many questions from both the media and members of Parliament about what the government is doing on the illicit drugs in Canada, particularly in Vancouver's downtown east side. What is being done to address illicit drug use across Canada in these vulnerable communities, and how does it tie in with the Mental Health Commission. Or is there a tie-in? There may not be.

Hon. Tony Clement: Actually, there is.

Certainly in a lot of distressed communities, where there's a high percentage of addicts, it's not just an addiction issue; it's a social supports issue generally. We feel that there has to be a national body of research on this—that was the money accorded to the Mental Health Commission—to pursue the pilot projects that you mentioned. It will create a national body of knowledge on how we can, through effective housing programs and social support programs, also have an impact on reducing addictions in some of these urban centres. Obviously it's not the whole solution for all of Canada, but I think it's a good start in dealing with these areas.

And of course one of the areas we're dealing with is the downtown east side of Vancouver. It's no secret that it's a distressed community, with over 5,000 injection drug addicts in a few square blocks. But at the same time, there are lots of people who do some wonderful work there. So we're going to be supporting them through treatment programs. We're going to be supporting them through these quick-response teams that we have funded, based on the announcement yesterday. And of course we're working in partnership with Vancouver Coastal Health Authority, with the mayor's office in Vancouver, and with the provincial government.

So there is a tie-in. You're dealing with not just an addiction issue or a homelessness issue, but also with a whole lot of social distress. That's why you have to look at it from a comprehensive point of view.

Mr. Steven Fletcher: Certainly I've heard many positive comments about how this government's looking at the whole perspective of the challenges in Vancouver's east side and across Canada. So I think we're definitely on the right track there.

To change gears a little bit, Minister....

It's unfortunate that the opposition members are heckling. I wish they would respect our ability to ask questions to the minister.

Many provincial governments have undertaken sustainability reviews and other publicly funded health care plans in the past year. The governments of British Columbia, Alberta, Ontario, Quebec, New Brunswick, and Nova Scotia have all concluded their reviews. With British Columbia announcing new legislation, the B.C. legislation seeks to enshrine the five principles of the Canada Health Act and add another principle: sustainability.

I wonder, Minister, if you could give us a perspective on the Government of Canada's plans for the Canada Health Act and how we are supporting the provinces to ensure that Canada Health Act goals are being achieved.

● (1215)

Hon. Tony Clement: Our party and our government support the pillars of the Canada Health Act, the principles that are enshrined in the Canada Health Act. Of course provinces are finding the need to innovate in their health care systems, and we support that. Quebec has done some quite far-reaching things in its system, and you mentioned the other provinces, including British Columbia, New Brunswick, Nova Scotia, and so on.

We do support those initiatives. One proviso, obviously, is that they have to be consistent with the Canada Health Act, but my view is that it is perfectly possible and appropriate to do a whole lot of innovation. You can do so within the Canada Health Act. There's a lot of innovation that can occur to increase accessibility, decrease wait times, improve management, improve accountability, improve sustainability, all of which can be done within the CHA, and we're very supportive of that. When provinces come to me, as they do frequently, and say they're thinking about doing this or trying that, I try to be as supportive as possible, as long as the principles of the Canada Health Act are not violated.

Mr. Steven Fletcher: Minister, there was some question from the opposition members about public health funding. Could you share with us how the Canadian Partnership Against Cancer and the cardiovascular strategy are reflected in the estimates?

Also, could you expand on the action the government has taken on transfats and sodium? That seems to be the topic of conversation among many people in the cardiovascular community. Given it is hypertension week, it seems like an appropriate time to ask you the question.

Hon. Tony Clement: Sure.

In terms of the Canadian Partnership Against Cancer, obviously there has been funding for that. There is also funding for research, for instance—-about $124 million—going to cancer research this year.

The strategy involves—and you were involved with this, of course, in your days in opposition, so I want to publicly commend you for all of the spade work you did for the Canadian strategy for cancer control. As you know, it's broadly based. It's multi-faceted. We have the provinces at the table. We have the cancer societies at the table and oncologists and cancer survivors. So I really think it is the wave of the future in terms of how we want to proceed. Indeed, it is animating our discussions on other disease-specific national initiatives, such as the cardiovascular strategy that you mentioned; it is probably a couple of years behind the cancer strategy, but is rapidly catching up. The diabetes strategy has been retooled and revamped, for instance.

You mentioned some of the work we've done on the transfat issue, which was a very hot issue around this place a few years ago, as you know, and led to the creation of the transfat task force. When we were in government we approved of their recommendations, and we've been busy working with them to reduce the incidence of transfat in a number of different foods. In fact, it seems to be working. There's a lot less transfat around now. I think it has been reduced by over 50% already, and we look forward to seeing them meet their goals in the next couple of years.

Mr. Steven Fletcher: How much time do I have left, Mr. Chair?

The Vice-Chair (Mr. Lui Temelkovski): A minute and a half.

Mr. Steven Fletcher: On the chemicals management plan, Minister, when we recently banned bisphenol A for baby bottles and things of that nature, I think that announcement touched a lot of people. I have a brother in California, and he actually heard about that announcement on the mainstream news in California, and he says he never hears about Canada in the news down there.

I wonder if you could tell us where you think the chemicals management plan is, where it's going, the costs associated with it, both upfront as well as the costs of not doing it.

● (1220)

Hon. Tony Clement: Thank you for that.

You're quite right that the bisphenol A announcement was carried world-wide. If mimicry is the most sincere form of flattery in politics, I noted that Senator Hillary Clinton introduced a Senate bill, basically mimicking what we're doing here in Canada. So it must be right, if she's doing that.

Looking at it, though, that was only one piece of a broader strategy, which again is world-leading, the chemicals management plan. We reviewed over 25,000 chemicals, legacy chemicals, as they're called. We identified 200 high-priority chemicals we wanted to get some research on immediately. The next stage is another batch, you should know. I guess maybe I'm releasing this a couple of days early, but there's another batch that will be gazetted in the next couple of days. There's another series of about 16 chemicals, I believe, upon which we have the research back and we'll be making some decisions on those as well, so you'll be seeing that.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much, Minister. Thank you, Mr. Fletcher.

Now we move on to Susan Kadis.

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

Welcome, Minister.

It certainly is the federal responsibility to work with the provinces to ensure there is surge capacity in the event of a pandemic, yet I'm not seeing anything in the estimates that would help hospitals cope with the demand for beds and care in the event of one, or to build the pressure rooms they would require.

Could you please explain how your plan you referred to before for pandemic preparedness addresses the matter of surge capacity in Canadian hospitals? As I'm sure you're aware, in Ontario Dr. McGeer, of Mount Sinai, and others in Calgary, etc., have raised serious concerns about the lack of surge capacity.

Hon. Tony Clement: I'll take a stab at that, and I'll leave the rest to Dr. Butler-Jones.

Certainly we are doing things within our federal mandate. One of those, as I mentioned, is the anti-viral stockpile, which is now up to the level that has been recommended by scientists. There is the work we've done on vaccine initiatives for a pandemic, and of course the structuring of our response on a national emergency plan, which we constantly work with the provinces on. We are responsible for our own jurisdiction. The provinces get increased transfers every year from the federal government, which they put to good use in their hospitals and with their doctors and nurses and so forth. That's how we help contribute to fund hospital capital and the surge capacity.

Dr. Butler-Jones might want to add to that.

Dr. David Butler-Jones: Just very quickly, within the federal role, and given the provincial responsibilities, in addition to coordinating activities so that we have a collective response nationally, we also have been adding to the national emergency stockpile in terms of mass anti-virals, etc. That's to go beyond what we've done jointly with the provinces and territories, to have that as a backup and support to that. As well as the facilitation of cross-jurisdiction licensing that we will have shortly, we have an agreement in principle around resource sharing between jurisdictions during public health emergencies, etc.

We're also developing a public health core—in other words, capacity that was there from a federal perspective to assist provinces as appropriate. So in the ways we can do that, within our jurisdiction we're continuing to try to build on that.

Mrs. Susan Kadis: Thank you.

If I have a little more time, Mr. Chair, I'd like to know the expiration date of the Tamiflu stockpile that was purchased by the government in 2006 and what the contingency is after that expires.

Dr. David Butler-Jones: There are two things. One is that there are variable dates because they were purchased at different times. Normally the expiry is five years, but we're working with the manufacturer and researchers and others, because we think the actual shelf life will be much longer and that there are other strategies to deal with that. In addition, we're in ongoing conversations with the provinces and territories about how to renew that, when and if that is required into the future.

Mrs. Susan Kadis: Finally, we heard testimony from the last witness that we're not anywhere near reaching our goal in terms of electronic health records. I think it's at 5%. We're trying to reach a goal of 50% by 2010, if I'm not mistaken. How are we going to reach that goal? I know our government had begun that process. You have added somewhat to it—modestly. But we're well below the goal.

It's such an important driver of improving Canadians' health and the health care system. Everyone is doing that globally. How can we expedite this? I believe more steps should be taken. I don't think we're going to reach that goal if we don't. What are your plans to do that?

Hon. Tony Clement: Thank you for the question.

I think the 5% number actually deals with family physicians; that's not a system-wide number.

In any event, you're an Ontario MP, and of course so am I, and I think we can honestly say that Ontario has to keep moving forward. They have not reached some goals. But if you were to travel to Alberta, British Columbia, the province of Quebec, other places, you will see that there has been a lot of movement in these areas. For instance, the capital health region, in Edmonton, and north, in Alberta, is going to be 100% EHR by the end of this year. So there are a lot of improvements happening.

Our goal, of course, is to make sure it's not lumpy. We have to make that happen throughout the country. That's why Infoway Canada is part of the solution.

● (1225)

Mrs. Susan Kadis: Thank you.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much.

We move on to Mr. Brown, for five minutes.

Mr. Patrick Brown (Barrie, CPC): Thank you, Mr. Chairman.

Thank you, Minister Clement, for being here again today.

I have three questions, and I'll just let you delve into them.

First, I remember having a conversation with you once about the recruitment initiatives the federal government has for doctors and the funds that were allocated over a four-year period. I found that intriguing. Perhaps you could share that with the committee, because in small towns we frequently hear about physician shortages. The role the federal government is playing in recruitment is something that needs to be better known.

Second, I always ask at my hospital what their issues are so I can raise them at the health committee. They certainly mention lots of the areas of success they're seeing with the influx of funds for wait-time reductions. But one issue they raised with me is that they're always at capacity: 96% to 98% of the hospital beds are in use. That problem is common around the country. Do you have any thoughts on the capacity issues hospitals are facing?

Third, Mr. Minister, I understand you had a Dr. Kellie Leitch produce a report on healthy ways for children, and I understand that you have taken action on some of her recommendations. I think that would be interesting for the committee to hear. It's certainly a good-news story on how we're helping the health of young Canadians.

Hon. Tony Clement: Let me just say a couple of things about recruitment.

One of the bits of good news that perhaps needs a little bit more media attention is the fact that we're always worried about the brain drain, when it comes to our physicians going to the United States, for instance. But for three years in a row in this country, more physicians have migrated from the United States to Canada than have migrated from Canada to the United States. So we're winning the brain-drain war; we're getting the brain gain. That's a very positive step.

More has to be done. As you know, we've increased our transfers to the provinces, but we also have a $38 million per year strategy, health human resource strategy, with the provinces. Part of it deals with international medical graduates. Part of it deals with focusing on where the recruitment and retention should be advanced. We are going to continue on that. I want to see some results out of that. I don't just want it to be money thrown away. So that's certainly one of the things I'm working on.

The capacity issue is a big issue in the hospital system. A number of provinces are starting to increase capacity by pushing some of the hospital-based functions into community care, for instance. That's what Ontario is doing. B.C. has a strategy on that. And I think Alberta will be going down this route a little bit more too. Certainly we're encouraging that. When we, as the federal government, on behalf of the federal taxpayer, put in 25% of federal funding, that's something we're always very interested in and we certainly do support.

Dr. Kellie Leitch's report focuses on a bunch of things, including injury prevention for kids, and some other child- and youth-specific policies—obesity issues, for instance. That was raised earlier in the committee. Obviously we're examining those very closely. And we believe we can implement a number of things.

This level of government has never had a comprehensive strategy for child and youth health and wellness. We're going to try to pull together a number of departments in government as well as things within my ministry to accomplish that goal.

Mr. Patrick Brown: In conversation with physicians in my community, when they talk about the physician shortage they reference the early 1990s, when the then-NDP premier, who's now a Liberal MP, cut spots in medical schools, which was horrific for the physician population in Canada. And one thing that's great to know, with having you as health minister, is that I remember you opened a new medical school in northern Ontario, which I think was a great step forward.

One of the recognitions is that, as much as there's a shortage and we can recruit from elsewhere, until we have provinces opening up more medical schools, there's going to be a challenge. Do you know if other health ministers around the country are going to take bold steps, as you did as health minister, and create more medical enrolment spots?

● (1230)

Hon. Tony Clement: Sure. Throughout Canada, more than 800 first-year undergraduate positions have been added in the last nine or ten years. That orthodoxy of the early nineties, and you mentioned Mr. Rae and other premiers at the time.... Bob Rae admitted in his memoirs that one of the worst things he ever did was cut medical school enrolment, which is saying a lot, because he did a lot of bad things. But regardless of that, we are reversing the trend now and we are seeing some improvements on that.

Northern Ontario School of Medicine is a big success story. I think other provinces are looking at opening new medical schools as well. And of course I'm very encouraging of that process.

You know it's a success when both sides at the table here are sparring over who should take the credit for the Northern Ontario School of Medicine. But you're right, I did announce that. I'm very proud of it. This year we'll have our first graduating year since the school was created.

If any of the graduates are listening, please stay in Canada and please consider Parry Sound—Muskoka.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much.

Now we'll move on to Madame Wasylycia-Leis.

Welcome back. You will get your ten minutes.

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you very much. I apologize, but thank you for juggling the schedule so I could get my time in with the minister. Forgive me if I ask anything that anyone else has asked.

I want to focus on the state of our health care system, of which we've been hearing so much as we deal with the ten-year review of the health accord. I guess what I'm a little miffed at is that in fact in your address today you don't even mention the terms “national health care”, or “medicare”, or the Canada Health Act. There has been no attempt on your part, that I can see, in the estimates or your speech or your actions, that would say to me and to Canadians that you are concerned about the erosion of our health care system and the growing evidence of people having to pay for things they need, the rise of private health group clinics, the growth in P3s, and just the incredible erosion of our system without any sense that you're going to hold the provincial governments to task and try to craft a system that resembles medicare and builds on our principles.

Is there anything you can tell us that you believe in in terms of health care? I know in the House when I've asked you questions, you say you're a great believer in the single-payer system and in the five principles of medicare, but it seems to me that you're sitting back and letting privatization, commercialization, and erosion happen by osmosis, by stealth. I don't see leadership from you to actually fix the problem. In fact I see the opposite. We hear about, obviously, the money and the budget for P3s, which by all accounts are going to lead to further problems in terms of public health care. We hear about a federally sponsored trade mission going to the Caribbean to support private clinics that are marketing surgeries. We hear all the evidence from the provinces and no action from the federal government. I think Canadians deserve to know what your plan to save medicare is.

Hon. Tony Clement: Thank you for the question.

Unfortunately you weren't here. Actually you were beaten to the punch by Mr. Fletcher—

Ms. Judy Wasylycia-Leis: Oh, I'm surprised.

Hon. Tony Clement: —our member from Winnipeg here.

Ms. Judy Wasylycia-Leis: I didn't think anybody was going to ask this question, and certainly not anyone from your party.

Hon. Tony Clement: He asked me a little bit about the Canada Health Act and how our party and our government are supportive of the CHA. Certainly we are interacting with the provinces and territories as they innovate their system to ensure that what they consider would be within the bounds of the CHA. I will continue to play that role. And I play that role quite forcefully, I think I should state for the record.

I think it would be fair to say, though, that we have been worried and concerned about the sustainability of the health care system. That's precisely why one of our five main promises in the last election was the wait-time guarantee and why we were so proud to at least launch the process, to have ten provinces and three territories have at least one wait-time guarantee to start with. Some provinces, like the province of Quebec, have announced three wait-times guarantees, and through our pilot projects we're announcing more wait-time guarantees.

These wait-time guarantees are all about reducing wait times and increasing the accessibility of the system, all within the public system—let me state that for the record: all within the public system—using innovative managerial techniques and administrative techniques to make progress as well. I think we are in fact on the same page on that.

● (1235)

Ms. Judy Wasylycia-Leis: I appreciate that. Although we've had good testimony from the Wait Time Alliance folks, most will say that the improvement in the wait-time issue is so slight as to hardly be noticed in many cases. It has not made a big impact on people's need to access the system on a timely basis.

Here are the crises we're facing overall in Canada, and I don't hear you mention any of them in your speech. A health human resource crisis—whether we're talking about doctors, nurses, technologists, or any other health care workers or professionals, on every front there is a serious shortage and crisis. We have a national pharmaceuticals strategy for which there has been no action on your part or the part of your counterparts that I can see, and it's sitting on the shelf gathering dust. There is no national emergency room strategy. There's no national birthing strategy. There's no national.... I could go on and on.

We've had so many representations from groups saying that in terms of a pan-Canadian strategy that will deal with the serious shortcomings of the system and help us sustain medicare and build on it, there's nothing. We don't even have an extension of the human resources strategy, which has ended as of now. There's no new program. Instead we have in the budget little cuts here and there, and no sustaining program. There are cuts to first nations and Inuit health. There are cuts to the Assisted Human Reproduction Agency. There are cuts to the Patented Medicine Prices Review Board. There are cuts to graduate students and post-graduate students in public health. There are cuts to HIV and AIDS. There are cuts to the Public Health Agency.

In every instance where you'd expect to see some focus, some vigour, some energy, you're retreating. So where is the pan-Canadian strategy that is desperately needed on so many fronts?

Hon. Tony Clement: It would come as no surprise to suggest that you and I might disagree on interpreting these things.

We're the first government in the history of the country to announce a national cancer strategy. I notice you didn't mention that. We are well on our way to a national cardiovascular strategy. Those two diseases together account for the great majority of deaths within the health care system, within society.

We've retooled the national diabetes strategy and we've been working on a number of other disease-specific strategies, and we will continue to do so. We have a strategy when it comes to obesity. We have a strategy when it comes to kids' health. These things are ongoing, and we will continue on that front.

You were not here for the health human resources discussion we had, but I did mention that there is within the health accord a $38 million per annum fund that we use with the provinces to assist them in some of their strategies, whether it's international graduates or, as we just finished talking about, medical schools and new places for human health resources within the education system. I did mention as well that for three years in a row we've actually taken more doctors from the United States than the United States has taken from us, so we've had a brain gain in those areas.

I'm not saying we're beyond the point of crisis. I'm saying that we are making steady progress, and the federal government is part of the solution.

Ms. Judy Wasylycia-Leis: Don't you think we actually need a national health human resource strategy that has clear targets, has an understanding of where the shortfalls are, and has some serious tenets to it that will give hope to people?

Hon. Tony Clement: I would put it to you that when you look at who has the levers to make the most difference, whether it's the regulatory colleges, credentialing issues, those kinds of issues, access to medical resident spaces, those are all with the provinces. We are funding the provinces more and more every year, but I don't think it is helpful....

Dr. Bennett made an interesting point about getting along with provinces, which we are doing when it comes to health care, and I respect them for the role and responsibility they have, just as they respect me for the role and responsibility I have.

Ms. Judy Wasylycia-Leis: I think the provinces would love to see some concerted leadership on your part, the kind of leadership we saw many years ago when the federal government actually got involved in setting up schools of medicine. I think we're in that kind of situation where it begs for a serious initiative on the part of the federal government.

We're not dealing with only a provincial, local, territorial issue. We're dealing with something that has to be dealt with on a national basis, or we lead to raiding and serious problems jurisdiction to jurisdiction.

Hon. Tony Clement: We're certainly not denying there's an issue. I guess what I'm saying is that we are working with the provinces and territories.

Ms. Judy Wasylycia-Leis: Given the ageing population, there's a serious lack of any kind of national strategy that is desperately needed and no attempt on your part to work toward national home care or community care programming. Instead, what we seem to see are cuts. You or the Liberals, both of you, eliminated the secretariat on palliative and end-of-life care, a vital pillar of the program needed in terms of an ageing population. Where is the program for home care, continuing care, and palliative care in your branch? Where is the national strategy?

● (1240)

Hon. Tony Clement: I would say to you as an honourable member that it sounds like you're making a bid for the provincial leadership of your party. I don't see why—

Ms. Judy Wasylycia-Leis: I've been in the provincial government. I'm now here federally because I believe the federal government has a very important role.

Hon. Tony Clement: You, of all people, should know that for the federal government to get involved in home care and community care.... We fund the provinces to do that. Obviously they are in charge of those files. We're not going to get involved.

Ms. Judy Wasylycia-Leis: So you don't agree at all with the ten-year accord that talked about national home care.

The Vice-Chair (Mr. Lui Temelkovski): Thank you. We'll move on to—

Ms. Judy Wasylycia-Leis: Can I have my other five minutes now?

The Vice-Chair (Mr. Lui Temelkovski): We'll let you have a rest, and then you can continue later.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Mr. Chairman.

Good morning, minister. Thank you for being with us today. I have a few simple questions to ask you.

The list of products that must be evaluated before being put on the market is growing longer. Few inspectors are currently conducting those evaluations. Consequently, a number of products, particularly natural products, are not always approved in a way that allows them to be sold safely to the public.

I see in the 2008 budget that you've set aside $113 million over two years for an action plan to ensure the safety of food and consumer products.

How did you determine that amount? How will that money be spent? How many new inspectors will there be? Is it clear that that $113 million over two years will make it possible to shorten the product list noticeably?

Hon. Tony Clement: That amount will be used to cover all planned changes to the system in order to improve the present situation. There will be more employees to meet this challenge. We can double the number of inspectors in this program. The budget has been adopted and supported, but the purpose of this bill is to improve the situation in Canada.

Mr. Luc Malo: How many others will there be, minister? Will staff be doubled?

Hon. Tony Clement: We'll double the number of inspectors.

Mr. Luc Malo: That could go up to how many?

Hon. Tony Clement: There are 40 now.

Mr. Luc Malo: So there'll be 80?

Hon. Tony Clement: Yes. There will be at least 80.

Mr. Luc Malo: Will those 80 individuals be assigned to inspection? And in the department, do you think—

Hon. Tony Clement: Yes. Those inspectors inspect only consumer products. There are also inspectors for drugs and others for food. There will be more inspectors in each of those sectors.

Mr. Luc Malo: How much more quickly will approvals be done? How many additional products can be inspected?

● (1245)

Hon. Tony Clement: The approach will be different. In English, that's called

[*English*]

a risk-based approach for these products, so that if the risk is relatively small, the burden and oversight can be less because the risk is small. If the risk is greater, obviously the burden and the oversight are going to be greater.

[*Translation*]

Perhaps the deputy minister can add a few words.

Mr. Morris Rosenberg (Deputy Minister, Department of Health): Thank you, Mr. Chairman.

There are three components to our action: prevention, targeted surveillance and rapid response, and that's for each of the areas of this plan, that is to say consumer products, food and drugs. It is obviously important to have the necessary staff in the field to do the work, and we've received resources to implement the plan. I can't give you the exact figure today, but we intend to increase the number of field inspectors in each of those areas.

Mr. Luc Malo: The inspectors also have to be given other tools to do the job.

Mr. Morris Rosenberg: What is very important in the new act is the modernization of our legislative framework. In comparison with that of other countries, Canada's current legislation has significant deficiencies regarding the power to recall products, for example, regarding other powers of inspectors and regarding fines which are currently very low.

Mr. Luc Malo: We'll be studying that here a little later—

[*English*]

The Vice-Chair (Mr. Lui Temelkovski): Thank you.

Merci, Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Already?

The Vice-Chair (Mr. Lui Temelkovski): You had five minutes.

Mr. Luc Malo: You've got a grudge against me, Mr. Chairman.

[*English*]

The Vice-Chair (Mr. Lui Temelkovski): Madam Davidson, please.

No, it's Mr. Tilson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Mr. Tilson's going first.

Mr. David Tilson (Dufferin—Caledon, CPC): I'm going to ask a quick question, and then it will be Ms. Davidson.

I'm going to ask a question on the investment in seniors. The 2006 census showed that the population of seniors over 65 passed the four million mark. One out of every seven Canadians is a senior citizen.

Your riding, of course, is cottage country. More and more people are moving to areas such as yours and living in those areas, retiring in those areas. The question is whether, of course, they have the facilities to serve seniors, whether they have facilities that are designed for seniors. There's no question that the Government of Canada is committed to ensuring that policies, programs, and services meet the needs of seniors.

My question to you, Minister, is what the role of the Public Health Agency of Canada is in regard to the healthy aging of seniors.

Hon. Tony Clement: Sure, and I'm sure Dr. Butler-Jones would be pleased to add some things.

Let me say at the outset that of course many of our policies are going to have a very positive impact on seniors' health and seniors' welfare. When I look at the national cancer strategy, for instance, when I look at our cardiovascular strategy, when I see what we're doing for seniors' mental health as part of our mental health strategy, all of these things have an impact. Drug safety, food safety, product safety, all these can all have a very positive impact on seniors' health and safety as well.

Perhaps Dr. Butler-Jones can add a few comments.

Dr. David Butler-Jones: Certainly, Minister.

Simply as a couple of illustrative points, we worked and funded WHO for a broad multinational look at age-friendly communities, age-friendly cities, as well as age-friendly rural areas, and what the components are that actually support healthy aging. They're not only for seniors but for all ages—everything from falls prevention to the kinds of characteristics of community that are supportive, as well as working with other departments of government and across different sectors around elder abuse, around falls prevention, around emergency preparedness. In other words, how do communities respond and ensure that we avoid the tragedy of Paris, where in a heatwave many seniors died alone in their apartments.

Those are some illustrative things that fall into a broader framework of what it is about communities that make them more conducive to the health and wellbeing of people of all ages, and in particular, in this case, of older persons.

● (1250)

Mrs. Patricia Davidson: I want to add a quick question on the end here, and this is perhaps for Dr. Butler-Jones as well. I think it comes under the Public Health Agency of Canada.

For a lot of years you've had a number of programs and initiatives targeted to pregnant women or women who may become pregnant, women in that child-bearing age, encouraging consumption of healthy diets and regular physical activity, those types of things, discouraging smoking and consumption of alcohol. I think last year you launched the first national advertising campaign to promote this healthy lifestyle, and it's my understanding that the second wave of this campaign is currently under way during this month.

Could you tell me what the federal government is doing to help young single women lower their chance of having an unhealthy pregnancy?

Dr. David Butler-Jones: May I respond to this question, Minister?

Hon. Tony Clement: Go ahead.

Dr. David Butler-Jones: I think the issue is that for support of healthy pregnancies and wellbeing, we have to think well before the pregnancy even occurs. That's why it really requires partnerships that cross over different levels of government, different sectors, voluntary agencies, etc.

One of the things we do is to kind of gather up best evidence and to have, for example, the healthy pregnancy campaign and information for women of whatever age in terms of what factors they can do and then how we, as communities, can support or create environments that are more supportive of healthy pregnancies. It covers everything from the things that we do as individuals, but also getting good medical care through the pregnancy, having systems in place, etc.

The honourable member mentioned the importance of how these pieces come together, and we play one piece of it. Most of the action happens locally, obviously, but we try to contribute in a way by pulling the pieces together and illustrating the kinds of things that we can do to actually improve the potential good outcomes and consistently, hopefully, good outcomes of pregnancy.

The Vice-Chair (Mr. Lui Temelkovski): Thank you.

Madam Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Thank you very much.

I'm very concerned to hear today that you, Mr. Minister, have dismissed the idea of any kind of role for the federal government in providing home care or community care. That's been a longstanding belief among Canadians; it's the next stage of medicare, and you've dismissed it as something that's strictly local. Frankly, without being disparaging to provincial governments, I find your whole approach today is very provincial, very local, and not national.

You suggest that by raising these questions I should be back in Manitoba running for provincial politics. I suggest to you, Mr. Minister, that what we desperately need is a national vision around health care, and nowhere have you described your vision, have you put down on paper or said to this committee or the House how you intend to sustain health care.

At your convenience you use the argument of provincial jurisdiction, so when it comes to home care you're not going to tamper with provincial governments. But when it's convenient to you to put on this front of being tough on drugs and consumer products, you're going to tell all the hospitals and all the provinces they must collect information on adverse reactions.

When you want to, you do it; when it's convenient to you to do it, you will, but not when it comes to building on medicare, which would be advancing—as many experts in the field have always said—from hospitals and doctors, to drug coverage, to home care, and to community care. Frankly, I'm absolutely appalled at the lack of vision coming from you and your suggestion that there is no room on the part of the federal government to engage in these areas.

Have you totally dismissed the idea of national home care? Have you totally dismissed the idea of a national pharmacare strategy?

You talk about a national cancer strategy, which is great. Everybody appreciates that. But it stops short of research and prevention issues. You draw the line conveniently between research and development of drugs and prevention, and ignore people who are dying of cancer.

● (1255)

Hon. Tony Clement: Sorry, but that's ridiculous.

Ms. Judy Wasylycia-Leis: I don't mean to exaggerate. I'm sorry, I will take that back.

Hon. Tony Clement: Thank you.

Ms. Judy Wasylycia-Leis: To suggest that palliative care has no place in the federal regime, because you have cut back, and there is no longer a palliative care office....

You say there's no place for a national home care program to help those who are in need of supports when they're trying to deal with cancer, heart disease, or any other issues.

Can you complete the picture and try to approach this from a holistic point of view and from a national perspective with some visioning?

Hon. Tony Clement: Sure. I appreciate that.

Certainly I wish to ensure that the record is accurate on this, because of course the federal government is involved in home care and in community care. It's called transfer payments. They have increased this year alone by 6%, $1.2 billion extra to the provinces.

I don't think you and your party wish to run on creating a whole new level of bureaucracy to deal with home care, rather than transferring the home care funds to the provinces so they can deliver better home care. You can run on that, go right ahead, but I'm not here saying we're going to have a whole new level of bureaucracy for home care and community care.

You talk about national vision. In my role as health minister we are focusing on the things the federal government should be focused on and we let the provinces do what is right in provincial areas of jurisdiction. If the NDP wants to run in our country on something different from that, I welcome you to do that.

But our vision on health care is that the federal government, for 40 years, didn't overhaul product safety and for 40 years didn't overhaul drug safety and food safety because it was too busy meddling in the affairs of the provinces. I'm letting the provinces do what they have to do, and I'm going to do what we have to do for Canada.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much, Mr. Minister.

Mr. Thibault, for a couple of questions.

Hon. Robert Thibault (West Nova, Lib.): Actually, because we're so short of time, I'm going to put two questions to you and a comment. If you have time to deal with them now, please do, but if not, could you get back to the committee on them?

First, I want to thank you for staying beyond the regular hours at our committee. Unfortunately, the votes cut us short.

I want to come back to the question of surge capacity. You're a former minister of health in Ontario during the SARS time. You said then that you personally felt we had to build in more surge capacity. All the hospital administrators across the country are telling us this is a huge problem in the case of a pandemic, especially when you get yourselves in a situation where your front-line workers are at risk and are the first affected. So we need that surge capacity.

I recognize it's provincial administration, but I believe there's a federal role, and the following is a suggestion I would like you to consider. In federal-provincial relations in all departments across the board, I think if we look at what we do in social housing, if we look at the role that CMHC could play—a role that it has played in the past, and I think it could play again—in helping to build nursing home facilities, and those types of things, we could at least optimize front-line hospitals and not have that broken capacity, which I think would help in emergency medicine and with surge capacity in having that potential.

I'd like to bring up another point that I have discussed with you in the House in the past. The bills that you're bringing forward now—and I know we'll be discussing them fully—give authority where there was not authority before. There's always a danger that it becomes a responsibility that must be used at all times.

Right now, your department advises Canadians of the health risks of certain foods and of certain behaviours, and that's fine and necessary, but sometimes it crosses the line. We had one example this week with lobster tomali, on which you gave Canadians an advisory that there was a risk. It's an advisory from the Department of Health, which has a great reputation and which Canadians trust. But when you read the third paragraph of the advisory, it says that if you eat the tomali of more than two lobsters a day, there may be some risk of parasitic shellfish poisoning—if that happens to be in that population of lobsters. It's a very, very remote risk, but you may be putting a billion-dollar industry at risk in coastal Atlantic Canada.

So my question to you is, what process do you follow? Do you talk to the Department of Fisheries and Oceans, and all of those people, and the provinces, before putting out advisories?

If you have time, there's one more question you could answer, on the Assisted Human Reproduction Act. The act has been in place for a number of years now. A couple of years ago we had the first set of regulations on signing, or consent. Where are all the others? Where are the seven other sets of regulations? Why haven't they been coming forward? When can we expect them?

● (1300)

Hon. Tony Clement: This fall.

Hon. Robert Thibault: The seven this fall?

Hon. Tony Clement: There are some more coming this fall.

The Vice-Chair (Mr. Lui Temelkovski): Thank you.

I think, Minister, if you could respond to the other two questions by sending your response to the clerk, that would be very much appreciated.

Hon. Tony Clement: Yes, I think that's probably the wisest way. Thank you.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much.

Before we go, Ms. Bennett.

Hon. Carolyn Bennett: I would just say that we, as a committee, had requested from the minister and the department a full analysis of the ten-year plan. We have not received it as yet; all we received was a bunch of other reports.

The Vice-Chair (Mr. Lui Temelkovski): Madam Bennett....

Hon. Carolyn Bennett: Can we just directly ask the minister for a proper report on that ten-year plan?

The Vice-Chair (Mr. Lui Temelkovski): I think we'll just move on to the votes.

Hon. Carolyn Bennett: No, Mr. Chair. This is very important. It was a motion of this committee to get a proper report on the ten-year plan—

Mr. David Tilson: We're out of time.

Hon. Carolyn Bennett: Your department, Minister, sent a list of health council reports instead, and a whole bunch of things. I want the departmental report on the ten-year plan to be tabled.

Mr. Steven Fletcher: Mr. Chair, we have to vote.

The Vice-Chair (Mr. Lui Temelkovski): Madam Bennett, you can move that as a motion at the next meeting, but it's not a point of order right now.

We need to vote, as you know.

I'll put the votes now.

HEALTH

Department

Vote 1—Operating expenditures.....$1,661,621,000

Vote 5—Capital expenditures.....$60,000,000

Vote 10—Grants and contributions.....$1,358,089,000

Assisted Human Reproduction Agency of Canada

Vote 15—Program expenditures.....$11,783,000

Canadian Institutes of Health Research
Vote 20—Operating expenditures.....$42,891,000
Vote 25—Grants.....$881,250,000
Hazardous Materials Information Review Commission
Vote 30—Program expenditures.....$3,097,000
Patented Medicine Prices Review Board
Vote 35—Program expenditures.....$5,211,000
Public Health Agency of Canada
Vote 40—Operating expenditures.....$360,479,000
Vote 45—Grants and contributions.....$199,617,000

(Votes 1, 5, 10, 15, 20, 25, 30, 35, 40, and 45 agreed to on division)

The Vice-Chair (Mr. Lui Temelkovski): Shall the chair report the said votes under Health to the House?

Some hon. members: Agreed.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much.

The meeting is adjourned.

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

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

Also available on the Parliament of Canada Web Site at the following address:
Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante :
http://www.parl.gc.ca
