Ottawa, Ontario

--- Upon resuming on Tuesday, September 14, 2004 at 1420 /
La réunion reprend le mardi 14 septembre 2004 à 1420

RT. HON. PAUL MARTIN (PMO Canada): We call the meeting to order. Si on veut, on peut recommencer maintenant nos discussions.

The next item is family and community care, which will be led by Premier McGuinty and Premier Williams.

Within that context, we are going to deal with territorial health, which will be led by Premier Handley. I want to thank Premier Handley. We are running a little short and he has graciously accepted to roll this item into the family and community care. In fact there obviously are a number of strong connections and we did have a very important breakfast yesterday so I want to thank him.

We are probably going to try to move this meeting along as quickly as we possibly can so I may be a little arbitrary and I would just ask you all to understand that.

Without further ado -- before I make any decision I want you to know we will all caucus together and debate it extensively.

Premier McGuinty.

HON. DALTON MCGUINTY (Ont.): Thank you very much, Mr. Prime Minister.

I have a text here. I am going to try to abbreviate that out of consideration for my colleagues so that we can take full advantage of the limited time that we have left this afternoon.

La présente séance porte sur la réforme de soins de santé. L'Ordre du jour indique que je dois vous parler de soins familiaux et communautaires. C'est exactement ce que j'ai l'intention de faire.

Toutefois, le sujet dont je vous entretiendrai véritablement, celui dont nous parlons tous, en réalité, c'est la réduction des périodes d'attente pou obtenir des services de santé.

The point here, Mr. Prime Minister, is what we do in family care and home care and illness prevention and public health affects our wait times. Quality family care helps us prevent illness and diagnose problems when they do occur as early as possible. That reduces wait times. Public health allows us to protect our people from disease and equips them to make healthy choices. That, too, reduces wait times. Home care allows people to leave hospital earlier, freeing up beds for people who need surgery or other procedures. That, too, influences wait times. Improved long-term care allows seniors to move out of hospitals and into more appropriate nursing home settings. That also has an impact on wait times.

As we speak, of course, Canadians are watching. And too

many of them are waiting. They are waiting for access to family care, for public health programs, for home care, for long-term care, as well as for access to cardiac and cataract surgeries, cancer care, joints replacements, MRIs and CT scans.

In all these areas here in Ontario we are doing what we can and we are doing a lot.

Tommy Douglas once said, and I quote:

"The ultimate goal must be to keep people well rather than just patching them up when they get sick."

There is a tremendous amount of wisdom to be found in that.

One key to keeping people well is ensuring they have access to quality family care. In Ontario we are blessed with some of the hardest working, most highly skilled physicians in the world. The problem is we just don't have enough of them. There are 140 communities, some of them major cities, which are short of family doctors. We could use 694 more right now.

I think all of us know some of the problems connected with not having a family doctor. These people are often compelled to attend at an emergency room where there is no medical history which a medical professional might draw upon.

Our government is making investments that is will expand primary care to as many as 167,000 additional Ontarians this year. Over the next four years we will set up more than 150 new family health teams. If there is one thread that runs throughout all of the reports prepared by all provincial governments and federal and Senate, regardless of political stripe, it is that primary care reform is the cornerstone for the reform of our health care system.

These teams are teams of doctors and nurses and other health care professionals who provide family care around the clock. This primary care reform deserves the support of our federal partners.

A family doctor or a family health team can help keep individuals healthy. It is our public health system, though, that works to protect our communities and society. To some, public health might seem like some kind of remote abstract concept, but in Ontario we know whereof we speak. We have been through SARS. We have been through the Walkerton tragedy. And Ontarians have risen remarkably and heroically to meet the challenges placed before them. We understand in a very visceral way the importance of protecting communities from emerging health risks.

There have been a number of reports, including one prepared by Dr. Naylor who is now in the hall, which have provided us with some excellent advice regarding the strengthening of public health in the province of Ontario, and we are acting on them.

Our government has developed a three-year plan to rebuild

public health. It is called Operation Health Protection. It is a comprehensive plan. Time does not permit me to touch on all its aspects, but among other things we are creating a Health Protection and Promotion Agency that is going to provide information and support, including research and lab services. We are strengthening the role of the Chief Medical Officer of Health, and we are implementing a human resources strategy no attract and retain the very best in public health.

This plan, too, of course requires the full support of you, our federal partner.

Ontarians of course are very interested in getting more home care. They like to stay at home for as long as they possibly can before they have to go into a nursing home. They would also like to get out of the hospital as soon as they can and take advantage of home care, if only it would be there. Roy Romanow referred to home care as the next essential service. Right now there are people watching this from hospital beds when they could go home if only the home care was there. And there are seniors watching this wondering when they will have to leave their home. Too soon in their minds because of an absence of the availability of home care.

We are making significant investments to provide more home care. In fact, we are bringing home care to an additional 95,000 Ontarians by 2007-2008.

We are also expanding community mental health services to an additional 78,000 patients. We have far too many people suffering, Mr. Prime Minister, from mental illness to be found in our jails, to be found in our streets. And about one in five families are affected by mental illness, many of them leading lives of quiet desperation. So we are lending a hand, providing assistance to 78,000 more.

We are also investing in compassionate end of life care for another 6,000 Ontarians. More and more Ontarians are making a very legitimate request. They want the right to die at home, in an environment which is comfortable and familiar to them and where they can be with their family.

Home care of course also deserves the support of our federal partners.

But Ontarians simply can't stay in their own homes or shouldn't stay in hospitals. They deserve long-term care that provides quality and dignity. We are adding another 3,760 long-term care beds to our system, hiring 2,000 more people to work in those homes.

One of the best jobs I ever had was I took some time off after high school, and I had a job in this city at a hospital called the National Defence Medical Centre. I was an orderly there. I provided basic hands-on care to World War I and World

War II vets. I bathed these men, shaved these men, brushed their hair, brushed their teeth, turned them from side to side. I learned how to treat bed sores, fed these guys, read to these guys, listened to these guys. It was a powerful experience, and one of the things that impressed upon me is our continuing responsibility to make sure we are caring for those people in their later years. They are not going to be marching. Seventy thousand in Ontario are living out the remainder of their lives in our nursing homes. They are not going to march on the lawns of Queen's Park or Parliament Hill. We can't lose sight of their needs. Hence our desire to invest in those services.

We have to do a better job to keep people well in the first place. It has been said almost too often. We are launching vigorous campaigns to promote fitness, to combat smoking and to defeat childhood obesity. In the matter of smoking alone, there are only 16,000 smoking related illnesses every year in the province of Ontario.

We have a lot going for us in our province: a huge province, a strong economy, a highly skilled workforce, blessed with wonderful diversity.

Within a few kilometres of my office, Mr. Prime Minister, in the last few days you would be able to see the best hockey players in the world, the best golfers in the world, and some of the world's most popular movie stars. So we have a lot going for us.

But we find ourselves between a rock, a deficit, and a hard place, tremendous demands for health care.

We have wonderful plans, innovative plans, drawing upon the best experiences available in this country. In order to deliver on those, we need your help.

Thank you.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

I call on Premier Williams.

HON. DANNY WILLIAMS (NL): Thank you, Prime Minister, and good afternoon.

Primary health care is at the very foundation of our health care system. It is usually the first point of contact for Canadians as they enter into the system. Whether we are suffering with a common cold, or a child with a broken arm, or maybe experiencing the onset of a more serious or even fatal disease, your primary care providers are those to whom we turn first.

Primary care is a vital part of the health care system, as are the professionals in that area who are on the front line, delivering services, diagnosing ailments, dispensing drugs and making decisions that feed into the larger system.

In Newfoundland and Labrador, primary care providers play an

especially vital role given our geographic realities and challenges. So the effective and efficient organization and delivery of primary health care cannot be left to chance. Too often in the past our primary health care providers have operated almost in a vacuum, individual practices operating under different organizations without linkages to one another. In other words, there has not been a team approach to this important aspect of health care delivery.

Patients who could easily have been treated by a nurse or pharmacist are seeing doctors with very limited time. This can be especially problematic in small rural communities where every efficiency is key to the sustainability of the system.

Moreover, as a result of these inefficiencies, it meant that the system was paying more attention to treating illness than to promoting wellness, which is another very key factor to sustaining our health care system.

All provinces and territories have recognized the need to renew primary health care systems in an effort to provide better, more coordinated services for Canadians. Primary care is the backbone of our system and must be our focal point for the future.

The federal government has assisted this process by providing the Primary Health Care Transition Fund from 2002 to 2006, along with additional operational funding to the provinces in 2003. At the federal and the provincial levels we all share the same goals for this vital area of health renewal.

As an example of commitment to action, allow me to tell you about Newfoundland and Labrador's primary health care model. We have established a comprehensive service model that will operate in every region of our province, approximately 30 primary health care teams altogether. Eight regions have been selected to start this process, covering 20 per cent of the province's population. Seven of the eight are already in the implementation stage.

Clustering specialized health services in a manner appropriate to the size of the region's population has been shown to achieve a better standard and quality of care, and this improves health outcomes for patients.

Our model for primary health care emphasizes a team-based approach to services in which all primary health care professionals are networked into the team. The teams will integrate services across the health care continuum from health promotion, disease prevention, episodic care, rehabilitation to end of life care. In every region people will be able to access an appropriate health care provider 24 hours a day, seven days a week. This is our goal, Prime Minister, as well as the national goal.

A number of key change issues are important for successful

primary health care renewal. We are developing processes and tools to ensure that every provider can work to the full scope of their practice, which ensures that people are treated by the most appropriate care provider and makes the system more cost effective. We are enhancing the skills our ambulance attendants so our people can have increased access to urgent and emergency and care. We are developing better processes to manage chronic diseases rather than just focus on acute care. We are developing new ways to apply information and communications technology, such as electronic health records, tele-medicine and tele-triage.

In a place like Newfoundland and Labrador, with a small population over a large geographic area, the use of technology is a key part of good primary health care. Rural and remote service delivery in Newfoundland and Labrador and in most provinces and in the territories is challenging, to say the least. The challenges exist on at least three fronts.

The first challenge is the difficulty in recruiting providers with the right balance of skills and interest to deliver needed health services often under harsh conditions. Providers with these traits are difficult to recruit and even more difficult to retain, and there are high costs for recruitment and retention.

Second, there are unavoidable inefficiencies in providing service to low populations dispersed over a large land mass.

Third, there is the challenge of providing access do even the most basic primary health care services for the people who live in remote and isolated areas due to transportation costs, loss of work time for both patient and family members, and accommodations.

Like Newfoundland and Labrador, every province and territory is working to improve primary health care delivery. We remain focused on the shared goal of providing access to an appropriate health care provider on a 24/7 basis to 50 per cent of our population by 2011.

We are committed to measuring and reporting on our progress to the people. The main requirement, Prime Minister, for full delivery on the promise of primary health care renewal is additional funding. For fear of sounding like a broken record every single time I open my mouth here in this particular seat, it is the facts and that is the way it is in Newfoundland and Labrador.

Again, we have talked about raising expectations in this room and I think we have to be very, very careful that we don't raise the bar too high. We all know there is a sustainability issue in the system that we have to realize. That is the reality. So we want to keep a reasonable expectation there and I can't deliver that in Newfoundland and Labrador without the

money.

I was comforted, to say the least, to hear your comment this morning when you said that back in the mid-'90s at that point 31 cents on every dollar was being borrowed for health care funding. My plight in Newfoundland and Labrador right now is that I am paying 45 cents. I am borrowing 45 cents on every dollar for health care funding.

Your comment in morning was: We wouldn't be here today if you didn't do what you did and you weren't able to compensate for that. I'm not using that statement to work against you. I am comforted by the fact that I know you understand the situation, the special financial circumstances and the deep financial hole that we are in in Newfoundland and Labrador.

So we are doing our best to provide the most efficient primary health care service that we can. We are going to do it in a modern state-of-the-art way to the best of our ability, but we will in fact need your assistance. That is why the recommendations by the Premiers, the provinces and the territories before you with regard to additional CHT funding, with regard to that escalator, with regard to a pharmacare contribution, with regard to additional funding for transportation for the territories and for Labrador is critical.

So I leave that with you. I have probably gone on a little too long and forgive me, Prime Minister, but I am pleased to know you have been there. You know what it is like and you know what is needed to correct it.

Thank you.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

Premier Handley.

HON. JOSEPH L. HANDLEY (NT): Thank you, Prime Minister. I also want to thank you again for visiting our part of the world a couple of weeks ago.

Let me begin by saying that we share the same national priority of improving access to timely health care as anyone else in Canada. Our challenge is that we are roughly 100,000 people living in an area that makes up one third of Canada. So people are spread out and cost of delivering service in this vast land is expensive to such a dispersed population.

Basic services that southern Canadians take for granted are difficult if not impossible. For example, the 9-1-1 numbers. We can't afford to have that kind of service in small communities.

In order for us to deliver sustained effective health care means considerable investment. We have had good discussion on that and I think the message you had yesterday with the $700 million to enhance Aboriginal health was one that is well received by all Aboriginal northerners and we appreciate that.

Yesterday, you heard a lot about the challenges we face and

I just wanted to expand on that few of those today.

Cost of medical travel. Premier Williams has talked about that. We have talked about it yesterday. It is expensive, and again I want to say thank you for your willingness to look at that as an issue that is one of our biggest challenges.

We are investing in tele-health. We are adding new sites each year. But again, it is a difficult challenge because we lack the satellite space and the infrastructure to be able to do it to the extent that we would like to.

One of the big challenges we face is that northern lifestyle has changed considerably over the last few generations. A lot of people lived on the land and with governments encouragement, and in some cases being forced, they moved from the land into the communities. That has had a big change, some of it detrimental in terms of nutrition, in terms of exercise, in terms of smoking, in terms of a lot of habits that people developed as they tried to readjust to this new environment of living in a town or living in a village.

Unfortunately, as a result of that, a lot of our residents wrestle with alcohol abuse and other addictions. The provision of proper treatment and programming is vital to improving this situation and we certainly look to federal assistance in addressing that kind of issue.

Part of the frustration we have as small jurisdictions is dealing with different federal departments and managing an integrated health care system.

We deal with Indian and Northern Affairs for funding related to physician and hospital services for First Nations and Inuit residents. This is totally separate from the funding we receive from Health Canada for non-insured services or the base funding for health care we negotiated with Finance Canada.

A long-standing and unresolved frustration we have, Prime Minister, is that in all three territories the funding we receive from Indian and Northern Affairs for the delivery of physician and hospital services for First Nations and Inuit people is short. Each year we are spending about 25 per cent more in the Northwest Territories than we receive from Indian and Northern Affairs for delivering a program that delivers of the same level of health services for every one.

As a result, we are not going to have two kinds of health for people. As a result, we have to take money from other critical programs in order to meet this shortfall.

It seems like a lot of bureaucracy for dealing with the health care of so few Inuit and First Nations People and I think there has to be a simpler way for us to be able to coordinate that delivery, preferably through the Department of Health and have the Department of Indian and northern fiduciary

responsibilities to the people with the Department of Health, but streamline it for us would certainly be beneficial.

I would like to point out we are making progress and we continue to be creative and innovative, as all Canadians are, in ways that we provide health care to our citizens. While we don't have enough trained staff to deliver adequate health care in our communities -- and I talked about our vacancies -- our long-term solution is to train northerners to work in our own communities as health care providers.

Yesterday I talked about some of our efforts to train nurses. I should also add that every health care provider graduate from our system, we guarantee them a job as soon as they graduate. We respect their training and we want to have our people as much as possible.

Then again, Prime Minister, I want to say that the $100 million that was announced yesterday for training Aboriginal people again is something that we again greatly appreciate as a way of getting more Aboriginal northerners trained as health providers.

Other initiatives. Our neighbours in the Yukon, as I mentioned yesterday, have a leading edge traditional health program in Whitehorse. Nunavut has done a lot on tele-health, making tele-health available to their citizens in the Northwest Territories. We are doing a lot on our much needed home care programming. So we are doing our part to try to improve and provide equitable primary health care to our people in this huge area we are responsible for.

Mr. Prime Minister, I want to thank you and my fellow Premiers for your understanding on northern issues over the last while and the extent to which you have allowed this or enabled this to be on the agenda, because it is a critical piece of our challenge as Canadian Premiers and Prime Minister.

Thank you.

RT. HON. PAUL MARTIN (PMO Canada): Thank you. You are absolutely right. The issues that you have been raising, as well as obviously the issues raised by Premiers Williams and McGuinty, are very important.

We will now go to the period of commentary. I would ask that people keep their comments very, very short, if we can, because we want to go on.

I have Premier Campbell, then Premier Okalik and Premier Fentie.

HON. GORDON CAMPBELL (BC): Thank you, Prime Minister. I will be short.

I want to underline one of the sort of hidden challenges of health care that we sometimes talk about and often forget and that is mental illness.

Mental illness has had a huge impact on communities and families. I think one of the things that we have to do is raise it up and put it clearly on the national agenda, the provincial agenda, the community agenda, so that we are addressing that. It costs the economy billions of dollars, but it costs families even more, untold more in terms of challenges.

In British Columbia, chronic disease management is a critical part of our strategy for the long term in terms of community health. Chronic disease consumes about 60 per cent of the health care services. I just wanted to outline quickly the chronic disease management strategy that we are developing in our province for things like heart failure, depression, diabetes, kidney disease. It is based on one of the cornerstones we talked about this morning, which is the family practitioner and bringing the family practitioner in contact with the specialist. We have found that has had an enormous positive impact on people, both in terms of proper protocols, in terms of proper prescribing and the use of proper drugs, and also in terms of proper lifestyle changes.

So as we move to develop even healthier communities, I think when we have a discussion about health we think about the challenges we have. We have a very healthy society generally speaking. We have to continue to build on that.

I would recommend the chronic disease management strategy to all of us in this room because we know that it is providing significant benefits to patients already and there are actually very cost-effective benefits to patients as long as we have the family practitioners available to deliver them.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier Campbell.

Premier Okalik.

HON. PAUL OKALIK (NU): Thank you, Prime Minister. I want to add briefly to northern travel.

For us to get basic health care we have to travel. There are no hospitals close by to be treated. So I very much appreciate the comments by my colleague from the NWT.

We have been trying our best. We have reduced airfares where we use them, but that is beyond our control. Oil prices affect us in travel. When fuel prices go up, then our travel costs go up. Those things are beyond our control, but we appreciate help wherever we can get them and we are trying to manage them as much as we can.

I alluded yesterday that we will be put willing in place the last few communities for tele-health in Nunavut. That will be happening in the next month or so. I would invite you to come and open up the last site in Nunavut so you can witness it yourself and see how it is working throughout the North. Merci.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

Premier Fentie.

HON. DENNIS FENTIE (YT): Thank you, Prime Minister.

Just quickly I want to express my thanks to my colleague, Premier Handley from the Northwest Territories. He certainly covered the issues that we face in the North. Also, the presentation on the community health issues are something that I believe is a huge challenge for us and I appreciate Mr. McGuinty and others in putting those on the table.

I want to make the point that our health system in the North has many pieces that need to be linked together. They are comprised of acute health care, primary care, continuing care, home care, public health, mental health, and so on.

We make use of the resources we have available in a balanced and coordinated way so we get the best use out of our people and our resources. But it is critical that we are able to maintain existing services and then move to reforming our system, but we must maintain those services.

I think it is important that we present to the Canadian public here, Prime Minister, that there is a recognition by yourself and the federal government of the challenges we face in the North. It is reflected in the approaches you have made in the last while in terms of health care in the North. We respect that and we appreciate that. We want to continue to work with the federal government in addressing these challenges and I know in doing so, if we do it in a common way with a common vision, we will be successful. So we thank you for that.

RT. HON. PAUL MARTIN (PMO Canada): Speaking to the three territorial Premiers, I think that as we are all discussing these health problems we are all aware of the unique nature of the health problems and the logistics problems that you face north of 60.

Premier Calvert.

HON. LORNE CALVERT (SK): Prime Minister, while I recognize we will not spend the bulk of our time at this conference on this area, and particularly on the area of primary care as has been introduced by Premier Williams, it is my view that this area of discussion and this area of future of health care is true reform.

We spend a great dealing of our time and money sustaining the existing acute care system and the existing structures, but if we are interested in true reform in Canada, in my view, this area of primary health care delivery is one of the true building blocks that we should concentrate on, to put together that team of health care providers to function as a team, the appropriate provider to the appropriate person at the appropriate time with the appropriate need. This serves well in rural Canada, rural Saskatchewan, and equalling little it serves well in urban

neighbourhoods. That is a significant step forward in reform.

And to take the concept of primary care and understand that our health care is determined by much beyond the traditional medicines and prescriptions and diagnoses, that our health care has much to do with our housing and our employment and our education, if in this primary health care model we are building across Canada, we can incorporate those determinants of health in that model and in the concern of that health care team, we will truly bring about reform in the system that can have some financial benefit and some very significant, I think, health care benefit to Canadians, and that is no matter where we live in small communities, in large communities, rural Canada and urban Canada.

RT. HON. PAUL MARTIN (PMO CANADA): Premier Calvert, you talked about the health care teams. Premier Campbell did as well. There are some tremendous examples of things that have been done. I know that minister Smitherman in Ontario with Premier McGuinty has been doing this. I was up in Sault Ste. Marie, and they have got some great -- I am quite curious as to do you think that we have made the kind of progress based on the experience we had have, and if we haven't, why haven't we?

HON. LORNE CALVERT (SK): My view, Prime Minister, is we have not made the progress that we should have and could have and will make in the future.

These are, I understand there is some difficult issues here. There are scopes of practice, there are professional guidelines. There are a variety of issues that we need to deal with.

But if we could conceive of all health care system when the patient approaches you get the right provider, at the right time, and that may be a medical doctor, it may be a GP, it may be a specialist or it may be a nurse or it may be a therapist or it may be a pharmacist, there are issues, difficult issues, but the concept of the system developing itself to meet the needs of the patient, as opposed to the patient being sent to various and sundry parts of the system, is, I think, both fiscally appropriate with the dollars we have and even more importantly provides a better level of health care.

RT. HON. PAUL MARTIN (PMO Canada): Thank you. Minister Mar.

HON. GARY MAR (AB): Prime Minister, in answering your question with respect to have we proceeded as far as we should have done on primary care reform, I agree with Premier Calvert when he says there are many difficult issues, one of which is the manner in which we remunerate our health care providers as an example.

Every system produces exactly what it provides the incentives to do and what we provide the incentive for with fee

for service remuneration is volume. We get lots and lots of volume. But it is not necessarily by the right caregiver at the right time.

I have two doctors, Prime Minister, Dr. Wong and Dr. Wong, Paul is my dentist, Leo, sorry Leo is my dentist and Paul is my physician. When I go to see Leo, my dentist, nobody ever questions the fact that the dental hygenist is competent to clean my teeth, probably does a better job than Leo, and we have a way of remunerating Leo's office for services provided by someone other than the dentist.

By comparison when you go to Paul's office no one would question that a nurse would be competent to deliver a flu shot but we only remunerate Paul's office when Paul delivers the flu shot, not a nurse within his office.

In Alberta, with the trilateral agreement that the Premier of Alberta referred to yesterday between the Alberta Medical Association, and the government of Alberta and our regional health authorities, we now have a different way of remunerating physicians to provide money to allow groups of physicians working in local primary care initiatives to hire other health care professionals so that we can bring them into the mix and your health care needs can be dealt with by a multidisciplinary team so that if you are condition, say, is a chronic condition of diabetes, instead of seeing the physician, you may instead see a nutritionist or a dietitian. If you have got a twisted ankle, perhaps you would see a physiotherapist instead of a doctor.

This is one of the ways that I think all of us as ministers of health in this country and our governments are working on delivering health care in a different way that extends the services of the people that we current have in the system, what we try, our very best, to continue to improve the numbers of people that we have serving our system overall.

RT. HON. PAUL MARTIN (PMO Canada): Thank you very much, Minister. That is very helpful.

If there are no other questions on this item, I am going to pass on to the next item.

Les soins à domicile, home care.

I am going to call upon Premier Doer and then Premier Lord.

HON. GARY DOER (MB): Thank you, Prime Minister.

Just as primary care can be an effective triage to keep people off of waiting lists and effective upstream action to keep before people get on a waiting list, home care is similar in the sense that we can provide people care and health in their home, in their community, with dignity, in a cost-effective way.

Home care was -- this is the thirtieth anniversary of when former Premier Ed Schreyer established home care in Manitoba with the health leadership of a woman named Evelyn Shapiro, who is an

international expert on home care.

It has grown to be one of the largest per capita programs in Canada and we utilize home care to keep people out of institutions as a diversion from emergency wards, as opposed to a hospital bed, and post acute care and post institutional care. We provide nursing, rehabilitation, daily living supports, we provide nurse IV programs to ensure that people, when they have difficulty, don't have to go to the emergency wards.

Before the Romanow report and since it, we have initiated a post acute palliative care program with home care and drugs covered so that people, as you noted yesterday, do not stay in the hospital because drugs are paid for by the provincial government in the hospital and not paid in the home care system.

It is very cost effective, it is $10 a day, on average, in home care, as opposed to over $100 a day for a personal care bed, and if you have a situation where you don't have enough personal care home beds, up to a thousand dollars a day in a teaching hospital. So much the cost effective argument is definitely there.

We, as I say, believe we have to have home care pre institution, pre personal care home bed, provide home care, not just after a person's in a hospital or not just as a referral from the emergency ward of hospitals.

We have over 21,000 people in our province on home care. It is interesting, there was a dispute over the delivery of home care a few years ago. The public decided that a public non-profit system, because of the staff, the ability to keep staff longer, the average stay at a public non-profit system was well beyond any other system in comparisons and the relationships between patients in home care and staff providing home care and the care they give and the love they give and provide really made the difference in a political debate that we had in our province. So that is the experience we had.

So those are some of my comments, Prime Minister. I recommend that we scope home care at the front end of health care, not just at the back end of acute care.

RT. HON. PAUL MARTIN (PMO CANADA): Just before we go to Premier Lord, if I could just -- maybe you could -- there are definite studies demonstrating the cost effectiveness of home care versus hospital, versus the cost to the system of staying in hospital.

HON. GARY DOER (MB): Yes, there are, of course, if people can get that service as opposed to a more serious intervention, but $10 as day is the average $5,000 a year per patient versus close to $40,000 a year in a personal care home and even further on other institutional care.

Now these are for people that can be in their homes and get

that kind of service and that kind of care and that is why I think I was critical of the last so-called accord or agreement -- we didn't sign anything -- but I was critical because it only dealt with post acute care and I thought we were missing an opportunity in Canada to have pre institutional care, community-based care. Just like primary health care does save us, it is the first triage in health care and it saves people from going on to the waiting lists, home care also saves people from going on to the waiting lists or diverts people out of emergency wards, as opposed to waiting for a hospital room or bed if appropriate care will meet the needs of the patient.

RT. HON. PAUL MARTIN (PMO CANADA): Thank you.

Monsieur le Premier Ministre Lord.

HON. BERNARD LORD (NB): Merci beaucoup.

The value of home care is not only saving money, it is the fact this is where people wanted to be treated. They prefer staying home than being in an institution. They prefer being home than being in the hospital. I have never met a patient, I have never met anyone who told me, "I can't wait to sleep in that hospital." I have never had that. I have had people say I wish I could get the care at home.

That is the value of home care and that is why I am equally proud as Gary is of the work that is done in Manitoba, I am just as proud of what is being done in New Brunswick.

New Brunswick has been a pioneer in home care and delivering health care outside the conventional settings for quite some time. About 20 years ago, late Premier Richard Hatfield established a hospital without walls, what we now refer to as the extramural hospital program in the province of New Brunswick, which has been emulated in jurisdictions across the country.

The extramural program of course is now an integral part of New Brunswick's health care system and is available in every single region of the province.

Through this program, we are able to shorten hospital stays and provide more community-based, patient-focused health care to our citizens.

Avec les soins à domicile, nous sommes en mesure de livrer des soins de santé de qualité aux gens qui vivent dans toutes les régions du Nouveau-Brunswick, y compris les régions rurales, et nous pouvons le faire évidemment dans la communauté où ils vivent.

I am also proud that we -- where we have been and where we are going and what we are planning to do under a provincial health plan. We will expand acute care services and provide enhanced palliative care in our home care program. Mental health crisis intervention and assertive community treatment services will also be expanded through the home care services.

Je suis convaincu que, malgré que nous en faisons déjà beaucoup, nous sommes capables d'en faire davantage si nous appliquons aussi les nouvelles technologies de ce qui est possible de faire à domicile.

Vous savez, au Nouveau-Brunswick, il y a des gens qui peuvent avoir des interventions de -- des opérations pour le coeur, à coeur ouvert -- et ils peuvent rester à la maison et le spécialiste peut les suivre de leur maison. Ils se branchent littéralement au téléphone et à l'ordinateur et le spécialiste, qui peut être à 200-300 kilomètres de là, peut suivre leur progression, et ces gens-là n'ont pas besoin de retourner nécessairement à l'hôpital.

Ce sont là des bénéfices réels et, en utilisant les nouvelles technologies, nous pouvons offrir les soins d'une nouvelle façon.

Lorsqu'on regarde les soins à domicile, je crois que c'est un exemple parfait de la nouvelle façon que nous devons voir les soins de santé. Même si cela fait déjà plus de 20 ans qu'on le fait d'une façon active au Nouveau-Brunswick, nous devons réaliser que, à ce moment-là, c'était un défi.

When the government of New Brunswick decided to create the hospital without walls, as it was called then, it was a challenge. People felt are we really going to get the same level of care. But now you ask the people, they prefer that care than being in a hospital.

And as we look at this, I believe we can be inspired by what has been done over the last 20 years in home care and realize that there are more innovative ideas that we can implement in our health care, but that requires change. It requires commitment. And at times it also requires funding.

In this way, home care could become an important tool in the management of chronic diseases, a challenge faced by all in our health care system.

By expanding the horizons of home care, we will provide the care that people need in their own communities at a cost that we can collectively sustain over the long term, and that is what I believe renewing health care is all about.

Je veux répéter clairement, les bénéfices des soins à domicile ne sont pas simplement le fait que nous allons épargner des argents, c'est le fait que la qualité des soins, la qualité de vie, des patients et des citoyens est plus grande.

Lorsque les gens ont le choix et que la qualité des soins est au même niveau, ils préfèrent être traités à domicile, et nous devons aider à mettre les investissements en place qui nous permettent d'améliorer les soins à domicile. C'est ce que nous faisons ensemble.

Merci, Monsieur le Premier Ministre.

LE TRÈS HON. PAUL MARTIN (CPM Canada) : Merci. Merci, Monsieur le Premier Ministre.

Pat.

HON. PATRICK G. BINNS (PE): Thank you, Prime Minister.

Again, one of the difficulties in this area is people's definitions of home care are quite different I think and so we are not always talking the same thing.

Our primary use of home care is not so much post acute, which it is for many. It is primarily to help keep people out of institutions to enable them to stay in their own home as long as they can before going into nursing care.

But of course we do also get involved in post acute care and follow up from people who are discharged from hospital et cetera.

Our program is I think a very good one, but it is a modest program. For example, we would cover drugs for people at home but only if they qualify under existing programs. For instance, our seniors' drug care program does not have a home care attachment. It belongs to the senior; it doesn't have anything to do with home care per se. Or someone on social assistance who is again receiving home care would qualify for drugs. But other people in between would not.

I just want to point out that to significantly expand home care, for example, to include a robust drug program, which I think the national program would suggest, would be for us quite expensive. To have federal funding for 25 per cent of that expansion would not be affordable by itself, particularly in the transition period. So the only point I really want to make is that I feel that some transition funding would be necessary to help shore up the existing level of services before we would be on a common base, if you like, with what I think many other provinces provide in terms of home care.

Again, the level of services do vary so much across the country. We are not talking about a standardized program. I think it is important in the long term that we continue to develop programs that meet the needs of our own citizens, because the needs are different as we are seeing around the table.

Thank you.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

I have Premier Fentie.

HON. DENNIS FENTIE (YT): Thanks, Prime Minister.

In the context of reforming the health care system in the North, home care has real possibilities. If we had the resources available, the Yukon would invest much more in home care.

Let me give you an example. If we could implement peritoneal dialysis, for example, instead of having to send patients every two days to a hospital for this procedure, we could do it in their homes, that means a lot to us in reducing

our costs in travel. It contributes to the wellness of the patient. They stay home. They are amongst family and friends, these types of things.

But it also allows us to go much broader in terms of palliative care, respite care. There are so many areas here that would help reform our system and allow us to better manage our costs if we had more resources available to invest in recruitment and retention of professionals, equipment, those things, because this is an area, we feel for the Yukon and possibly across the North that we could really take steps in reforming our system.

One more item. Here again is an area where we run up against the deficiencies of on reserve/off reserve policy for Aboriginal people. I want to reiterate that our belief is that Aboriginal people, no matter where they live in the country, should be entitled to the same standard and level of care and would urge the federal government to abolish such a deficient policy.

Thank you.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

Premier Campbell.

HON. GORDON CAMPBELL (BC): Thanks, Prime Minister.

Briefly, I think we have all said for some time that home care is an important component of the health care delivery service, a continuum of care. The provinces united to provide the federal government with the response to the 2003 accord defining home care where we were committed.

There is a couple of things that I think are important about that.

First, if you go across the country there are different definitions of home care in different provinces, so we are trying to raise those up. There are different levels of drug support with home care programs in different part of the country. So I think that that is a standard that we can make, that we should be reaching for.

We have tried to look at how we could do this. We tried to price out what we thought some of the proposals were on home care, and they were an additional cost of $2.5 billion across the country. So the question I think we face is not whether we think it is a good idea or a bad idea; it is how we deliver on the good idea.

I actually have a question for you and that is: How do we bridge that? How do we bridge that gap, that funding gap that is in place, and how do we bridge that standards gap that is in place so that Canadians do have an equivalent level of service available to them across the country?

RT. HON. PAUL MARTIN (PMO Canada): Premier Binns talked about transition funding, as a partial answer to your question; I

am very tempted to say that what is required is long-term funding.

Laissez-moi vous poser une question. De point de vue des patients, c'est souvent le meilleur endroit où se faire soigner. C'est ce que vous avez dit, en même temps que le premier ministre Doer, qui est d'accord avec vous, et je pense que tout le monde est d'accord avec vous. Du point de vue du système, c'est là où les coûts sont les moins élevés.

I want to go through something that follows really on I think what both Premiers Binns and Campbell have said.

If in fact it is not only the best place for somebody to be taken care of but it is also the least expensive place for somebody to be taken care of, and if you provide them with the drugs in the hospital and pay for it, then it is going to be the same cost if they are being given home care at home. Then where does the cost lie to the provinces in making the switch, the transition, very quickly, and why hasn't it happened more quickly? Or is there something wrong in the equation that I have just set out?

HON. BERNARD LORD (NB): I am happy to talk about that, Prime Minister.

We have built up infrastructure already, and we have made choices in New Brunswick. This year Minister Robichaud of health delivered a provincial health plan. We talked about new investments and improvements we want to make in home care to build on what is already one of the best systems in North America in terms of home care. We know there is more to do but we have to free up resources to do it. To free up resources, we are closing 11 per cent of our hospital beds because we believe there are people that are hospitalized that don't need to be hospitalized. We can realize savings and provide better care at home. We can provide better pharmacare. We can do so many other things for patients.

But that is not an easy choice when it hits a community like -- I will use a very clear example -- St. Cantin where we saw yesterday, we all saw in the news that there were hundreds of people blocking a road because we were closing the hospital beds in that community. Those are tough but real concrete choices that I believe we have to make in order not just to spend more and fund more.

One thing you have said that I agree with, and I have said it for many years now: funding is one component, change is another. It is not just a question of doing more, more, more of the same. We also need to change what we do.

That is why we are making the choices in New Brunswick to change what we are doing to be able to dedicate more of those resources in home care. It requires support.

Where the costs lie is the fact that the demand is growing. That is where the costs come from. It is the growing demand, growing demand from the aging population, the growing demand from the fact there are new drug treatments available today that were not available 10, 20 years ago.

You know, Prime Minister, if it was just a question of delivering health care the way we did in 1990, we all have enough money for that. But it is delivering health care that is expected in the 21st century, and that is where the costs lie.

HON. GARY DOER (MB): I can answer as well on that, because it is a very good question.

Just because you can keep a person out of a hospital and provide the palliative care drugs and have a person be in their home with dignity in that last period doesn't necessarily mean that you get the savings, because unless you make the decisions that Bernard Lord has just talked about, closing the hospital bed, which has challenges in terms of redeploying nurses and other people, you have difficulty.

We are tracking our palliative care, home care drug program. So we have to work with our nurses and work with our doctors and others as well to not only make the proper medical human transition but also to make the other cost effective side of that.

That is exactly right. I guarantee you that if you have an empty hospital bed it gets filled, not by people making decisions here but by medical professionals, as Premier Charest suggested before. It is the right thing to do. It is the right thing to do, but to get the cost savings it is sometimes like steering a car. You have to take some time to get it around. It is better to do it all at the front end, but if you close something at the front end without something there to replace it, that is even more serious for patients.

It is a legitimate question and the answer is more difficult than the proposed solution.

RT. HON. PAUL MARTIN (PMO Canada): Thank you.

I have Premier Campbell, Premier Hamm and Premier McGuinty.

HON. GORDON CAMPBELL (BC): I would just like to say there is not a fixed universe we are dealing with, Prime Minister. It is not arithmetic we are dealing with, unfortunately. There is a demand that is moving into the acute care infrastructure. We can provide better quality as we take some of those people who can be at home and want to be home out of the acute care infrastructure. There is increased intensity in the acute care infrastructure, so there are things that we can't actually provide at home as well.

So there is a lot of people in our acute care hospitals today that should be out of them and at home, but we haven't got

those facilities to do that.

Palliative care drugs would also add additional costs to the drug regimes that we already have. So there are additional costs that come through.

So it is increasing demand. It is increasing intensity and it is increasing service. And I think it is important to underline this: it is an increase in quality. It is one of those things where we can increase quality but there are increased costs that go with that in terms of increasing the quality.

RT. HON. PAUL MARTIN (PMO Canada): Premier Hamm and then Premier McGuinty.

HON. JOHN HAMM (NS): Thank you, Prime Minister. A quick comment.

The acute program, the four-week program post hospital, is one that I strongly support. We have already costed it in Nova Scotia so when the time comes I will let you know the cost.

The reason that there are costs is that there is somebody in a queue somewhere waiting to get in the hospital, so that bed will be filled. You don't eliminate a cost, but what you will do is shorten your wait times to get into the hospital, which is an issue.

The other thing is in addition to the drugs, there is an increased cost to the administration because often times if it is an intravenous or intramuscular medication obviously a nurse has to go and deliver it. So it is not just paying for the medication; you also have to pay for the administration of that medication in the four-week period post hospitalization.

It is an excellent program and I am glad that you consider it part of your program.

RT. HON. PAUL MARTIN (PMO Canada): I don't think there is any doubt. We think it is absolutely essential. It is probably one of the most important structural reforms that can be brought in.

Premier McGuinty.

HON. DALTON McGUINTY (Ont.): Mr. Prime Minister, it is just to share with you our experience of late in Ontario. Our hospitals have been growing. The cost growth there has been about 10 per cent a year for four or five years now. What we are doing this year is saying no, it is not going to be 10 per cent; it is going to be 4.3 per cent. And that, as you might anticipate, is causing much wailing and gnashing of teeth and renting of garments.

What we are doing is we are also at the same time dramatically expanding, putting half a billion dollars, close to, in home care; a quarter billion dollars into public health. We are putting about half a billion dollars into our long-term care.

Hospitals are indispensable. There is no doubt about that.

There is still some work being done in terms of finding out how many hospitals you need and how many beds you might need on a per capita basis. But they are not the beginning, the middle and the end. If you were to ask Canadians about that, they don't want to spend any more time in the hospital than they absolutely have to.

So our challenge now is to find a way to put less growth into hospitals so that we can allow for expansion into those areas where people want us to go: community based care.

RT. HON. PAUL MARTIN (PMO Canada): One last question, if I might. I am picking up on something that Premier Binns said.

You talked about the insured drugs. My understanding is that the discussions that have been held, at least the discussions that were held in the 2003 accord with the federal government, were talking only about insured drugs, weren't they? So that in fact there should be no added drug cost.

Am I right in that or wrong?

HON. PATRICK G. BINNS (PEI): I don't know if I can precisely answer that. My understanding was there would be a higher level of drug coverage than we are currently providing in our province, which would mean adding certain drugs to the formulary, perhaps. But not only that. There are some drugs that if they are administered at home, as someone pointed out, there are extra costs to go with that. You can't have a home care provider necessarily do that. So, it is all tied together.

HON. GARY DOER (MB): To give you an example of that, some of the drugs are much more expensive now. The drug for leukaemia, Glaxo -- I will get the right term.

John, get me the right term here.

It is $18,000 per year per patient. It can extend the life of a leukaemia patient by two years. If you have a hundred of those in Manitoba and you multiply that across the country, there is better care closer to home, more dignity. Yes, it is an insured drug, but the drug costs -- and this will segue into Premier Campbell's presentation and his vision and his passion for something that is very sensible for Canada, I am sure.

But the drug costs are going up dramatically, a way beyond even the hospital costs that Premier McGuinty was talking about.

Here we are. Governments have a choice. Each of us have choices to cover this drug that allows a person to live two longer years as a leukaemia patient, a survivor. We have to make those choices. But in a province like Manitoba and other provinces, you multiply that across the country, it is the right thing to do, but it is very, very expensive.

So the answer to your question, it is not just apples to apples in terms of insured costs because the drugs are much more sophisticated today. They allow people to live longer, which is good. They should be living at home with their families and

their communities. But it is not the apple from 2000 years to an apple today. It is much more expensive and the quality of extending somebody's life two years is an obvious major quality outcome that is important for all Canadians.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

I think you said it quite well, we can use that as a segue. I think what we should do, if there are no other questions on this item, we will turn to Premier Campbell on la Strategie relative au produits pharmaceutiques, Pharmaceutical Strategy.

HON. GORDON CAMPBELL (BC): Thank you, Mr. Prime Minister.

I think that we have had some discussions in the last few weeks with regard to a national drug strategy and I personally think it is an important next step in providing a full scale national medical program to the people of Canada.

First, let me say that there has been a lot of discussion about the costs of a drug strategy. I think the costs of the drug strategy obviously are determined by the quality of the drug strategy that you put in place.

I think it is also important to note that I think in this health care debate it is important for us to accept good ideas from other parties, even when they may come from surprising sources. I'm glad to steal any idea that you give me, Prime Minister, that I think we can move this agenda forward with.

I think there are two things that are important. First, there is no question there are cost savings in applying a national strategy. You take 13 formularies and you create one formulary.

The federal government already has said that you are interested in moving forward with faster approval processes. I think there is clearly administrative savings there. We would estimate anywhere from $100 to $200 million in administrative savings.

We also know that a national drug purchasing plan will generate substantial additional servings -- savings and servings. I think we know that is already taking place in other jurisdictions, in France and the UK, in Germany, New Zealand, Australia. In fact, in the OECD countries only Mexico, Turkey and the United States don't have a national drug plan.

So we have an opportunity here, I think, to improve the quality of health care for people across the country and do it in a way that establishes accountability alignments, cost effectiveness and I think in a way that is equitable, affordable and where we provide I think truly beneficial results to Canadians.

There is no question that an appropriate drug program across the country will also help us in one of the primary areas of concern, which is the reduction of wait lists.

I know, Prime Minister, that there are many anecdotal stories, but I think we all know that there are times when families are pressured in terms of drug costs. I don't think that is right in Canada.

I think we know that there are some provinces that cover the full immunization regime that is available to young people. There are some who can't afford it. I am not willing to sit here and choose which child in Canada should be properly protected with immunization and which ones shouldn't.

We also know that a proper drug strategy can help us in terms of prevention in the long term.

So I believe there is a true benefit to Canadians. I think it is a sensible and straightforward public policy implementation idea.

I recognize the challenges that are in front of us, but they are in front of all of us at any rate with regard to drug costs. Drug costs are going up, between 13 and 14 per cent a year across the country. Most of the tools to contain those costs actually rests at the federal level, not at the provincial level.

So rather than have jurisdictional debate about that, it seems to me what we should do is say, "Here is an alignment. It is a program the federal government can truly deliver, can be accountable for, can deliver the reports to the public on, it connects in with the provinces in true partnership."

For those who are concerned that there may be some savings for the provinces, I can tell you that the dollars that are supposedly reallocated for the provinces will go to other health needs in British Columbia in a way I think that will be useful and beneficial.

I believe we already have a model that we could use. The Canadian Blood Services is a model that we could use where all the provinces are partners in that. The federal government -- we could develop that model, we could perhaps even add to that model, but the federal government as one of the partners.

So let me finish by saying this: The pharmaceutical purchasing agency in itself, the drug purchasing agency in itself, would recognize substantial savings across the country. Anywhere from 21 to 51 per cent in other jurisdictions have been recognized in that kind of a bulk purchasing plan.

So it seems to me this is something we should start with, we should move forward with. I think Canadians deserve it. I think we can afford it. I think we can focus on making sure we are getting the most cost effective benefits for the health care system. This is an area where we are already investing substantial dollars, and I know you recognize that -- approximately $7.6 billion at the provincial level at this point -- and it seems to me it is an idea that we should take, we

should move forward with because I think Canadians will benefit from it.

RT. HON. PAUL MARTIN (PMO Canada): Thank you very much, Premier.

I have Premier Calvert, Premier Doer and Premier Lord.

HON. LORNE CALVERT (SK): Thank you, Prime Minister.

I know from conversations that we have had you will know that I am a strong proponent of moving towards a national drug plan or a national pharmaceutical strategy. It is, from my point of view, the right thing to do for the right reasons.

I think we all accept now that pharmaceuticals play an integral part in health care delivery. We have had this discussion just in the last half hour. That is much more so today than it was even a decade ago. I understand from some of my officials and medical friends, for instance, in our province 10 years ago we were still putting many people into the surgical suites to deal with ulcers. Today very few are dealt with through surgeries but now through pharmaceuticals. We know the increasing and integral role that pharmaceuticals are playing in health care.

We also know that across our country there is inequity of access to pharmaceuticals. There is an equity in terms of the drug plans. It is a patchwork quilt in some ways across the nation. We do know that there can be some real significant advantage in working together as a nation to provide pharmaceuticals.

As Premier Campbell has just indicated, there can be advantages through bulk purchasing, advantages through a nation formulary, advantages through the legislative powers that exist nationally in terms of generic drugs, and so on.

But it is the right thing to do also in terms of equity and our conception and our value that we have around medicare, that our access should not be determined by our ability to pay. When we have in Canada today some Canadians whose access to pharmaceuticals is in fact limited by their ability to pay, I believe it is incumbent upon us to find a solution to this. The best solution, in my view, is to begin the work towards a national drug strategy, a national drug plan, however it might be described.

I have said very publicly in this discussion that even if today in the Nation's Capital we were to come to an agreement that we are going to have a national drug strategy, it may well take us three years to put such strategy in place.

I am hopefully that as a result of these discussions that we can begin the process -- that we can begin the process. It may be a long-term vision or a medium-term vision, but if we do not begin progress then we will never reach the vision. Therefore, I

am hopeful that as a result of the discussions that have led up to this meeting and over the next several hours and days, that we will make the kind of progress that can see us pointed towards a national drug strategy and eventually a national drug program.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

I have Premier Doer, Premier Lord and Premier Williams.

HON. GARY DOER (MB): Thank you very much.

Of course we had a tremendous and positive step forward yesterday with the confirmation of you, sir, of the nurses costing of this program, which I think was a valuable contribution to the debate.

I just want to say that I agree with my two predecessor presentations.

I think it is clear that the federal government has the gatekeeping jurisdiction here. It is responsible for the trade negotiations, the trade contracts. Maybe some day down the road with all the controversy in the United States, perhaps amendments to NAFTA or other trade agreements, the world trade organizations, the patent law protection, the patent law issues, it also has the ability to approve drugs and disapprove drugs, evaluate drugs, research drugs, and it has the legal authority on marketing to consumers of drugs. So it has a tremendous role to play.

When we look at some countries that have become more federalist, more federalist in this capacity, as sometimes we are urged to do by your Ministers, be more federalist. When we look at those recommendations to be more federalist, you look at Australia where the costs have been controlled at a much lower level. They saved some $2 billion on efficiencies, compared to Canada which is 12 per cent increase a year, and United States which is an unmitigated challenge or disaster on drug costs at about 20 per cent a year.

So we have an opportunity. We should not leave here today or tomorrow, or next Monday or whenever, without some desire to have a national vision.

I regret that the Premiers were perceived to be developing this at the last minute as a tactic to come to this meeting, because I actually believe beyond tactical considerations that this is a very, very important new program for Canada.

I am also really delighted that the Premiers have designed this program with the beauty of Canada in mind, the flexibility of Canada in mind, the QPP/CPP pension plan. We all support the concept of asymmetrical federalism and the capacity and ability of Quebec to deliver this program as they do with their own pension plan.

So this is a wonderful vision for Canada. The only regret I have, because this idea has been rattling around for a long time

and perhaps we should have come to a conclusion earlier and not be perceived to be doing it only for this meeting.

I am not doing this just for this meeting. I believe in it. I think it makes a lot of sense for Canada. It makes a lot of sense to have the same drug coverage in Kenora as in Yorkton as in any other community in Canada. It took a long time to get the same medical coverage in Canada. You mentioned yesterday your family was involved in.

It took a long time for this idea to come forward, but let's not throw this idea out. Let's have that vision, because it is a sound one and it is one of the areas where we could be more cost effective and provide greater equity to benefits. Let's not lost that vision of Canada. We have a chance to do it with this idea.

Thank you.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

Premier Lord.

HON. BERNARD LORD (NB): Thank you very much, Prime Minister.

A lot has been said, there has been a lot of discussion surrounding pharmacare and I fully support the concept and the idea of a national pharmacare program. There are a lot of discrepancies in our country today in terms of drug coverage.

Just in the Province of New Brunswick there are 22 per cent of the population that have no drug coverage whatsoever. When they need drugs, they buy them themselves. If they face catastrophic drug costs there is no protection for those people. That is the situation that I believe is unacceptable and that we have outlined in our health plan that we will fix. We want to make sure that there is, at the very least, catastrophic drug coverage for every New Brunswicker and every New Brunswick family.

C'est une situation difficile pour plusieurs famille lorsqu'ils font face à des coûts exorbitants pour les médicaments, et les choix sont, pour ces familles-là, parfois très difficiles.

Comme je l'ai mentionné dans l'autre langue officielle, 22 p. 100 de la population du Nouveau-Brunswick n'a aucune assurance médicaments. Il y a 61 p. 100 qui ont de l'assurance médicaments avec le secteur privé et 17 p. 100 la reçoivent du gouvernement. Là, ce sont surtout les gens qui sont sur l'aide sociale et certaines personnes âgées.

Il en demeure, que 22 p. 100 sans aucune couverture, n'est plus une situation acceptable. Ce que nous constatons, c'est qu'il y a des différences importantes à travers le pays.

These differences are important. We often hear people say we should not have two-tier health care in Canada. I don't want to shatter anybody's perceptions here, but we do; maybe not in

the traditional way of thinking of two-tier when we talk about for profit or pay for service health care, but there is different drug coverage covered by governments across this country.

Drugs that are paid for by the Government of B.C. may not be paid for by the Government of New Brunswick, and the citizen of New Brunswick for the same care must pay for that drug coverage. Examples abound across this country.

So there is a multi-tier level of care in Canada.

Once we state very clearly, as we have today, and we have heard about this for quite some time -- and I believe you agree with this, Prime Minister -- that pharmacare is a component of health care in the 21st century.

I have a quote from Mr. Romanow in his report where he states that we can no longer -- I will just find the direct quote here.

"We also need to renovate our concept of medicare and adapt it to today's realities. In the early days, medicare could be summarized in two words -- hospitals and doctors. That was fine for the time, but it is not sufficient for the 21st century." (As read)

What have we been talking about today? We have been talking about wait times, home care. We are going to talk about wellness strategy, health promotion, and we also are talking about pharmacare.

Pharmacare is part of health care. There are too many discrepancies across this country when it comes to drug coverage. We will do our part in New Brunswick to address some of that. But I believe that if we worked collectively we could do a better job. That is why I support the proposal of pharmacare and that is why in New Brunswick we will put in place a catastrophic drug plan to make sure that at the very least every single New Brunswicker will have some drug coverage to face catastrophic drug costs.

I believe if we can't do it all today and we can't do it all tomorrow, it is not a reason to say that we can't do it at all.

Let us begin, to quote my friend Gordon Campbell. Let us get on with doing this. This is good for Canada.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

Premier Williams.

HON. DANNY WILLIAMS (NL): Thank you, Prime Minister.

There is not much I think I can add to the eloquent statements of my colleagues. I can tell you on a personal basis that when this came to the table at Niagara, I was quite excited about it. It was a wonderful concept. As Premier Doer indicated, it is too bad it came to the table late. That does not mean it is any more diminished or any less a concept or a policy for our government and the federal government to look at.

What a wonderful national piece. What a wonderful national vision.

The reality is affordability. The decision that you face as Prime Minister is the cost. Again, that is unfortunate because something that has far reaching ramifications across the country, like this, it would be nice if we had the available funds immediately to implement this.

Even Premier Klein referred to it as a stroke of brilliance. And when Premier Klein says something is a stroke of brilliance, I think around our table we certainly sit back and take notice. It certainly turned him, so we should certainly have a look at it.

I do commend the Nurses' Association for their recommendation, for what they have done to put the recommendation forward. They did it at Niagara on the Lake, and they deserve full credit for doing that. They costed it, and they costed it accurately.

What it does represent for my province, though, is the glaring inequity in the country. Premier Lord referred to a different concept of a two-tier service in the country. In this particular area of my province, the people of my province, the people who have pharmaceutical needs, are disadvantaged.

I have to tell you that the toughest decision -- and it hasn't been easy over the last 10 to 11 months. But the toughest decision that myself and my cabinet had to arrive at when we sat around that cabinet table to prepare a budget was to decide to play God, to decide who gets what medication and who doesn't get a certain medication. That's not a very nice position to be in, believe me, and I am sure you would not envy that position or any of the other Premiers around this table.

We have always chosen life-saving drugs because they save lives, and whether we can afford them or not we have to go there. But when you talk about medications that refer to the quality of life of people who are the seniors in our country, or can extend lives, that is a tough decision to make.

In Newfoundland and Labrador, we are way behind because we can't afford the levels that some other provinces have. And hats off to the other provinces for doing it and being able to do it and obviously making difficult decisions and tough decisions in order to accommodate the people in the province.

Premier Calvert said our access to medication and pharmaceuticals should not be limited by our ability to pay. That says it all. It really does say it all.

So if there is something really fine and really good that we can do for this country, I think we have to look at this and we have to look at it seriously. I understand the financial limitations, and it is going to take some time to accumulate

those kinds of numbers. But we have to start.

As Premier Campbell said, let's get on with it. Let's start it. Let's have a good hard look at this. This is important because this will create equality and an equity across the country and take away this glaring inequity which we have before us now.

That is all I have to say.

One final thing, Prime Minister, on the catastrophic drug program, which is a wonderful initiative. From our perspective, according to Romanow calculations and the Kirby calculations, that would cost our province anywhere from 40 to $60 million in additional funding. That is something we simply couldn't afford.

So if there is going to be a national initiative there, then I would have to depend on the federal government for that funding.

Thank you, Prime Minister.

HON. GORDON CAMPBELL (BC): Prime Minister, could I just say one last thing?

RT. HON. PAUL MARTIN (PMO Canada): Sure.

HON. GORDON CAMPBELL (BC): To put this in context, in British Columbia our program, we were able to lower the drug costs for 280,000 British Columbians. I think that we have heard from my colleagues about what an incredible shot in the arm this would be to the entire Canadian health system in terms of quality and in terms of equity and in terms of the goals and values that you have so clearly advocated. One of the things that is clear to us, and I think we have to acknowledge this, is even a catastrophic drug program will cost dollars.

Premier Williams has said what it would be for his province. Across the country, a catastrophic program could be anywhere up to 2.5 to $3.5 billion, depending on how to you describe it. I think we should recognize that.

We can come up with a program, though, that says to seniors across the country we will maintain your drug costs. The maximum we will go is 2 to 3 per cent of what your resources are; or, for families, 3 or 4 per cent of what your resources are. That is what we have been able to do in British Columbia. That is a pretty significant step in terms of building the foundation for the future we are all trying to do.

A good national drug regime will keep people out of the hospital. It will keep people out of the system that is so overburdened at this point. It will help us reduce the wait lists that we face at this point. It will assist us in building the home care support that we need.

Obviously, I am a strong advocate for this. I think it is a smart idea. I think it is an idea that we can move forward with. Even more importantly, Prime Minister, we have worked, officials

have worked, the community in Canada has worked across the board with the Canadian Blood Services to create a model that can actually work, that we can adapt pretty quickly if the will is there.

I have said earlier that this is an idea that has been brought forward time and again. It is an idea that can work if we work together and I would encourage that. I would encourage an acknowledgement that even a catastrophic program will require additional resources.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

Premier Hamm.

HON. JOHN HAMM (NS): Thank you, Prime Minister.

The idea of drug coverage available for all Canadians is one that I wholeheartedly endorse. We are starting there. You have talked very positively about the acute home care program and the provision of drugs within that program. I totally support that.

You have talked about, and we actually have agreed to as part of the accord, the catastrophic drug program. In Nova Scotia, there are some 20 per cent of the population that have no drug coverage.

There are a significant number of those who are diabetic and one of the initiatives that we must address in Nova Scotia is a drug program for low-income diabetics; and, again, we have costed that.

I do know I have mentioned this to you in the past, the whole idea of high-cost drugs. There is a drug study going on in Nova Scotia now. We have a significant number of Nova Scotians with Fabry's disease; 17 of them are on a drug trial. The annualized cost of this drug, if it were to become approved -- and that would occur if it is proven to be solidly effective -- is over a quarter of a million dollars per patient per year.

Another group of high-cost drugs are those that are used for cancer patients, and Premier Doer mentioned one such drug. There are a number of the chemotherapeutic agents for cancer that are extremely expensive, and that gives me a little segue into a little message I was asked to talk about here.

I recently attended a meeting with the Canadian Cancer Society, the National Cancer Institute. They have a national cancer strategy that is almost entirely funded from the government side by provincial governments. But they do have other sources in the private sector. The federal government in a very substantial way does support other strategies, like the diabetic strategy, the HIV/AIDS strategy. I am putting in a pitch, Prime Minister, for you and your Minister of Health, who is looking over your shoulder, to have a look at some funding for a national cancer strategy.

Right now the commonest cause of premature death in Canada

is cancer. It very soon will become the number one cause of death in Canada as our population gets older. All of these are elements of a national pharmaceutical strategy.

I think we are going to get there in bits and pieces. What I hear my colleagues saying, and what I am saying myself, I think we should go about it in a rather more organized fashion. I think we are going to get there anyway, and we would do a better job in reaching the destination if in fact we planned it a little better.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier Hamm. Premier McGuinty.

HON. DALTON McGUINTY (Ont.): Mr. Prime Minister, when you hear my colleagues speak to this issue of pharmacare, there is something profoundly Canadian about this ideal. We know that there are some real costs connected with it and other kinds of challenges to be found in implementing wholesale pharmacare.

But the notion that no matter where you live in this great country you wouldn't have to worry about your drugs should you become ill -- you know, somebody once said that what matters most in every age are the ideals that inspire our efforts and the integrity of those efforts.

I think this is a wonderful ideal. It might take us a little bit longer to get there than we would desire, but I think it is important that we find a way to recognize we have given birth to something here. We are going to go beyond hospitals and doctors to pharmaceutical coverage. Now, we can talk about how long it takes us to get there, but I think it is important for us to come out of this meeting with some kind of a process that helps us breathe still greater life into this wonderful ideal. I understand the challenges, financial and otherwise. The reason we came up with this, the reason it resonated with all of us so well is because it seemed like a natural evolution in medicare. It is the next stage.

That is why we have embraced it and why we think it is worthy of our careful consideration, and that is why we hold it up there as an ideal. I think we have to find some way to tie it down to the bedrock of reality, find some way coming out of there meeting for us to begin to move on that wonderful ideal.

RT. HON. PAUL MARTIN (PMO Canada): Premier Binns.

HON. PATRICK G. BINNS (PEI): Thank you, Prime Minister. My throat is getting worse.

In some ways, I am hesitant to talk about this subject because I have to admit that we I guess have the lowest per capita drug care program in the country -- Fisherman's Friend again. We spend $133 per capita on our drug program where the average in the country is $203, so we are $80 below the norm.

And so, while a number of drugs have been recommended for

inclusion in our formulary, and we are not able to cover them, some drugs for diabetes, cancer, osteoporosis, emphysema, et cetera. That doesn't mean we have coverage in some areas that no other province has.

A pharmacist told me recently when I was in the drugstore that we have a better diabetes program, as far as drugs are concerned, than the province of Ontario. And I am not encouraging Ontario residents to all move to P.E.I. because we have a better diabetic program; but, again, there are differences, and I guess we would love to be able to come up to at least the Canadian average in terms of the drugs provided. I don't think our costs are lower because we are healthier on average. In fact, the data would suggest otherwise.

So, in the first priority we would like to come up to a national average and a national drug program would enable that to happen much quicker than anything else. If there was consistency across the board on a minimum level of drugs available.

But I just want to touch on one other thing and that is that the whole notion of a catastrophic drug program is of course one that we continue to talk about and that we have to move to.

There is a concern, I think, out there that, at least I have, that what is catastrophic to one individual is not necessarily catastrophic to another. And when some of the studies have been done to look at this, I think, in some cases they have looked at, you know, a floor of the individual pay the first $1,500, for example.

That would be catastrophic for someone earning $20,000 to have to pay the first $1,500 in drugs. You know, if it was more as, I think, Senator Kirby recommended a 3.4 per cent on the income of that individual or that family, it would be much more affordable. So, I just would urge that we look at catastrophic in terms of what the real costs are to the individual and what that person's abilities are.

But I think that we have to continue to work towards a national program, and the sooner that we can get there, the better it will be for all Canadians, particularly those of lower income.

RT. HON. PAUL MARTIN (PCO Canada): Thank you, Premier.

Perhaps if I could just respond quickly. Before I go to the national drug strategy, I would just like to say to Premier Hamm I am really delighted that you raised the question of a national cancer strategy.

I met one of Canada's leading cancer specialists, who asked me to raise it at this meeting, and I was trying to figure out how to do it. I talked to the department and they said we have been embarked on something that hasn't worked all that well, and so you have given me the opportunity to say I agree with you

fully and that I really do hope that, if there is a reporter from Cambridge, Ontario, who is hanging on my every word, that that reporter will write it up so that it will be seen that I did raise it and I really do support it.

I guess, in terms of the national drug strategy, the first thing I want to do is to congratulate the Premiers, Premier Campbell in particular. Let me say to you that we are very interested in a national drug strategy, and we are very interested in working on it with you, working on it together.

I can tell you that whatever tools we have as as federal government, either internationally or to contain costs, we are prepared to use them. In fact, whatever tools we have to this end, we are prepared to use them.

One suggestion about creating one formulary, we shared that at the beginning, I am prepared to work with you immediately. The whole question of bulk purchasing, again, we are prepared to work with the provinces forthwith.

As far as catastrophic drugs are concerned, we are not here to impose any one model. We just think that between us we should develop the best model and, certainly, I think that we are quite agnostic as to how in fact that should be done.

Now, our reaction to the proposal was not just cost, but it was philosophical as well. We are open to the best structure, but we do feel that whatever that structure is that the national pharmacare strategy has to be integrated fully into the health care system, for precisely the reasons that you have been given.

In fact, because of the increasing importance of drugs, because of the importance of the drug strategy, to separate it from the rest of the system in a way that would appear to be, if the federal government took it over completely, we think would be counterproductive.

We don't think in terms of a publicly funded system, government to government, that we should be separating the payer from the cost driver. So, because we think that would lead to a distortion of the system.

So the answer is -- and also I mean to be -- it would also probably considerably loosen our participation in the rest of the health care system, which I don't think would be a good idea. I don't think it is in any body's benefit to see us have a reduced area in one area of the health care system because I think there is a national interest which the federal government represents.

So, if what we are looking for, and again I congratulate you, Premier Campbell, and the provinces, all of the provinces on this, if what we are talking about is let's work together on this, recognizing that pharmacare is an integral part of health care, we are there and we would like to work with you, very, very much.

Premier Doer.

HON. GARY DOER (MB): You made the statement about the costs and the responsibilities and, of course, as the gatekeeper, you control the international treaties, trade treaties, the patent law protection. You control what is approved or disapproved and then we eventually, believe me, pick up, in the case of Manitoba, about 95 per cent of the costs. So the argument can be made in a different way on the same point.

The other issue that we have to wrestle with, and I would be curious about your views on this, is the whole issue of the whole marketing strategies to consumers. I know this is touchy to probably some of my colleagues, but it is probably isn't touchy for me. What is the analysis of the federal government on the marketing of drugs to consumers and how much -- what is their view on the consumption levels based on marketing?

The costs now for drugs are exceeding almost every other sector in the health care sector, and so what is the position and the vision of the national government on this national question?

RT. HON. PAUL MARTIN (PCO Canada): Well, I think that, number one, there was a balance that has been established between generics and the pharmaceutical products. It is a balance that is under constant review and it certainly is one that we constantly review.

As far as -- unless I have been given a note that totally contradicts everything I say -- no, it just said "don't swear". --- Laughter / rires

It is also written by somebody who obviously had very bad primary school education, Sanskrit -- no, it says essentially that we are not able to, under the current law, we are not able to provide direction on consumer advertising.

HON. GARY DOER (MB): I know what the current law is. That is not the question I asked.

RT. HON. PAUL MARTIN (PCO Canada): In terms of what we can do, you know, just recognizing the balances that have to be made, we are prepared to look at the whole area and work with you on this.

This is as important to us as it is to you.

HON. DAVID McGUINTY (ON): Mister Prime Minister, could I suggest, might we strike a working group? We are keen to pursue this further and feel that we are -- in many ways you hold sway over the kinds of drugs we end up using and you influence the pricing and all those kinds of things. We certainly feel that would be worth our while to strike some kind of a working group where we can pursue this in more detail.

RT. HON. PAUL MARTIN (PCO Canada): Subject to, you know, one overriding caveat that we believe that the national drug strategy is something we have to work on together and that it has

to be integral to the total system. I am with you 100 per cent. The health minister is here. I am prepared to ask the health minister to head up the working group from our side to bring any other officials from other departments or ministers required. If you would like to strike a working group from your side, we can get on it --

HON. GORDON CAMPBELL (BC): Could I recommend, Prime Minister, that we strike that working group to discuss both what is the right model and what the incremental costs of what a catastrophic program should be, so we are all singing from the same song sheets and we can move forward with this?

RT. HON. PAUL MARTIN (PCO Canada): Premier Campbell, I think that we can jointly set the mandate. The answer is that we are very open as to what it should be. Let's just put it this way, you tell us who represents your side and Minister Dosangh will head up our side.

HON. GORDON CAMPBELL (BC): That is satisfactory. Thank you.

HON. BERNARD LORD (NB): Prime Minister, we are all on the same side.

RT. HON. PAUL MARTIN (PCO Canada): Yes. Three and a half years out of four, Premier Lord --

--- Laughter / Rires

Okay. I am sorry, are there any other questions on this?

Okay. We will now go to actually the last item on our agenda today, which is prevention, promotion and public health.

I would ask Premier Hamm to take the floor.

HON. JOHN HAMM (NS): Thank you very much, Prime Minister.

I am delighted to have the opportunity to speak on a Nova Scotia initiative that is near to my heart, and that is the issue of health promotion. It is my objective that on an issue agenda in future meetings that interest in this particular topic will grow and we will not be the last item on the agenda, but eventually will become the first.

It is no secret that the people of Nova Scotia are the high risk of chronic disease. In fact the highest in Canada.

As a result, Dalhousie University's population health research unit concluded that Nova Scotia has the highest per capita health requirements. I circulated copies of this report at the 2000 ministers' meeting. The issues have not changed. But in Nova Scotia we looked at the report and we felt it was time for us to act.

In December 2002, we created the Nova Scotia Office of Health Promotion. For us, it made sense. We must in Nova Scotia focus on prevention and promotion now.

Author Hanna Green once said, "Health is not simply the absence of sickness." In my previous life as a family doctor, I

treated many thousands of patients in an over 30-year career, and Hanna Green is right.

There is a real need to coordinate treatment with prevention, hand in hand. Prevention investments now will manage cost drivers later. A healthier population reduces pressures on our health care system and, more than anything else, a healthier population is the ultimate long-term solution to bringing down wait times for a generation.

We cannot survive on treatment alone. Health promotion will contribute to a more sustainable, quality health care system and contribute to a priceless return to a better quality of life.

A quality system can only be the result of federal and provincial territorial investments. That is the only way to have great impact. An example is tobacco control, which I will talk about specifically in a little bit.

There is an urgency in Nova Scotia. Our entire provincial budget is $5.5 billion; health care consumes $2.4 billion. Budgets for health care are a significant portion of our provincial budget, as that ratio suggests, and that ratio and portion is increasing at an alarming rate. We have to act now to change all of that.

As you know, three risk factors predict eight chronic diseases: tobacco use; obesity; physical inactivity. The direct medical cost to treat chronic illness in Nova Scotia is $1.26 billion, which is over 50 per cent of our health care budget, and over 50 per cent of chronic illness is preventible.

We are not alone in the urgency. I would suggest my counterparts could provide very similar mathematics.

The good news is we can change this. Nova Scotians and all Canadians can enjoy longer, healthier and more productive lives and we can avoid many of the costs to our health care system and to our economy if we focus more on preventing illness and injury. Over 40 per cent, perhaps over 50 per cent, of chronic diseases like cancer, diabetes, heart and lung ailments, are preventable. Moreover, up to 95 per cent of injuries are preventable. It is this mix of challenges and opportunities which drive our Office of Health Promotion.

The Office of Health Promotion is a separate ministerial voice in cabinet, which means the health promotion issues have an independent focus when decisions are being made at our cabinet table. Its budget is uncompromised by acute care. The health promotion budget in its second fiscal year is $18.5 million. We have committed to doubling that budget within four years, to $30 million. Doubling a budget is unheard of in our province, with this one exception, but we know we have no choice. Each jurisdiction knows that we simply cannot keep up with treatment costs. The only way to tame the dollar demands is to prevent

more costly diseases from developing.

There is tremendous support in Nova Scotia for promotion and prevention and for the Office of Health Promotion.

I didn't come here alone. For example, a valuable stakeholder, Jane Parkinson, the Executive Director of the Heart and Stroke Foundation of Nova Scotia, is here in Ottawa this week. Allow me to quote Jane. She said recently:

"The best case scenario for future health delivery is that we have sufficient investment in primary prevention and health promotion, not only in Nova Scotia but across the country so that we have reduced demand and need for care within the system." (As read)

To further illustrate the support from Nova Scotia, the President of Doctors Nova Scotia, Dr. Maria Alexiadis, her organization, Doctors Nova Scotia, commits 17 per cent of their dues to health promotion work. This is significantly higher than the national average. And we are always thankful for support and cooperation from health stakeholders.

The model that we have of a single office of health promotion is working for us. To successfully and effectively promote better health, all risk factors must be addressed from one place. Separate budgets and a separate ministerial voice assure this.

Our focused efforts on the causes of preventible disease and injury enhances collaboration and reduces red tape. It allows for more efficient decision-making and our stakeholders know they have a voice as we undertake a cultural shift toward healthier living.

We are easy for people to find, and not only for stakeholders but for everyone. The Office of Health Promotion has close links between 10 provincial departments in the work it does. But it needs to be easier at the federal level. Sport is with Heritage Canada, physical activity with Health Canada. Our Constitution has no role for the federal government in a key health delivery setting, our schools.

I am not suggesting we rewrite the Constitution. But we do feel that the federal areas of health promotion should be found in one portfolio, one portfolio in the federal cabinet to improve efficiency and communication.

Similarly each province, I would much appreciate if they would consider aligning their related health promotion areas so that the public has one-stop shopping.

Allow me to share with you some of our other plans, our actions and accomplishments that we have had in our province thanks to our Office of Health Promotion.

We have a health promotion plan and it is working. We call it Healthy Nova Scotia. The plan is focused on seven strategic

priorities: one, physical activity; two, healthy eating; three, tobacco control; four, injury prevention; five, addiction prevention; six, chronic disease prevention; and seven, healthy sexuality.

Here is a success story from our Office of Health Promotion anti-tobacco strategy. In 2000, according to Statistics Canada, Nova Scotia had the highest rate of tobacco use in Canada, something just over 30 per cent. That is the year 2000. In 2001, after extensive consultation with our many health and education partners, we introduced our first ever comprehensive anti-tobacco strategy. Through the strategy's main components, tobacco pricing and taxation, legislation and policy, treatment and cessation, community initiatives, school-based initiatives and marketing, we have made real progress over the last four years.

From the worst rate in 2000, with the strategy beginning in 2001, we were already down to the national average in 2003, from 30 per cent to 22 per cent.

Our efforts are even drawing international recognition. In fact, our anti-smoking ads, which were funded through a federal-provincial program, placed in the top 10 at the Cannes Film Festival.

Here are a couple of other examples from the Office of Health Promotion and Action.

Through the Active Kids, Healthy Kids strategy, among other things we provide funding and work with schools and communities to develop and implement plans to get children and youth more active.

By funding kids' sports, we work with sport organizations to help low income families with the costs of registering their children in sports. In fact, this year we have added more than a quarter of a million dollars to provide new physical activity opportunities to a thousand children from low income families in our province.

Through Healthy Nova Scotia we will institute school-based healthy eating programs next fiscal year, trying not only to influence what is available in the high school cafeteria or the school cafeteria but also trying to get to the home front to influence what the kids carry to school to eat in their brown paper bags.

Our provincial injury prevention strategy is focusing on reducing preventable injury from motor vehicle crashes, falls and suicide.

And we are moving in the right direction toward our vision, one of shared goals and collaboration among communities, provinces and the federal government, a vision of reduced chronic disease and preventible injury.

Finally, we want to contribute to achieving a healthy and strong productive Canada. We know this is a vision shared by everybody at this table. It is every Canadian's vision and it works in Nova Scotia. It is very likely it could work in any province because it is an evidence-based model.

But none of us can do it alone and we must act now. So my request today of the federal government is for three specific things.

Number 1, a single federal voice for health promotion. The federal government must establish one channel for its health promotion work.

Number 2, sustainable long-term funding. We have said it before and I will say it again: We need predictable long-term funding for health care and for health promotion.

Number 3, continue existing healthy living funding that is successful. We appreciate the federal help we have had. Without the tobacco cessation funding over the past three years, Nova Scotia would not have reduced its smoking rates from the highest in Canada to the national average in three short years. That funding is due to dry up next year. We can't allow that to happen.

So my final request is, Prime Minister, continue the funding that has proven successful in tobacco cessation so that the good work can continue.

Thank you.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Dr. Hamm.

I have Premier Lord and Premier Doer.

HON. BERNARD LORD (NB): Thank you very much, Prime Minister.

I am pleased that we are raising the issue of prevention and promotion of health, or how we like to call it, wellness in the province of New Brunswick.

As I mentioned earlier today, last week leading up to this meeting I invited stakeholders in health care to meet with me in the province of New Brunswick and we have representatives from all sorts of groups. I was amazed buy the consensus that emerged.

There were two main consensus that emerged from the meeting. One, that the federal government should fund at least 25 per cent of health care and enhance equalization. But we will leave that aside for the moment. That was the number one consensus.

The number 2 consensus that I found really interesting was the need to invest more in wellness and health promotion.

This is all about health outcomes. We talked about that yesterday. It is easy when we talk about health to quickly get caught up in dollars, in programs, and so on, but this is about health outcomes: increasing life expectancy, having more

productive lives, quality of life, and all of this is to improve the wellbeing of citizens.

The secondary benefit is the cost savings, but it should not be the main driver for a wellness strategy. The main driver for a wellness strategy is improving the quality of life of citizens.

The first Minister of Health that I had five years ago, Dennis Furlong, was a family physician who practised for over 20 years in northern New Brunswick. I remember one day in cabinet we were talking about this and he stated there is a fundamental difference between being not sick versus being well. For a long time our health system has focused on helping those that are sick and preventing them being not sick, while we will need to focus equally on being well.

Le mieux être, ça fait partie intégrante des choses que nous devons faire, ce n'est pas une question simplement de réduire les coûts, mais réellement d'améliorer la qualité de vie des citoyens. C'est ça l'avantage principal.

I mentioned on many occasions in the last two days we have just released a provincial health plan. In the health plan we looked at the health status of New Brunswickers. It is not always an easy thing to do, to look in the mirror. But we did and we realized that we have some big challenges in New Brunswick. When we look at current percentage of people in New Brunswick who are smokers, we are ahead of the national average. We have more than the national average. People that suffer from high blood pressure, we are higher than the national average. People that suffer from diabetes, we are higher than the national average. People that suffer from obesity, higher than the national average. People that are physically inactive, higher than the national average.

The good news in this is a lot of this can be prevented and changed by ourselves. That is why when we crafted the provincial health plan, the first strategic priority that we set out in our health plan is to improve population health. The first initiative outlined in the provincial health plan is a wellness strategy.

We highlight four key areas: nutrition and healthy eating; physical activity; tobacco cessation; mental health programs.

The beauty of when we look at this is we know that if individuals take responsibility of their own lives and make the proper choices, they can have an immediate impact and a lasting impact on their health status.

Nous pouvons réduire le nombre de personnes qui souffrent du diabète; nous pouvons prévenir des maladies cardiaques; nous pouvons réduire l'incidence du cancer par les choix que nous faisons; mais il faut aider les gens à faire ces choix.

Il y a, je crois certains rôles que le Gouvernement fédéral

peut faire et fait très bien.

I want to highlight one role, and that is in the sector of food labelling. I believe we need to help consumers make appropriate choices. The federal government does that already, but there are other improvements that can be added to that to make sure that people when they buy food from the grocery store know exactly what they will be eating themselves or what they will be feeding their children.

When we can make those choices, it has a direct impact on the quality of our lives.

Therefore, we have adopted a strategy in New Brunswick of prevention, of promotion, of education, to improve the quality of life. Yes, there will be a secondary benefit. It will reduce costs. But the primary benefit is healthier, more productive citizens having a better quality of life.

Thank you, Prime Minister.

RT. HON. PAUL MARTIN (PMO Canada): Merci, monsieur le Premier ministre.

Premier Doer.

HON. GARY DOER (Ont.): Thank you, Prime Minister.

Again, I would like to reiterate Dr. Hamm's statements about the smoking and anti-smoking campaigns. Our teen smoking rate has gone down from 26 per cent to 21 per cent over the last number of years and the federal-provincial cooperation on this educational strategy has been very, very helpful. I think some of the fact that some of us have raised taxes on tobacco has also helped because there is a sensitivity.

But the other issue we have taken is we are banning all smoking in the workplaces by this October 1st. And it is not that popular with bar owners and restaurant owners and it will cost the economy money and people jobs, but it is, in our view, the right thing to do. We have given people enough lead time, hopefully, to be able to implement it properly.

I was also very delighted with the immunization program from the federal government, the national immunization program. Just a study came out last month from the United States saying that chicken pox immunizations could save thousands of families the pain but $100 million in cost in the health care system in the U.S. So I think the federal government had the right strategy with the provinces in the last non-accord that we came back with in the meeting.

The interesting part of that is we are I implementing that in Manitoba for chicken pox, meningitis and pneumococcal infections, but it is only three years -- 2004 to 2007 -- this is the former government, and now the new Prime Minister -- for a health care fix for a generation. This is a good thing to put part of it. Kids five years from now, you know, will need the

immunization program.

So it is a good idea. That is the example of things that start and stop. It's just good ideas should continue.

When I go to my focus groups, the soccer fields, and talk to other parents about what is going on, they want the schools open longer for kids and recreation -- and I am trying to do as much of that as I can -- they want to extend phys-ed to grade 12 -- and we are having community meetings to do that, hopefully, we are having public discussions right now as we speak -- and they are angry about transfats.

I don't have all the policy issues and analysis that is going on, but this train -- Premier Klein talked about, you know, find out which way the parade is going and get in front of it. I tell you, the public is so far ahead of everybody that I know on the policy side on this issue. There is such an anger when they hear of what happens with arteries with this material.

Now, I know that there is a food industry here and some of it is located in Manitoba. I know that it is not that simple just to change things. Labelling is effective. But certainly there is a strong populous view out there that we should be stronger on materials that are sold in our foods for food processing that eventually clog our arteries.

I don't know all the science about it, but I'm sure the federal government is hearing about it. I'm hearing about it and it is a lot louder and stronger in the communities than I sometimes hear in my policy briefings that take place.

So I raise those questions to you and I thank you for the opportunity to speak.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

Premier Williams.

HON. DANNY WILLIAMS (NL): Thank you, Prime Minister.

Again, the time is moving on. I will try to be as brief as I can.

I am disappointed in myself for not raising the profile of this issue even more. I think it is a huge issue. Premier Doer took the words right out of my mouth. If we want to talk about a fix for a generation, this is it. This is it.

When we think of sustainability -- and it is quite obvious around this table that, when it comes to sustainability, we don't want to look at some of the other option that are out there. Nobody around this table wants to consider those options, but this is a sustainability issue. It is a very, very important one. It is long term. It is visionary. There is no quick political return on it. There is no quick monetary return on it. But there is a huge return, at the end of the day, if we put enough funding into promotion and into wellness.

Now, as provinces, we are doing it and the federal

government is doing it, so I think we have to give ourselves a collective pat on the back for having doing something. Our Department of Health is working with the Provincial Wellness Advisory Council with a plan that promotes healthy eating, physical activity. There was an announcement by the Department of Education just today. We have an award-winning Newfoundland Heart Health Coalition, considerably one of the most successful programs in the country. We are leaders in initiatives to address tobacco addiction. We have invested in healthy children, healthy schools.

We are there, we are doing it, but we are not doing enough. This is a real investment. As Premier Lord said, there is two aspects to this. One is the health and one is the wellness and the ongoing health of the youth in our provinces. And it is also an investment. It is also a savings investment in the future of health care in our country.

In Newfoundland and Labrador, we are considered a little heavier than the rest of the country. The stats show we are a little plumper, to put it the best. The word "obese", I don't like. I don't think it is a good word. I don't think we should even use it. But the food is so good down there, we just tend to eat a little more of it. Corn beef and cabbage is going to get us in the end.

It's still cool to have a smoke in Newfoundland and Labrador, as well. But we have a duty to inform our populous, our people, specifically our children, and to inform them at a very, very early age that they are not doing themselves any good. It is too late when they look at the grotesque ads that are on the cigarette packages. I think they are very effective, but it is too late. They have already had a smoke that they got from a buddy at a very, very early age.

So I think we have to continue doing what we are doing in our provinces. I think that is probably the best money that we can spend in the country because we are going to make the young people of this country healthier, at the end of the day.

I think as a group here -- and the reason I am disappointed in myself -- I think we probably should have raised that issue to a much higher priority. And we have huge issues on the table here and we can't be expected to think of them all, but this is a big one and I think, collectively, it is an initiative that we should look to put more money into. I think we should look at something that we can do with the federal government, whereby there is an allocation whereby we can do national advertising and have some uniformity in our approach.

I welcome the initiatives of the other provinces. I have talked to Premier Calvert, who indicated that Premier Doer, in some of his focus groups, is testing some of the ads on the

children, themselves, to find out which ads would be the most effective. So we have to be smart about things like that.

It was interesting, when the Federation, at the Council of Federation meetings in Niagara, when the students across the country presented to us, it was interesting that they said that the medium that impacted them the most during the election was MuchMusic.

Now, the average age around this table, except for Paul, is probably up there a little bit, so we might not immediately think of MuchMusic as being the medium to go to. Now, we all watch it. We are still there. But we have to go to where the children are, what the children are watching.

So we have to be smart about this, but I just don't want to underestimates the importance of this. And even though it is late in the afternoon and we are dealing with it late in the agenda, it is a true investment in the health of our people and our country, especially the young people, and it is also a true investment, with an ultimate return on it, even though we will all be long gone by the time we probably see it.

Thank you, Prime Minister.

RT. HON. PAUL MARTIN (PMO Canada): I have been on MuchMusic. I have been on MuchMusic and let me tell you that the most expensive and panic-struck briefings I have of had in my life was before going on MuchMusic. It makes this look like a picnic, I have to tell you.

Minister Mar.

HON. GARY MAR (AB): Thank you, Prime Minister.

I would like to start where Premier Hamm started, and that is that I hope that some day there will be the case where matters of wellness and health promotion, in fact, are the first thing on our agenda, rather than the last thing in the day. I think the fact that it is the last thing in the day does not, in any way, suggest it is the least important thing that we are discussing today. I think every premier has made that point. I know every Minster of Health in this country could talk about the good things that are being done with respect to tobacco cessation, promotion of physical activity, proper eating habits.

The reason for that is because in 2002, Ministers of Health got together to work on a federal-provincial-territorial strategy for a pan-Canadian Healthy Living Strategy. It is through that strategy that every Minister of Health is able to find the best practices of every other jurisdiction. So I can assure you, Prime Minister, that every province has got programs similar to what Premier Hamm described and others have described.

I want to say this, Prime Minister, that, in looking at our health care system, we ought not be looking at it with respect to a time horizon that is consistent with the election schedule. It

should be something that we look at on a 20-year horizon. So sitting here today, in trying to project out what will be the large things that loom on our health care horizon 20 years hence, I would point out two: one is diabetes, Prime Minister. There are over a million Canadians with diabetes right now. In the province of Alberta, 1,000 more will be diagnosed this month, a thousand more next month and a thousand the month after that. This is something that, over a 20-year horizon, looms large on hour health care horizon.

The second area is one that has not been touched upon, other than in a very cursory manner here, and that is the issue of mental health, Prime Minister. This is something that I think also looms large on our health care horizon, as we look at it 20 years down the road.

So, the only point I wish to make, Prime Minister, is that I hope that we can continue with support for things like the pan-Canadian Healthy Living Strategy and that we address our minds to issues of mental health that heretofore have not been addressed in a particularly meaningful way and ought to be.

Thank you.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

Premier McGuinty.

HON. DALTON McGUINTY (Ont.): Hopefully, I can add something to the sense of priority that people have attached to public health.

Just to speak a little bit further about the diabetes issue, Prime Minister, I got some numbers recently which are shocking. If current eating and inactivity trends continue, one-third of children born after 2000 will develop acquired diabetes, type 2 diabetes -- one-third of our kids.

Of those cases, one-half will suffer renal failure, one-third will suffer heart attacks and one-third will have a stroke all because of insufficient levels of activity and poor eating habits.

There are some things we can do, obviously, in our provinces and territories. We are banning the sale of junk food in schools, we are making physical phys ed mandatory, not with a view simply to get kids to run around but, hopefully, in an ideal world, to have them develop an appreciation for and a desire for, an innate desire for, levels of activity throughout the remainder of their lives.

We gave, I think it was $20 million this summer to our schools. We found one of the problems we are having is that schools were charging kids some pretty healthy user fees and we weren't -- we couldn't use the gymnasium during the summer and we couldn't use the school grounds and kids were sitting around watching TV.

I just want to pick up on something I think that Gary Doer started here. We have an EcoLogo Program, we have energy efficiency standards. People today lead hectic just-in-time lives. You go to the supermarket today and you have to make a quick food choice for your child and you have to look at the back of the can. First of all, it doesn't matter whether you wear glasses or not, you are going to need glasses to read the ingredients there. And then, you have to be a nutritionist, some kind of expert, when it comes to comparing different kinds of products. What you really want to do is you want to give your kids the best quality food and we are not making it easy enough for them to make those choices. We know what an eco logo is all about. Some of us are familiar, at least, with that. We know that there is something that tells us when things are energy efficient for us. But we don't know the most important thing of all. We are what we eat and we are not equipped enough.

I think our government, at the federal level, should find ways to do more to inform us when it comes to making those important food choices for our families.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier.

Premier Okalik.

HON. PAUL OKALIK (NU): Prime Minister, one area that, unfortunately, we have been leading the country on is suicide. We lead the country and our rates are eight-and-a-half times the national average. We have been struggling very hard in trying to tackle this very real problem in our territory. We have set up working groups, tours throughout the territory and we are not getting very good results. So I mean to turn to your good government for help and trying to find the best solutions to the real problem that we are facing in our young territory.

A lot of our young people, unfortunately, have chosen to take their own lives. That is a very preventible thing. We are trying to find ways to work around it.

So I look forward to working with your government and trying to find a solutions to this very real problem in our territory.

Other issues that we face are smoking. We have banned smoking in all workplaces in our territory, in bars or any other place. So we are trying to do those things to offset some of the real problems that we are facing, but one real issue that we keep turning to is trying to prevent suicides. So I look forward to working with all governments on there real problem.

RT. HON. PAUL MARTIN (PMO Canada): Thank you.

I think once again, Premiers, it just shows you how the problems are different. I understand.

Premier Handley.

HON. JOSEPH L. HANDLEY (NT): Thank you, Prime Minister.

I want to also support those who have said this is an area

where we have to spend more money, where we can make a difference. Unfortunately, it is this area that always ends up getting funded the last. It is only natural that we fund the hospital care and the doctors and the nurses and the community health centres first. We have to do that.

This is an area that is chronically underfunded. It is also an area, though, Prime Minister, where I am finding in the North that a lot of Aboriginal governments are now beginning to recognize that they have to do more as well.

I think again I want to say the initiative from yesterday is a good one, because I think people are getting there and they recognize the relationship between diabetes and the food they are eating and alcohol and the accidents and the other things that are happening, and so on.

There is a lot of interest in doing more for young children. We, along with Nunavut, have banned smoking in all workplaces as a workplace safety issue. We did it last May. It has been implemented, it is in place, but we still have a problem with 65 per cent of our people in our small communities smoking. I think we are making some headway.

We do have areas -- and again this will be one of the last few examples of the high cost of doing business in the North I will mention. There will be more, but I don't want to bore you with them.

Just to give you an example of the kind of challenges we face, first of all, we are not able to afford to have public health agencies or services in three regions in the Northwest Territories that take up a lot of our Aboriginal population. We just can't afford to put the public health sections in those areas yet. We will when we have the money, but right now there is nothing.

We do a lot of public ads and we do as much as we can with the nurses in the communities, but there is not a focused effort in a big chunk of the Northwest Territories.

This year, as an example, we had a meningitis outbreak in the Northwest Territories. We had Arctic Winter Games going on, where we would have people from not only the Northwest Territories but Alberta, the other territories, eastern Russia, from Scandinavian countries, and so on, who would be participating, Greenland and so on. So we had no choice but to immunize every person under 20 years old in the Northwest Territories in order to make sure that we were not going to be spreading this on and have some kind of real crisis on our hands.

That cost us about $600,000 -- sorry, $533,000. The total amount of money that we get in the public health immunization trust fund is about $600,000 -- sorry, I think I got these backwards. $533,000 is what we get. We spent $600,000 just one

immunization program in the territories. That leaves us with nothing left for the rest of the immunization that has to be done across the territories for the balance of the year.

That kind of distribution of the money doesn't take into account the high costs we have.

Another incident in Colville Lake. We had an outbreak of tuberculosis, of TB. Because we don't have the money for a mobile testing unit, we had to fly practically everyone out of that community to Inuvik to have them tested, have them brought back. About 30 per cent of those people had to be put on pills for eight months. A nurse had to be hired. We are going to have to take them back out again. This is a huge expense of trying to deal even with public health in the remote communities.

So again, Prime Minister, that is the kind of challenge we face. It is also an area that I believe a lot of people in the North understand it but aren't yet turning it into action, but it is an area where I believe it is timely to put more money into public health but we will really have to deal with the other urgencies first and then have some money to be able to deal with it.

But I agree with everyone, this is an area where we can make a big difference.

Thank you.

RT. HON. PAUL MARTIN (PMO CANADA): Thank you, Premier.

Premier Campbell.

HON. GORDON CAMPBELL (BC): Thank you, Prime Minister.

I think that clearly a lot of the health development programs that have been done by the federal government have been very worthwhile and have helped Canadians. A lot of the prenatal care programs we will have are making a significant difference and we can talk in big sort of public policy ways about this.

But I have something that actually I think will work. I think we should actually encourage Canadians to have fun. We should invest in sport, and when we invest in sport we will have lots of Olympic gold medallists who will take the public health message out across the country so that kids actually can hear it and it is not us talking to them.

So I would encourage you to -- let's get behind those Olympics, let's get some medallists, get some participation and let's have a good time and we will get people being healthier.

Prime Minister, we do have the Olympics in 2010 in British Columbia.

--- Laughter / Rires

RT. HON. PAUL MARTIN (PMO CANADA): That's right.

Premier Binns.

HON. PATRICK G. BINNS (PE): Thank you, Prime Minister. A lot has been said and I will try not to be repetitious.

We certainly do support the panCanadian strategy for healthy living. We think it is a good one. It complements what we are doing provincially.

I want to mention a couple of things in terms of what we are doing to try to reduce chronic disease. The first one would be relative to tobacco.

We have had a number of programs going which have been helpful, programs like Operation I.D. with the great cooperation from convenience store owners and even tobacco companies to help ensure that kids buying tobacco are of age. Your support in that has been appreciated.

We brought in a Smoke Free Places Act in P.E.I. over a year ago. It has been very successful. It bans tobacco consumption in the workplace. It was somewhat controversial at the start, but we did quite a bit of education before introducing it and as a result it is being quite well accepted.

Many of the restaurants, bars, that sort of thing, were absolutely sure that, you know, this would destroy their businesses. I think it has had a minimal impact on most. Restaurants, for example, who may have initially experienced a drop in patrons saw a reversal in the months ahead. People came back, came back without their pack of cigarettes. Other people went to the restaurants that previously wouldn't go because they didn't like the smoke in the restaurant.

So I think it is been positive all around. It certainly reduced tobacco consumption. The reason I know for sure it has reduced tobacco consumption is because we have traditionally looked at revenue from tobacco as one of our revenue generators in the province and our revenues have dropped dramatically in the last couple of years from tobacco consumption.

In terms of increasing physical activity, we are obviously working with schools and so on. as everybody else is. We have been encouraging people to do their 10 kilometres a day, the 10,000 steps; encouraging people to put on a pedometer and figure out how far they have to go to get those 10,000 steps a day.

It is a sort of basic start in terms of good health. Once you generally know how far to go, then you don't have to continue at least wearing such an instrument. But it is important that we educate people in terms of sort of a minimum level of physical activity and we have been trying to do that.

In terms of improving eating habits, again working with our schools implementing eating guidelines which are given to school children.

I have given speeches, and so on, to encourage people to improve their eating habits. I set off a bit of a controversy when I suggested that everyone should drink at least 10 glasses of water a day. Some people thought, no, you don't have to drink

10 glasses of water a day, you can get by with six. Other people say, "Well, as long as it is an equivalent of liquid intake of 10 glasses of water, and so on."

It did set off a little bit of a local debate, which was interesting because it got people talking about it and at the end of the day people knew they should consume more liquids, and hopefully other than alcohol, and so on.

Here comes a glass of water. Thank you, Gary.

--- Laughter / Rires

But, yes, we all have a role in terms of educating. It doesn't take much sometimes to change a society. Some of these things don't cost a lot of money and are obviously important in prevention. So there are a lot of best practices here and I'm glad we are sharing them because progress can be made right across the country by picking up these measures.

Thank you, Prime Minister.

HON. LORNE CALVERT (SK): Mr. Prime Minister, very, very briefly.

I would suggest to all Canadians tonight a very healthy thing to do would be to vote for Theresa at Canadian Idol, from Saskatoon, Saskatchewan.

RT. HON. PAUL MARTIN (PMO CANADA): I think, Premier Calvert, we are all politicians and well done.

--- Laughter / Rires

On the subject that we have just discussed, public health and promotion, I think that we all -- I certainly share the view that you have all set out of both the importance and the necessity to raise the awareness.

Let me just make a couple of points as we close today's session.

First of all, as you know we have established a public health network really based on existing facilities across the country, the facility at Winnipeg, I think right across the country. I think that is very, very important. We will be appointing a new Chief Public Health Officer within a very, very short period of time.

The importance of this -- I don't think again I have to stress -- infectious diseases from abroad, from West Nile to SARS to Avian flu, to God knows what, are clearly on the rise and it is something we have to deal with.

In terms of having a federal government focus both on public health and on health promotion, Dr. Hamm, your request, I can tell you that Dr. Carolyn Bennett, who is here, is that focus. We very much share your view and she has the responsibility.

So let me put it this way, Gordon, there is no doubt about the Olympics, but if we do not win a bunch of medals it is Dr. Bennett's fault.

I am told in terms of the point that you raised, the point -- le point que vous avez soulevé, Monsieur Lord, en même temps le point, je pense que M. Doer -- in terms of new nutritional labelling, my understanding is that we expect that within the next two years. I'm not quite sure why it is taking two years and I will find out, but it is well under way and it will deal with transfats, among others.

Just one very small point. It is interesting and coincidental Dr. Hamm that you were the one who in fact made the presentation here on promotion. Perhaps the greatest insight I saw into the need for health promotion occurred at a meeting I had at Coal Harbour in Dartmouth with a group of community activists on the importance of community in health promotion and taking charge. I have to say, that is a tremendous beehive of activity in terms of health promotion of which I'm sure you are very proud.

In closing on the overall day, I think we have had a good discussion on the health agenda. There is a lot of agreement. I think that this was probably pretty close to the way in which a behind closed doors meeting takes place in terms of the presentations and then the dialogue.

A number of consistent themes. Certainly about timely access. I don't think there is anybody who disagreed. Need for quality health care services; the need to reduce wait times and make it principal focus; the fact that information, the targets, the benchmarks are very important.

Toute la question de l'accessibilité, la question de baisser les délais d'attente, la question de l'information, les cibles, tout cela, je pense qu'il y a un accord fondamental entre nous.

Also, the overall broad agenda from health professionals to primary care to home care to pharmacare. I think, Premier McGuinty, we will very quickly -- Mr. Dosanjh, on your suggestion and the whole question of prevention and public care.

Je reconnais aussi que tout ce dont nous avons discuté, cela prend de l'investissement, cela coûte de l'argent. C'est ce dont nous allons discuter, je crois, ce soir.

I recognize that all of this takes money, and I believe that is what we are going to be discussing tonight.

I know on your behalf that we all want to wish Canada, Team Canada, the best of luck tonight. It is clearly "Go Canada go".

I want that for two reasons. I want Canada to win and I also hope that they put all of you in a good mood.

So thank you very, very much.

--- Laughter / Rires

--- Whereupon the meeting adjourned at 1700 /

La réunion est ajournée termine à 1700