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FIRST MINISTERS' MEETING

RÉUNION DES PREMIERS MINISTRES

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RT. HON. PAUL MARTIN (PMO Canada): If I could call this First Ministers' meeting on health care to order.

Je declare la réunion ouverte.

I will begin as soon as our friends depart.

Messieurs les premiers ministres, chers Canadiens, chères Canadiennes, Premiers, fellow Canadians, medicare speaks eloquently to our values as a nation, to our priorities as a people, to both our unity of purpose and our sense of self in an evermore and challenging and complex world. It makes us proud.

Over the course of the past half century, medicare has become a vital aspect of our shared citizenship, what every Canadian can rightfully expect wherever they live, whatever their income. More than that, it is quite simply a good and sensible idea. And like so many good and sensible ideas, it was difficult to achieve, almost two decades from aspiration to realization. It was a hard slog.

tout comme ceux qui nous ont précédés dans les fonctions que nous exerçons aujourd'hui ont eu à le faire. Nous qui sommes assis autour de cette table, nous avons un défi à relever. Nous devons renouveler la confiance dans la qualité de notre système public de santé en assurant la viabilité. Nous devons redonner un sens au principe d'égalité d'accès aux soins et nouer un véritable partenariat afin de réaliser ensemble un projet rassembleur.

Les Canadiens et les Canadiennes veulent que soient réglés les problèmes en matière de soins de santé, les problèmes dans leurs collectivités, les problèmes qui affligent leur famille. Ils veulent voir un médecin lorsqu'ils en ont besoin, dans un lieu qui leur convient. Ils veulent savoir que le système de santé sera en mesure de leur fournir les services nécessaires en temps opportun et que ce système sera solide.

Nous sommes conscients du besoin de renforcer le système de santé. Nous comprenons le défi qui se pose. C'est à nous que ce défi est lancé. C'est à nous de le relever.

As we begin our discussions, we are fortunate to have at our disposal recommendations provided by several provincial commissions on health, including those of Ken Fyke in Saskatchewan, Michel Clare au Quebec and Don Mazankowski and Gordon Graydon in Alberta, as well as two national commissions

on the state of the Canadian health care system, those of Michael Kirby and Roy Romanow.

We have come here to talk about reform. But in so doing, we must not lose sight of the fact that, for the most part, and for the great majority of Canadians, the health care system serves us well, efficiently, delivering high quality services and we have good reason to be optimistic.

Let me just say to my 13 counterparts around this table, that, as Prime Minister and as a former finance minister, I understand the challenges that you and your governments have had to overcome and the problems that you have had to solve to maintain quality health services in an era of rising costs. It has not been easy for you. I understand that and I both see and salute the good work that you have been doing. All Canadians should be proud of the choices that we have made as a nation over the years and all Canadians should be proud of the leadership shown by the provinces in managing and reforming health care.

We have built a publicly funded and universally accessible system of health care and improved the quality of life enjoyed by the people of our country. Possessing a key to the past will not by itself allow us entry to the future.

Few would dispute the prevailing realities of our time. People in this country are increasingly anxious about their ability to get in to see the right health care professional at the right time. Meanwhile, financial pressures are increasing as our population ages, as medical knowledge and specialization expands and is beneficial, but expensive, new treatments become available. Plainly, costs cannot forever grow faster than government revenues.

L'une des raisons qui explique pourquoi le système public de santé du Canada se compare si favorablement à d'autres est liée au type de fédéralisme qui existe au Canada. Ce fédéralisme nous permet de travailler ensemble, dans un but commun, en misant sur les forces de chacun mais avec une flexibilité qui, non seulement permet, mais favorise l'adaptation et l'innovation.

Tout cela nous rend plus forts. Nous pouvons profiter de l'ingéniosité et du bon travail des uns et des autres.

Ce genre de collaboration n'est pas nouveau. En effet, ses origines remontent aux vifs débats qui ont précédé la création du système public de santé. Quand je pense à cette époque, ce

qui ressort le plus, c'est l'émergence, non pas d'une solution provinciale ou fédérale, mais d'une solution canadienne, collective : l'engagement à l'égard d'un objectif commun et le respect des responsabilités de chaque ordre de gouvernement.

Canadians want to know that their governments, Canadians want to know that we are working together to preserve and strengthen the health care system. Quite simply, they are tired of us fighting. We, at this table, occupy different points along the Canadian political spectrum, but we must be guided by the greater good. We must be guided by the same spirit that enabled those who came before us to forge medicare, to build health care, and, in so doing, to achieve that rare government initiative that not only speaks to a people, but speaks for a people.

With authority comes responsibility. Our responsibility, as First Ministers, is to ensure that there are no second-class citizens, in terms of the scope, the standard, the quality and the timeliness of care. It is a responsibility that alone we cannot meet, only together can we succeed.

The best measure of the success of our efforts will be access: access to the right health providers, to diagnostic procedures and treatments, where needed, when needed. If we are to enhance the quality of care, if we are to increase the confidence of Canadians in the system to better address their health needs now and in the future, then this is where we must focus.

Anxiety over waiting times is beginning to erode Canadians' confidence. People worry about having to wait months to see a specialist or having a critical test. They worry about needing to wait a year or longer for the replacement of a hip or the removal of cataracts. It is commonsense that when you treat people sooner they get well sooner.

But the reduction of waiting times is not just an important end unto itself, it is the catalyst for much broader reform and improvement within the system. It will drive positive change and spur innovation. This is not theory, it is fact. It has already been demonstrated across the country.

There are specific examples in which the efforts of the provinces are already paying off: the Western Canada Wait List Project, the Ontario Cardiac Care Network, the Orthopaedic Surgery Wait List Project in Nova Scotia. What provincial experience demonstrates is that when you begin to reduce waiting

times, you get a culture change, a shift, from a system-based care to patient-based care. This is a transition we all aspire to achieve and that is why we must emerge from these meetings with a solid action plan for addressing the challenge of access and waiting times.

La réduction des temps d'attente exigera une approche globale qui intègre tous les secteurs du système de santé en partant des services et des ressources humaines jusqu'au financement et aux comptes rendus aux citoyens. Elle exigera une réforme accélérée des soins offerts aux familles et aux collectivités, la hausse du nombre de médecins, d'infirmiers et d'infirmières et d'autres professionnels de la santé ainsi que l'expansion des soins à domicile et de l'assurance médicaments. Elle exigera à la fois l'augmentation des fonds consacrés généralement à la santé et un fonds spécial réservé uniquement à la réduction des listes d'attente. Elle exigera, en dernier lieu, des points de référence et une information crédible et comparable afin de mesurer les progrès accomplis et les écarts existants et d'en faire rapport publiquement.

According to the experts, real results await us on waiting times if we have the discipline to be focused in our approach. We must measure the existing queues, we must find out where the bottlenecks are and precisely targets the resources required to fix the problem. The upshot is that if we shorten waiting lists systematically, smartly, relentlessly, the whole health care system becomes stronger and better able to help Canadians get well and stay well.

So now let me touch briefly on some of the main elements of reform.

Toute discussion sur les délais d'attente et sur la viabilité du système de santé doit comprendre l'examen des soins primaires ou de la médecine familiale ou communautaire, la porte d'entrée des Canadiens dans le système de santé. Parlez-en à ceux qui sont au courant et ils vous le diront. Si vous voulez améliorer le système de santé, vous devez veiller à ce que les Canadiens puissent consulter le professionnel de la santé qui convient dans un lieu qui convient.

C'est pourquoi, lors de rencontres récentes, nous, autour de la table, nous nous sommes fixé un objectif : que d'ici 2011, au moins 50 p. 100 des Canadiens aient accès à des fournisseurs de soins de santé de qualité, 24 heures sur 24, 7 jours sur 7.

To help accelerate family and community care reform, the federal government established a Primary Health Care Transition Fund. We did this to encourage health professionals to come together and to work in interdisciplinary teams to deliver better quality care to their patients. The fund also assists in the development of tele-health and tele-medicine applications so timely access to quality care becomes a reality for Canadians in rural and remote parts of the country. We have also invested in Canada Health Infoway to facilitate the creation of electronic health records that allow patients to move seamlessly across the continuum of care. This is an important demonstration of the potential allies in achieving health solutions through information technology.

Provinces have made important strides to date in family and community care reform and I believe that at this meeting we should explore how we can accelerate progress, how we can learn from one another and share best practices, like P.E.I.'s family health centres, Alberta's tripartite agreements and Saskatchewan's primary health care teams, where nurse practitioners, physicians and other health providers share responsibility for patient care in community settings. We must closely examine scope of practice and the role of various health professionals in the context of our need to improve access to medical care, so I look forward to the constructive proposals as to how the federal government can support these efforts.

La réforme des soins primaires est essentielle mais elle ne peut se faire sans augmenter le nombre de médecins, d'infirmiers et d'infirmières et d'autres professionnels de la santé. Il faut être franc, ce n'est pas par magie que nous allons accroître le nombre de chirurgiens, de radiologues, de techniciens, de pharmaciens et d'autres professionnels indispensables. Comme nous le savons, nous ne pouvons pas former des professionnels de la santé du jour au lendemain. Nous ne pouvons donc pas nous permettre de perdre du temps.

Dans le cadre de l'accord de 2003 sur la santé, le gouvernement fédéral investit 85 millions de dollars dans l'élaboration d'un cadre national de planification. Ce cadre permettra de prévoir avec précision l'offre et la demande des professionnels de la santé, de faciliter la formation interprofessionnelle et de contribuer au recrutement et au maintien en poste du personnel médical.

Nous avons déjà fait des efforts dans ce sens mais ce n'est que le début.

Tout d'abord, il est essentiel d'augmenter le nombre de professionnels de la santé formés chez nous, ici, au Canada. Pour ce faire, les efforts individuels ne suffiront pas. C'est seulement en travaillant ensemble, en tant que pays, qu'on y arrivera.

Accreditation is another route to increasing the supply of doctors and health professionals and here, again, we have serious work to do. When it comes to accrediting the foreign trained professionals who already live here, we have not achieved enough in the way of progress with the licensing and regulatory bodies. We need to end the terrible waste of scarce human resources that occurs when these professionals are unable to seek work in health care.

To that end, we, as a government, are committed to spending $75 million to help train 1,000 new Canadians to provide first-class primary care right across the country. But this, too, is only a beginning. We must, all of us, do more on accreditation, on recruitment and on creating more spaces in our medical schools.

Prenons maintenant les soins de santé à domicile, un des éléments de l'accord de 2003 sur la santé. Des sommes avaient été affectées à l'établissement d'un programme national de soins à domicile qui ferait en sorte qu'il serait plus facile pour certains patients de choisir de recevoir des soins chez eux, dans un milieu plus confortable et moins coûteux. Cette mesure réduirait les temps d'attente en libérant des lits d'hôpital.

Le programme devait se limiter aux patients qui récupèrent d'une intervention médicale majeure, comme une chirurgie, patients ayant des besoins en matière de santé mentale qui seraient traités, autrement, dans un institut, et aux malades en phase terminale qui nécessitent des soins de fin de vie.

Common sense tells us that for home care to meet its objective, the quality of care that is available to patients at home must be equal to that obtained in a hospital. Our health reform fund was designed accordingly and yet serious gaps still exist. Canadians have yet to see the home care vision expressed in the 2003 accord take shape. We simply have to do better. Just think of it from a patient's perspective. You are in a hospital, your drugs are paid for; you go home, they are not. Patients may prefer to get well at home. Their doctor may agree

it is the best medical course, but most of the time the patient stays right where they are. And no one can blame them. I have to tell you, we need action on this. We have to deal with the issue of first-dollar coverage and we have to do the hard work of building on existing home care services, while ridding them of inconsistencies and barriers.

Finally, I want to address pharmacare, as you have done in recent weeks. Pharmacare has evolved to become an integral part of the Canadian health system. It is not simply an ancillary service that can be cut off and segmented from the rest of medicare. It is something that we are going to have to deal with together. That is why we provided funds for catastrophic drug coverage in the February 2003 accord: to help relieve pressure on provincial and territorial budgets and to assist Canadians in need. And that is why we should work together toward a national strategy that will contain costs, improve quality and access and, perhaps the most important of all, make certain that no Canadian family ever suffers financial ruin because of the costs of needed drugs.

We need a strategy that recognizes that both orders of government have responsibilities in this area. The federal government will continue to do its part.

Nous devons consacrer plus d'efforts à l'évaluation de la sécurité des médicaments, au soutien d'une gestion efficace des traitements pharmaceutiques et à la modification des processus d'approbation des médicaments pour accélérer l'accès aux nouveaux traitements.

Nous pouvons aussi évaluer la possibilité de créer un formulaire pharmaceutique national et la mise en ouvre de stratégies communes pour l'achat de médicaments de façon plus avantageuse pour tous.

Laissez-moi maintenant vous dire quelques mots sur la santé publique.

La santé publique est une composante essentielle de tout bon programme de réforme de la santé. Le gouvernement a des responsabilités très claires en matière de santé publique, qu'il s'agisse d'assurer la sécurité des instruments et des produits médicaux ou établir des critères d'inspection pour les aliments et les médicaments. Nous croyons que l'immunisation est un volet essentiel de la promotion de la santé. C'est pourquoi nous contribuons de 300 millions de dollars en vue de l'introduction

de nouveaux vaccins recommandés pour les enfants et les adolescents.

The creation of the new Public Health Agency, along with the appointment of Canada's first Chief Public Health Officer, will be an important step towards our shared objective of combatting epidemics and other health emergencies while improving collaboration on public health issues.

I believe we need to emerge from this meeting with a commitment to work together to establish benchmarks for health outcomes, to coordinate our efforts to reduce risk factors like obesity and smoking and to pool our resources to support public education and awareness. The benefits of such cooperation will be real and many.

Aboriginal health: we had a successful meeting this morning, thanks to you and thanks to the Aboriginal leadership. The federal government has very specific responsibilities to provide health care services directly to First Nation communities across Canada. The Prime Minister of Quebec said we have a fiduciary responsibility, and we accept that.

Earlier today, as those who were watching on television may have seen, we sat down with the Aboriginal leaders to discuss the principles of a collaborative agenda to address health needs among their people. The challenges in this regard are real and, in some cases, very much unique, as was also said this morning. Our session this morning was productive and the federal government will build on its existing contributions to Aboriginal health: we will invest directly to increase the number of doctors and nurses in Aboriginal communities. We will also fund an increased number of clinical placements, which will bring more health professionals to First Nations and Inuit communities, as well as rural and remote regions.

We also recognize -- and I say this to the premiers of the three territories -- that we recognize how important it is that we cooperate in a specific way, in terms of Aboriginal health and in terms of the health of your own peoples.

Geography is but one of the challenges facing health care service north of 60 and is a formidable one. Earlier, I spoke of tele-health and tele-medicine applications. These services offer real potential to improve the quality of care available to people who live in the North and while some progress has been made here, more must be done.

We should, for instance, invest in improving transportation services in the North, and we are prepared to share with you. We have must make it easier and faster for people in need to travel the distance they must to get the care they require.

J'aimerais maintenant passer à la question du financement. Rappelons quelques faits récents.

En 1999, le gouvernement fédéral s'est engagé à affecter à la santé la somme supplémentaire de 11,5 milliards de dollars sur cinq ans. Dix-huit mois plus tard, en l'an 2000, il a versé encore 21 milliards de dollars à cette fin. En 2003, nous avons annoncé un investissement de 35 milliards de dollars de plus sur cinq ans. Depuis, ce montant a été bonifié d'un autre 2 milliards de dollars. Voilà près de 70 milliards de dollars en nouveaux fonds affectés à la santé depuis 1999. Si l'argent à lui seul pouvait améliorer le système, le tour serait joué.

Cela dit, le financement constituera un volet important de la réforme. Il faut un plan de financement à long terme, de dix ans, qui fera en sorte qu'à l'automne prochain nous ne serons pas encore de retour ici.

Canadians do not want us to reprise and rehash the traditional arguments about money, arguments that have obscured more than they have informed.

Canadians deserve more than an annual dispute about shares and the value of tax points. This is not federal money. It is not provincial money. It is Canadians' money and there is only one taxpayer. Canadians deserve a 10-year plan that actually holds for 10 years. That is the plan that we would propose here today.

First, we will fill the Romanow gap, a one-time shortfall in federal health funding that was identified in the report of Commissioner Roy Romanow.

Second, we will establish a new base for the Canada health transfer next year, consistent with the recommendations of the Romanow report.

Third, for the first time the federal government is prepared to provide an annual escalator that will ensure predictable and growing federal funding for health care.

Fourth, we will provide $4 billion in a partnership fund to deal with current backlogs and to kick-start reform.

Now, some provinces have made the point that they can't really have a legitimate discussion about health care reform and funding without addressing questions related to equalization.

This issue was to be discussed at a subsequent meeting before the next federal budget, but we are prepared to advance that meeting, to accelerate it, to have it now instead of at a later date. We are committed to long-term financing because we believe that is the best way, the only way to end the perennial debate over funding, enable us to stop focusing on how much money we get and to start focusing on what we get for our money.

Sound and responsible fiscal management by the federal government over the course of the last decade has put us in a position to do this. We have the opportunity here and we must seize it.

When it comes to health reform, Canadians expect real and meaningful accountability. This point was made by Premier Campbell, it was made by Premier Calvert this morning. They deserve to know what they should expect and what they are getting. It is Canadians' right. They deserve evidence-based benchmarks that define timely care, scientific benchmarks determined by the best advice of health professionals and established objectively. They deserve clear targets, again as was discussed this morning, reflecting these benchmarks and provincial priorities, and they need to see how their governments are doing and how they stack up.

We must agree on a detailed process of information, on benchmarks, on targets and accountability to Canadians. They are essential components of genuine reform.

We need good, comparable information to manage effectively. We need benchmarks to know what we should be doing. We need targets to drive change. And we need credible reports to ensure Canadians know how we are doing.

We need to safeguard not only the principles of medicare, but also the principles of accountability. I know that all of you are doing enormous amount each within your jurisdictions toward this end. Where we have disputes, let's formalize the mechanism that governments have already agreed to, thanks primarily to the work of Alberta.

In conclusion, the debate about health care costs, its reform is not new. In 1968 and 1976, during the infancy of medicare, there were 10 major inquiries commissioned, federal, provincial, into growing health costs and how to ensure the health care system could be made sustainable.

We find ourselves on familiar, if somewhat frustrating, ground. But what is new is a kind of critical mass that we take

with us into our discussions. We have, in recent years, witnessed the futility of annual deals, deals entered into in good faith, and we have learned from these disappointments. We find ourselves today presented with the opportunity to break the cycle and now I believe is the time to take action, to get a handle on costs and encourage new innovation and reform, by taking direct aim at waiting times and improving access.

We all have roles to play in achieving this progress. As I indicated earlier, much of the strength of our federation lies in its flexibility within common purpose. It is the federal government's role to articulate national objectives to protect the national interests, but it is of course the provinces and the territories that deliver and manage health care; and, in so doing, tailor health care services to the specific needs of their population.

It is my firm belief that some key principles transcend regional interests. Canadians want our nation's familiar high-quality health care system to be there for them no matter where they go in the country.

La base d'une entente commune est présente, une entente qui répond aux diverses visions provinciales et les réunit dans le cadre d'un accord canadien commun.

La génération qui nous a précédé a créé le système public de santé. Il nous incombe aujourd'hui de renouveler pour notre époque ce qu'elle avait accompli pour la sienne.

La question des soins de santé est primordiale pour les Canadiens. Nous sommes ici pour exprimer leur point de vue et nous aurons des comptes à leur rendre.

The federal government is absolutely committing to working with you, our partners, to secure not just any plan but a lasting and productive plan that brings real results that Canadians can see. I look around this table and I see provincial and territorial leaders who are committed, who are determined and who are focused. We know this is hard work. We know there is no simple solution; and, heaven knows, you know of the challenges. But that is our job. It is what we signed up for, so let's get down to it.

Thank you very much.

I would now like to call on the Premier of Ontario.

HON. DALTON McGUINTY (Ontario): Thank you very much, Mr. Prime Minister.

As Chair of the Council of the Federation, I have the honour of speaking on behalf of my fellow Premiers. As Premier, I have the privilege of speaking on behalf of Ontarians. But I speak as well as a son, a husband and a father. In this respect, I speak for my fellow Canadians.

We want quality health care for our parents and grandparents when they need it; for our own generation as we need it; and for our children and their children should they need it. We want health care that is more responsive today and that can be sustained for the future.

We bring to this table what Canadians have brought to the task of building the greatest country in the world, namely, equal parts realism and optimism.

Let's be clear-eyed about the challenge facing us. Our populations are growing. The baby boom is about to become a patient boom. Medical treatments and technologies are expanding and we, as provinces and territories, as the people who deliver health care, simply don't have the resources we need to provide the care Canadians deserve.

But we know we can meet this challenge if we meet it together, if the provinces, territories and the federal government become full partners in health care. We agree with you, Mr. Prime Minister, on the goal. We simply must reduce wait times. We can reduce wait times with a comprehensive approach that improves health care across the board, from family medicine to home care, to long-term care, while making the system more accountable, but we need the full support of the federal government to make the plan happen and to reach our goal. And we need that support not just for one or two years, but year after year after year.

Prime Minister, that full support, the full support that will give us the resources we need to deliver the health care Canadians deserve, is not what the provinces and territories have been offered so far. We remain optimistic that the gap can in fact be bridged. We are optimistic because we believe that each of the 14 sitting around this table is genuinely committed to better health care for Canadians. I assume, Prime Minister, that each of us are drawing inspiration from the 30 million we are privileged to represent here today. But we insist that we be realistic and start these proceedings by realizing a gap does exist and it is significant.

There are two challenges with the funding the federal government has offered so far. One, it falls short. Two, it is short term.

It falls short of what we, on the front lines of health care, need to aggressively need to attack waiting times. Officials from three provinces costed the health care plan outlined in the federal Liberal platform. This analysis, which we are happy to offer for independent verification, concludes that it will cost the provinces and territories $8 billion a year to make the plan happen. The latest federal offer would increase annual funding by $2 billion a year. It is like going to the store to buy $8 worth of goods with only $2 to spend, but not quite because we are not talking about items in a store. We are talking about cataract surgery for people who are struggling to see; joint replacements for people who can't walk without pain; cardiac and cancer care for people who can't wait without worry. On these kinds of items, we just can't fall short.

But the federal proposal so far does. It is also short term. While numbers in excess of $10 billion have been used to describe the federal offer, it would in fact deliver an average of $2 billion each year in ongoing annual funding. The funding allocated to reduce wait times declines by half in 2008 and disappears completely in 2009, just when baby-boomers will be turning to the health care system in unprecedented numbers. I know that none of us around this table would want to hire nurses and open up MRIs this year, only to fire those same nurses and shut down those same MRIs a few years from now when they will still be desperately needed by patients, if not more so.

En même temps, les Canadiens veulent que nous soyons tous prudents et raisonnables avec leur argent. C'est un fait qu'il est prudent et raisonnable de penser que le gouvernement fédéral a les moyens d'en faire davantage.

Bien que les chiffres fassent l'objet d'un certain nombre de discussions, tous conviennent que le gouvernement fédéral disposera d'importants surplus qui augmenteront avec le temps, tandis que les provinces et les territoires font face à des déficits chroniques.

A study conducted for the federal government by the Conference Board of Canada, based on assumption provided by the federal government, estimated annual federal surpluses will reach $31 billion by 2014-2015, while provinces and territories face deficits as much as $9 billion over the same timeframe.

It is no coincidence that the provinces and territories are taking on the lion's share of the growing demand for health care. Health care accounts for an average 41 per cent of provincial program spending. It is 46 per cent in Ontario. But it is only 15 per cent of federal program spending.

Prime Minister, we are proud to deliver health care. It is a responsibility we cherish, but we need your full support to deliver the health care Canadians need. We work on the front lines. We know what needs to be done.

The Council of the Federation, along with our finance and health ministers, have been working on ways to deliver the shorter wait times that we all want for Canadians. They include a human resources strategy to attract more doctors and nurses; improved access to community care; more diagnostic tests; more health promotion and preventative care; better technology for sharing information; improved Aboriginal health; and a national pharmacare strategy.

We know what needs to be done. In fact, provinces and territories are already taking the first steps. In Ontario, for instance, we know that surgeries are delayed not so much because of a bed shortage but because of a shortage of nurses. So we are working to make nursing more attractive by creating full-time jobs for 8,000 nurses and purchasing 12,000 new bed lifts to improve their working conditions.

We know that some Ontarians can't get into a hospital because other Ontarians can't get out of the hospital and into home care. So we are working to provide home care for an additional 95,000 Ontarians.

We know that thousands of Ontarians don't have access to a family doctor. So in addition to building a new medical school, and expanding medical school spaces at our existing medical schools, we are working to create 150 new family health teams. These are teams of doctors, nurses and other health care professionals working together to provide primary care around the clock.

Our plan is to provide an additional 9,000 cataract surgeries every year, an additional 36,000 cardiac procedures every year, and an additional 2,300 hip and knee replacements every year.

Ontario is laying the ground work to shorten those waiting times. With the resources that we have we are doing all that we can. But to do all that needs to be done, we need more

resources, not just for a few years but year after year after year.

I want to speak for a moment specifically on behalf of the Ontarians I am privileged to serve.

Ontarians are proud Canadians. We are proud of our country and our contribution to it. In fact, we contribute $23 billion more in taxes and non tax revenue to the federal government than we receive in federal program spending. And we are proud to be a full partner in Confederation. We ask only that the federal government now be a full partner in health care.

Pour les Ontariens et pour les autres Canadiens, l'assurance-santé représente la plus belle expression des valeurs canadiennes. Nous nous soucions les uns des autres, nous nous entraidons et nous ne le faisons pas en privilégiant les mieux nantis, mais en considération des personnes qui ont les besoins les plus grands.

Canadians are proud of our health care system. They are realistic about the challenges it faces, and they remain hopeful that we can meet those challenges. As their representatives we share their pride. As their servants we must equal their realism. But most of all, as leaders we must do all we can to realize their hopes for the future.

We must seize this historic opportunity to forge a full partnership, one that will deliver quality health care for our parents and grandparents when they need it, for our own generation as we need it, and for our children and their children should they need it.

Mr. Prime Minister, Canadians are counting on us. We can do this.

Merci.

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

Because there are many speakers and because there are many of you and one of me, I will perhaps respond later rather than respond every time.

Je demanderai maintenant le premier ministre du Québec, M. Charest.

HON. JEAN CHAREST: Merci, monsieur le premier ministre. Je comprends qu'il y a un seul premier ministre du Canada, il y a un seul premier ministre du Québec et premier ministre des territoires et des provinces, mais il est vrai également qu'il y a un seul contribuable. Et lorsque les citoyens canadiens se présentent pour recevoir des services de soins de santé, il y a

une seule personne, qui eux s'attendent, évidemment, à ce que nous travaillions en étroite collaboration pour qu'ils puissent justement recevoir les services auxquels ils ont droit.

Cela explique, je crois, les attentes très considérables qui ont été placées sur nous pour cette conférence fédérale-provinciale-territoriale sur la santé, un engagement que vous aviez pris avant la campagne électorale, un engagement que vous aviez répété pendant la campagne électorale, et je tiens à vous dire que tous les collègues qui sont ici aujourd'hui et qui sont membres de ce conseil de fédérations ont applaudi le fait que, dès votre entrée en fonction, vous avez manifesté la volonté de faire davantage de réunions et d'échanges avec les autres partenaires de la fédération.

Alors il est, je pense, de mise, que l'enjeu le plus important auquel nous faisons face fasse l'objet de cette première réunion. Il faut le dire, pour nous, ce n'est pas seulement des statistiques et des chiffres, surtout pour ceux et celles qui ont la responsabilité de livrer les services de soins de santé, pour qui c'est notre première compétence, évidemment, par ce que les pressions sur nous et sur le réseau de la santé sont très, très importants. Pour nous, c'est des salles d'urgence dont on parle, c'est des délais d'attente qui sont trop longs dans certains cas, des listes d'attente qui se sont allongées, des soins qui augmentent aussi de façon très rapide.

Parce qu'il faut souligner que les soins de santé au Canada sont aussi tributaires d'un phénomène de vieillissement de population qui, il faut le dire en même temps, n'est pas en soi négatif, mais qui ajoute des pressions, année après année. Ça, je peux vous dire, je peux vous confirmer que c'est encore plus vrai au Québec, où le phénomène de vieillissement de la population est plus important qu'ailleurs. Eh bien, année après année, tout ça ajoute des pressions considérables sur le réseau de la santé.

Comme les autres Canadiens, les Québécois et Québécoises adhèrent à ces valeurs qui sont énoncées dans la Loi canadienne sur la santé qui veut que nous ayons un système public, basé sur un principe de justice sociale, de compassion, et qui permet à chaque citoyen et citoyenne d'avoir accès à des services de soins de santé et de le faire peu importe leurs revenus.

Cela étant dit, monsieur le premier ministre, je me suis beaucoup réjoui que, pendant la campagne électorale fédérale, vous avez annoncé la santé comme étant votre première priorité

parce qu'il y a là une convergence aussi avec les priorités de tous les autres gouvernements qui sont autour de la table aujourd'hui. Et tout ça est le reflet du fait que, chez les citoyens canadiens et les citoyennes canadiennes, certainement au Québec c'est la première priorité.

Je tiens à vous dire que, d'entrée de jeu, le gouvernement que j'ai n'a pas hésité un seul instant à bouger. On n'a pas attendu non plus après quiconque pour remplir notre engagement, de telle sorte que, lors de notre premier budget, on a augmenté, nous, notre financement de l'ordre de 7,2 pour cent. On a augmenté notre financement de l'ordre de 5,1 pour cent lors de notre dernier budget. Depuis 18 mois qu'on a été élus, nous avons augmenté au Québec le financement pour la santé de l'ordre de 2,2 milliards de dollars. Le financement de la santé a passé le cap des 20 milliards de dollars au Québec. Ça représente, dans l'ensemble des dépenses de programmes du gouvernement du Québec, 43 pour cent de nos dépenses de programmes. Et la tendance que je viens de vous décrire est exactement la même tendance que le Nouveau-Brunswick, la Colombie-Britannique, la Saskatchewan, tous les autres gouvernements.

Soixante-quinze pour cent de l'augmentation des dépenses de programmes de la dernière année sont allés chez nous à la santé.

Je le dis peut-être en élevant un peu la voix pour une raison fort simple, vous comprendrez que ça nous irrite un peu quand on se fait dire par certains intervenants, dans le domaine de la santé, qu'il faudrait que les gouvernements provinciaux, territoriaux soient redevables à quiconque pour leurs dépenses dans la santé. S'il y a quelqu'un qui cherche à avoir des réponses, il n'aurait qu'à interroger tous les autres ministres de mon gouvernement pour savoir où va l'argent.

Cette tendance en soi devrait retenir notre attention parce qu'il y a là un enjeu très important pour l'avenir du réseau de la santé mais aussi pour toutes les autres missions essentielles de l'État.

Du côté des réformes, je vous souligne aussi que l'État québécois n'a pas attendu après quiconque pour entreprendre des réformes depuis les 20 dernières années et toutes tendances confondues, que ce soit la télémédecine, que ce soit les réformes qu'avaient entamées, par exemple, Marc-Yvan Côté, sous le gouvernement de M. Bourassa, la création des CLSC, dont nous sommes si fiers au Québec, qui est un élément très important

dans le réseau de la santé québécois. Tout ça témoigne de notre volonté de faire des réformes, notre volonté historique.

Mais, depuis l'élection du gouvernement, j'ajouterais à cela les changements pour la création d'agences, la mise en réseau de notre système de soins de santé, de telle sorte que ce soit un réseau qui reçoit le patient à la porte du CLSC, de l'hôpital ou du centre d'hébergement de soins de longue durée, un réseau qui est en lien, et que ce patient puisse recevoir les mêmes soins, monsieur le premier ministre.

On a changé l'organisation du travail. J'en profite pour en parler parce qu'il m'arrive de lire des constats. Je pense entre autres à la Commission Kirby et d'autres qui pointent l'organisation du travail et qui viennent nous dire : * Écoutez, ce n'est pas juste une question d'argent, il faut changer l'organisation du travail. + Chez nous, on l'a fait. On l'a fait en réduisant le nombre d'unités d'accréditation de 3 700 à 1 200.

S'il y a une chose que je peux vous confirmer, c'est qu'il y a là un changement qui n'est pas facile à mettre en place et à mettre en vigueur politiquement. Par contre, c'est nous qui en sommes responsables.

On a également agi pour réduire les délais d'attente et pour, entre autres, augmenter le nombre d'interventions. Nous avons, en particulier, augmenté de 57 000 les chirurgies de 2002-2003 à 2003-2004. Pour les cataractes, dont vient de parler M. McGuinty, on a augmenté de 7 750 le nombre d'opérations d'intervention. On a baissé de 20 pour cent notre liste d'attente. Je dis bien * la liste +, parce qu'il faut faire la distinction entre les listes et les délais d'attente. On a diminué de 36 pour cent le nombre de cas dépassant les délais recommandés.

Pour les chirurgies de remplacement du genou, on a fait 1 085 interventions de plus, dans la même période. On a baissé de 13 pour cent la liste d'attente, de 6 pour cent les cas qui sont hors délai. C'est donc dire qu'on fait des progrès.

Vous avez parlé tantôt de la formation des médecins et des infirmières, des technologues, dont il faudrait parler aussi, et même des administrateurs. Je vous dirais que, chez nous, on a vécu une situation particulière il y a quelques années. Il y a eu un programme de mise à la retraite de médecins et d'infirmières, pour lequel on paie encore très cher aujourd'hui. Eh bien, depuis les dernières années, en 2002, de 2002 à 2003,

on a augmenté de 60 le nombre d'inscriptions dans nos facultés de médecine. De 2003 à 2004, on a augmenté de 84 le nombre d'inscriptions. On est passé de 666 à 750 étudiants en médecine. On a investi 9 millions de dollars dans un programme pour les infirmières praticiennes spécialisées. On a formé une unité de recrutement pour l'extérieur, pour aller recruter à l'extérieur du Québec. On a annoncé la création d'une faculté de médecine à Trois-Rivières, en Mauricie, une des régions du Québec qui souffre le plus des pénuries de médecins et d'infirmières, de technologues, une antenne, une faculté, qui sera un satellite de l'Université de Montréal.

Tout cela pour vous dire que vous voyez dans ces chiffres mais aussi dans ces efforts, ces ressources financières, que les réformes n'ont pas attendu. Les réformes, on les a faites et on les a faites parce qu'on s'est engagés à en faire la première priorité. Pour cette raison-là, comme je le disais il y a une minute, il était encore plus important d'entendre de votre bouche, comme vous l'aviez fait pendant la campagne électorale, que c'était également votre première priorité.

Pour bien comprendre les enjeux aujourd'hui, il faut parler évidemment de financement, et je veux revenir sur la partie qui touche le gouvernement du Québec, la partie qui touche le gouvernement fédéral.

La première précision que je veux faire est la suivante, sur les rôles, parce qu'il faudrait quand même prendre un instant pour parler des rôles de chacun. C'est quoi le rôle de l'État fédéral, c'est quoi le rôle de l'État québécois pour les soins de santé et pour les autres partenaires.

Rapidement. D'abord, la santé, c'est une compétence qui revient au gouvernement du Québec, comme ça revient au Nouveau-Brunswick et à nos autres partenaires. C'est nous qui avons la responsabilité de livrer les services de première ligne. Et quand les urgences sont bondées, quand il y a un problème dans le réseau de la santé, quand il y a des délais d'attente, c'est à nos portes à nous que viennent frapper nos citoyens, ce n'est pas à la porte du gouvernement fédéral; ça, c'est la première chose.

Quel est le rôle du gouvernement fédéral? Son rôle consiste à financer sur la base des valeurs énoncées dans la Loi canadienne sur la santé. Traditionnellement, son financement est à la hauteur de 50 pour cent. Là-dessus, je reviendrai dans quelques minutes. Mais outre ce financement, c'est quoi le rôle

du fédéral? Tant qu'à nous, le fédéral a un rôle à jouer au niveau de la recherche, un rôle qu'il remplit très bien, soit dit en passant. La recherche fondamentale, c'est un rôle que le fédéral fait de façon très équitable, et c'est un rôle que vous devez continuer.

Le gouvernement fédéral, si on cherche un rôle peut très bien faire du financement au niveau d'un programme ponctuel. Je dis bien * ponctuel + pour relever ou pour rénover les infrastructures physiques, ou encore au niveau des technologies de l'information. Je verrais très bien -- d'ailleurs, vous êtes déjà dans un programme qui s'appelle Infoway. Le gouvernement fédéral a une responsabilité au niveau des brevets pharmaceutiques, ce qui est d'une première importance pour le Québec, puisque vous savez que, chez nous, on a favorisé, on a fait une politique d'équilibre entre les innovateurs, pour que nous puissions justement encourager aussi une culture d'innovation au Québec dans le domaine pharmaceutique.

Vous avez une responsabilité dans la reconnaissance des médicaments, une responsabilité pour les forces armées, les Autochtones, comme on en a parlé ce matin, vous en êtes les fiduciaires, pour les détenus, pour les anciens combattants. Voilà des responsabilités qui relèvent de l'État fédéral.

Je prends la peine de le dire, parce que je ne voudrais surtout pas vous laisser l'impression qu'on ne voit aucun rôle pour le fédéral et que nous sommes les seuls à intervenir, alors que ce n'est pas le cas.

Je venais de vous mentionner il y a une minute que, au moment de la mise en ouvre des programmes, l'État fédéral finançait à la hauteur de 50 pour cent. Or, nous savons, et c'est là le noud du problème que, depuis ce temps-là, le financement fédéral n'est pas à la hauteur de 50 pour cent; il a même diminué radicalement.

Monsieur le premier ministre, lorsque vous avez parlé de financement, vous êtes revenu à l'année 1999 mais, pour nous, l'année cruciale, c'est l'année 1994-1995, alors que le gouvernement fédéral a annoncé unilatéralement et sans consultation une réduction dramatique dans les transferts fédéraux. Les transferts fédéraux qui étaient à la hauteur de 18,7 milliards de dollars sont passés à 12,5 milliards de dollars. Vous avez créé un nouveau fonds à ce moment-là, à un point tel où vous ne dépensiez plus que 12 pour cent de ce qui était dépensé dans le réseau de la santé. Le noud, le début de

cette histoire qui nous amène autour de la table aujourd'hui, c'est ce moment-là. Eh oui, par la suite, il y a eu une augmentation, mais sur la base d'une coupure qui avait été faite précédemment, il y a eu une augmentation du financement fédéral.

Or, monsieur le premier ministre, depuis ce temps-là aussi, parce qu'il faut compléter, il faut donner tout le portrait, en même temps que les augmentations ont commencé du côté de la santé, le gouvernement fédéral a commenté à diminuer les transferts pour la péréquation. Huit provinces sur dix reçoivent des paiements de péréquation. La péréquation, ça sert justement comme principe à l'intérieur de notre système fédéral canadien -- c'est un principe très important qui nous caractérise -- sert à donner des moyens à l'ensemble de nos gouvernements pour que nous puissions, avec une fiscalité différente, livrer des services comparables.

Or, si je fais le compte pour ce qui est du Québec, si on prend la peine de faire le calcul dans les cinq dernières années de l'augmentation du transfert de fonds pour la santé et que nous calculons la réduction des transferts en péréquation, c'est un milliard de dollars de moins que nous avons reçus.

Un milliard de dollars de moins, on vient tout juste de dire que les besoins augmentent rapidement. Il y a un phénomène de vieillissement de population. Les technologies nous coûtent très cher. Il y a des pressions énormes. Il y a 43 p. 100 du budget du programme de dépenses de mon gouvernement va à la santé.

Et bien, vous comprenez mieux pour quelles raisons cette réunion est importante et pourquoi nous insistons tant pour que, au niveau du financement d'abord, que nous puissions revenir à un niveau de financement minimum de l'État fédéral, mais que nous puissions également aborder les questions de péréquation.

Je vous ferai remarquer qu'au niveau de la péréquation, les changements se sont faits, aussi, depuis plusieurs années. Le gouvernement fédéral a remplacé ce qu'on appelait la norme des dix provinces par la norme des cinq ce qui a eu pour effet de baisser les transferts. Il y a eu des changements faits au niveau des sources de revenus dans le calcul des droits sur la tarification. Il y a eu des changements faits au niveau du calcul des impôts fonciers qui ont également eu pour résultat de diminuer les transferts de péréquation.

Vous avez donc là un portrait qui nous amène à vous proposer ceci.

Monsieur McGuinty, au nom du Conseil de la Fédération, comme président, l'a bien exprimé. Nous croyons que le gouvernement fédéral, dans un premier temps, doit rehausser son niveau de financement à un niveau de 25 p. 100 de ce que coûte le réseau de la santé.

Certains parleront du * Romanow gap +, nous, nous vivons avec le * Reality gap +. Le * Reality gap +, c'est quoi? C'est du monde dans les salles d'attente. Ce sont des gens chez le médecin. Ce sont des gens qui ont besoin de soins de santé.

Je me suis fait dire que les premiers ministres avaient demandé de combler le * Romanow gap +. Moi, j'ai pris la peine de reprendre les communiqués de presse des conférences du Conseil de Fédération qui ont eu lieu depuis que je suis premier ministre du Québec. Que ce soit en juillet 2003, au mois de février 2004 ou au mois de juillet 2004, à chaque fois le Conseil de Fédération a demandé que le niveau de financement soit rehaussé au niveau de 25 p. 100 des dépenses réelles en santé et services sociaux. C'est pour nous, il nous semble, une proposition équitable compte tenu du fait que le gouvernement fédéral a des moyens financiers également.

Le gouvernement fédéral, rappelons-le, a fait des surplus budgétaires dans les dernières années. Il a même sous-estimé, de l'ordre de 73 milliards de dollars, ses revenus au cours des dix dernières années.

Nous avons donc, devant nous, un défi très important, presque une obligation de résultat. Ce que nous souhaitons, aujourd'hui, c'est que nous puissions arriver à des résultats concrets.

Personne ne s'attend à ce que, dans l'espace de quelques jours, nous puissions régler à tout jamais les questions qui touchent à la fois la santé et la péréquation.

Toutefois, nous nous attendons quand même à ce qu'il y ait du mouvement et que nous puissions sortir de cette réunion avec des résultats concrets sur les transferts, également sur la péréquation.

Ce que nous avons proposé au niveau de la péréquation, c'est que le gouvernement fédéral rehausse son niveau de financement au niveau de l'année fiscale 2000-2001, soit à 10,9 milliards de dollars, ce qui représenterait une augmentation de 1,3 milliard de dollars par rapport à ce que nous recevons cette année.

Voilà, au niveau du financement, ce que nous proposons.

Un autre élément retient notre attention et là-dessus, je veux vous dire à quel point nous avons, au Québec, reçu avec satisfaction -- je dois le dire -, les positions énoncées par le Conseil de Fédération, par les chefs des partis politiques fédéraux. Certains sont avec nous aujourd'hui : Monsieur Harper; j'ai vu Monsieur Layton; j'ai vu Monsieur Loubier qui représente le Bloc québécois. Dans chaque cas, ils ont reconnu que le Québec doit faire respecter sa différence dans le cadre fédéral canadien.

Ce débat est arrivé par la discussion sur l'assurance médicaments. Lors de notre réunion du Conseil de la Fédération, à Niagara, il a été proposé que le gouvernement fédéral mettrait en place un programme national d'assurance médicaments. Le gouvernement du Québec a déjà son programme. Le gouvernement du Québec a également manifesté sa volonté de protéger ses compétences, pas par caprice, en passant, pas parce que c'est juste écrit dans la Constitution, mais parce que le bon sens veut que ce soit à nous de livrer ces programmes. À nos yeux, on ne peut pas disconnecter le gouvernement qui livre les politiques d'assurance médicaments du gouvernement qui livre les services de première ligne. Il doit y avoir un lien entre les deux.

Ce qui me réjouit, Monsieur le premier ministre, c'est le fait que, plutôt que d'être reçu comme étant une exception, cela a plutôt été reçu comme cela doit être reçu dans notre système fédéral canadien, comme étant une chose normale puisque le propre d'une fédération c'est de pouvoir reconnaître les différences et non pas chercher à les aplanir ou à les effacer.

En cela, nous avons, je pense, fait un très grand pas en avant.

À notre réunion de Toronto, nous avons réaffirmé, à nouveau, le fait que ce fédéralisme, qu'on appelle asymétrique, est une caractéristique de notre système fédéral canadien. Les chefs de partis politiques fédéraux ont également reconnu ce fait.

Sur cette question, je vous réitère à nouveau l'intention du gouvernement du Québec d'assumer pleinement ses compétences et de faire en sorte que nous puissions tailler sur mesure les services de soins de santé selon les besoins de la population du Québec.

Il y a quelques questions que je veux aborder qui me semble également extrêmement importantes. La première est la suivante : les programmes temporaires.

Monsieur le premier ministre, je vous conseille fortement d'éviter les programmes temporaires. Un programme temporaire, un programme de deux ou trois ans, quant à nous, c'est exactement le contraire de ce que nous devons faire dans le réseau de la santé. On ne peut pas simplement fermer le robinet après deux ou trois ans.

Je ne crois pas que vous souhaitiez revenir autour de cette table, dans trois ou quatre ans d'ici, pour reprendre les mêmes discussions parce que les programmes qu'on aura, ou que vous aurez proposés, auront depuis ce temps-là expirés.

Le réseau de la santé ne fonctionne pas comme cela et ne devrait pas fonctionner comme cela.

Sur le plan de l'administration publique, nous devrions tout mettre en ouvre pour éviter des programmes temporaires. C'est exactement le contraire de ce que nous devrions rechercher.

J'ai évoqué, il y a quelques minutes, l'assurance médicaments. Je veux également réitérer que le gouvernement du Québec, depuis plusieurs années maintenant, a une politique d'équilibre sur cette question-là. Nous avons l'intention de poursuivre la mise en ouvre de cette politique alors que mon ministre de la Santé, Monsieur Couillard, qui est avec moi aujourd'hui, a le mandat de mettre en ouvre une nouvelle politique du médicament qui sera livrée au début de l'année 2005.

En conclusion, nous avons effectivement beaucoup de travail à faire. Ceux et celles qui ont besoin de services de soins de santé comptent sur nous. Peu importe le résultat de cette conférence, je tiens à vous dire que nous allons, nous, au gouvernement du Québec, continuer à faire de la santé notre première priorité.

Nous espérons, nous comptons sur vous pour que vous puissiez remplir également le rôle qui vous est dévolu et que le financement fédéral puisse être à la hauteur des besoins.

RT. HON. PAUL MARTIN (PMO Canada): I will now call on Premier Hamm of Nova Scotia.

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

In my 30 years as a family doctor, I never once imagined that some day I would be speaking at a nationally televised First Ministers' meeting on health care. However, I am here speaking today on behalf of Nova Scotia's patients, their families, and the dedicated professionals who provide health care: the doctors, the nurses and the many other providers working day in and day out. I am speaking on behalf of all Nova Scotians who want to make sure that their health care is there for them and their loved ones for cancer treatment, for heart surgery, a new hip, an MRI or appropriate drugs, when and where they need it.

Prime Minister, in May of this year you spoke of building a new partnership with provincial and territorial governments for better health care. We all agree we need a new partnership.

In Nova Scotia we have already worked hard to build a partnership with our health professionals, a partnership based on listening, trust, accountability and change for the better: a partnership that forms Nova Scotia's plan for better health care, Your Health Matters. This is a plan to reduce wait times, a plan to put more doctors, nurses and other professionals on the front lines and at the bed sides, a plan to expand care for our seniors, a plan to help Nova Scotians get healthier.

What do I mean by partnership? Here are some examples.

When we identified a chronic nursing shortage, we listened to our nurses and worked with them to put together a nursing strategy three years ago. As Janet Hazelton, the President of the Nova Scotia' Nurses Union, called it, a strategy for nurses by nurses.

Three years after the introduction of the strategy, Nova Scotia has more fulltime nurses. We have more training opportunities for young nursing students, and our province's retention rate has gone from 50 to 80 per cent.

While StatsCan recently reported that more Nova Scotians reported they had access to a family doctor than any other province in Canada, there were still too many communities without access to the care they needed. So we increased the number of training seats at Dalhousie Medical School, and we enhanced our physician recruitment strategy with a new Chief Health Human Resources Officer at the Department of Health.

But we also moved forward with changes to primary care. We now have nurse practitioners working in more than a dozen remote

or historically marginalized communities, like East Preston, one of the country's oldest African Canadian communities.

We also had a successful primary care project under way on the Eskasoni First Nation, a project whose success was recognized in the Romanow report.

When our heart surgeons identified unacceptably long waiting times for cardiac surgery at the Queen Elizabeth II Health Sciences Centre, which is Atlantic Canada's largest hospital, Nova Scotia listened and acted, dedicating $5 million to improve access. Cardiac wait times are now down within nationally acceptable standards.

Four years ago StatsCan said that Nova Scotia had the dubious distinction of the worst smoking rate in Canada, at 30 per cent. We worked with our medical community to put together the province's comprehensive Anti Tobacco Strategy. Our smoking rate today is at 22 per cent, from the worst in Canada to the national average, and our rate continues to fall.

We know we must do more to encourage our people to eat better, get more active, live a more healthy lifestyle. So we established Canada's first ever Office of Health Promotion, led by a minister and a core group of staff whose sole job is to get Nova Scotians to make healthier choices today so they will live healthier lives tomorrow.

Through Your Health Matters, we have managed to do a lot of good things to reduce wait times and improve health care, a lot of good things through the power of partnership. But we have many challenges persisting, challenges that the Liberal Party's A Fix for a Generation plan are meant to address. These two documents complement each other.

Our wait times continue to be too long for joint replacement, for palliative care, for mental health, for long-term care, for oncology, for diagnostics and challenges in a host of other areas: for example, putting in place a program to help low income diabetics pay for the cost of their equipment and medications.

In Nova Scotia alone, the annual cost to bring down wait times and implement the five priorities identified in A Fix for a Generation, the Paul Martin health plan, is $175 million annually, at minimum.

Fixing health care for a generation, reducing wait times will not happen unless the Liberal platform commitments are fully funded through a new partnership. Without a more

significant funding partnership, led by the federal government, Canadians will be disappointed because there will not be sufficient funds to deliver the health care commitments made this spring.

Nova Scotia also lacks coverage for catastrophic drugs, which could cost anywhere from $15 million to $20 million, but more money for care is only one part of the long-term solution. We must also do more to support health promotion and illness prevention. Nova Scotia has some of the highest rates of chronic diseases in Canada. We have also one of the highest percentages of seniors in Canada, seniors who demand and deserve more care.

So what is the message our health care partners would like to bring to this meeting? Last week, I met with more than 150 of our health care partners in Nova Scotia, our doctors, our nurses, our medical professionals on the front lines and at the bedsides. We have worked together with our partners to make plenty of progress, but we have a lot of challenges remaining unresolved. The message Nova Scotia's health partners gave to me, and which I am sharing with you today by way of this presentation and by way of the video presentation that is being distributed as I speak, their message: get a long-term solution done. Don't put in place another band-aid because, to quote one of our province's senior health administrators, Cape Breton's John Malcolm, "The band-aids rarely stick".

Prime Minister, Nova Scotians, indeed, all Canadians, want you to provide sustainable long-term funding for health care so we can build the new kind of health care partnership you spoke of earlier this year. What has been presented thus far by the federal government will not achieve the lower wait times that Canadians expect and deserve. It will not build the kind of partnership you talked about this spring, the kind of partnership our citizens rightfully expect of us. Prime Minister, we must do better.

Thank you.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier Hamm. I will call on Premier Lord of New Brunswick.

HON. BERNARD LORD (New Brunswick): Thank you very much, Prime Minister. Merci beaucoup, Premier Ministre.

First of all, Prime Minister, I want to congratulate you for taking the initiative to host this First Ministers' Conference on Health Care and to demonstrate to Canadians your

personal commitment to finding solutions to some of our health care challenges in Canada. We are all here in the same spirit of cooperation and collaboration and I want to state very clearly that I welcome the new tone that you have brought to building a new relationship with provinces and territories.

Je souhaite que nous serons en mesure de nous unir au nom des Canadiens et des Canadiennes et d'établir un plan réel à long terme afin de livrer de meilleurs soins de santé plus accessibles pour les patients, les personnes aînées, les enfants, et que ce système soit viable pour les contribuables.

But that new tone must go hand in hand with the new dialogue, a new dialogue that will lead to real solutions that will last, for we have come here this week at a time of raised expectations and hard realities.

Les attentes élevées des Canadiens qui espèrent que leurs chefs politiques fourniront des réponses claires à leur demande d'un système de soins de santé réellement viable et qui répond à leurs besoins et aux besoins de leur famille et à la dure réalité de la nécessité toute aussi manifeste de modifier et de réformer notre système pour qu'il devienne réellement viable et qu'il réponde aux défis réels auxquels il est confronté.

Entre les deux, la possibilité. La possibilité d'établir un nouveau partenariat entre le gouvernement fédéral, les provinces et les territoires pour les Canadiens, dans le but d'obtenir les nouveaux investissements nécessaires pour faire ces changements et ces réformes en vue de rendre notre système réellement viable.

This week is not about us around this table, it is about Canadians. It is about their needs. It is about their hopes. It is about their concerns. It is about their aspirations. It is really about patients, seniors, children and families. And the best way to respond to Canadians is to be honest and straight up with them, for this is the real gap that we must close at this meeting: the gap between the raised expectations that we will leave this meeting with medicare truly sustained and truly fixed for a generation and the increasing financial choices required by all of us, including the federal government, to actually bridge that gap and address these expectations.

I do not believe that we are yet able to say that we have bridged this gap. In fact, I believe there is a real danger that this gap is getting bigger this week.

Voici les faits. Les provinces et les territoires consacrent des sommes sans précédent aux soins de santé, aux soins aux aînés, mais le gouvernement fédéral n'a pas suivi le rythme.

Gouverner, c'est faire des choix. Nous le savons tous, Monsieur le Premier Ministre, et, le Nouveau-Brunswick, nous avons fait des choix. De meilleurs soins de santé et une éducation de qualité appuyés par une économie en croissance et une discipline dans la gestion des finances publiques.

But to make those choices something else had to give. That is the reality of the health care squeeze we have all experienced. More money for health care means less money for almost everything else.

In New Brunswick, it looks like this -- and I have a chart here for you, Prime Minister. Since 1999, we have spent $2.4 billion more on health care, $900 million more on education, and $272 million less in everything else. I have heard numbers thrown around of 40 per cent, 45 per cent, going to health care. The reality in New Brunswick in the last five years is close to 80 per cent of new funding has gone to health care.

We have made the choice to support health care, to support families, to support patients and provide better care. And these investments have improved health care for New Brunswickers in a real way. We have addressed recruitment retention issues of health professionals. We have a records number of doctors working in New Brunswick. Wee have nurse practitioners for the first time in our history. We have a record number of nurses working full time, as well. We are training more doctors. We are investing more in training of nurses. We have invested in medical equipment and infrastructure, from CT scans, MRIs, dialysis equipment, community health centres, collaborative practices.

Nous avons aussi augmenté l'assurance-médicaments et les sommes que nous investissons dans les médicaments pour les patients en doublant ces sommes dans les cinq dernières années. Nous avons doublé nos investissements.

Plus, we have started a series of wellness initiatives to work on health promotions and to deal with health problems before and prevent health problems before they become problems.

Cela signifie que le secteur de la santé, ainsi que les soins aux personnes aînées, au Nouveau-Brunswick, exigent une part de plus en plus grande de notre budget.

En effet, il y a seulement cinq ans, c'était 29 pour cent de notre budget, tandis qu'aujourd'hui, c'est plus de 39 pour cent du budget total.

La question se pose. Est-ce que le gouvernement fédéral a suivi le rythme? La réponse est non.

Je comprends bien, Monsieur le Premier Ministre, que vous dites que vous préférez parler de soins et de patients plutôt que de dollars.

Je suis d'accord avec vous. La raison que je me suis lancé en politique et les choses qui m'animent à tous les jours sont mon désir d'améliorer la qualité de vie des citoyens au Nouveau-Brunswick, et cela, ça veut dire d'améliorer les soins de santé pour les familles.

La réalité que nous vivons partout au Canada, c'est que nous avons une population vieillissante. Nous avons de nouvelles technologies qui coûtent cher et de nouveaux médicaments qui coûtent aussi très cher.

Donc, lorsque nous voulons parler d'améliorer les services, lorsque nous voulons parler d'améliorer les soins de santé, il faut aussi parler d'allocation des ressources humaines, des ressources financières, afin d'atteindre les objectifs que nous nous sommes fixés.

Il n'est pas suffisant simplement d'énoncer des objectifs, nous devons travailler pour y atteindre.

In New Brunswick, spending on health and social programs is rising faster and higher than federal health and social transfers to us. In fact, in the last 15 years, New Brunswick has invested almost 100 per cent more in health and social programs, while direct transfers from the federal government have gone up by 40 per cent.

The federal government has not made the same funding choices as we have. In fact, this fiscal year federal health transfers to provinces and territories represent 9 per cent of total federal spending compared to 38 per cent in provinces and territories.

We understand that in the past you have had to make other choices. We respect the choices that have been made, but this is a new opportunity. This is a new opportunity to make new choices to set us on the right track for the future.

In New Brunswick, we are working extremely hard with our health care providers, regional health authorities and New Brunswickers, themselves, to improve access and quality to our

health care system. Last June, we tabled a four-year provincial health plan called Healthy Futures, the first-long term plan in the province's history.

Ce plan se veut un schéma directeur précis visant à assurer la viabilité de notre système de santé grâce à de nouveaux investissements et des changements importants et des réformes réelles.

Notre plan renferme quatre grandes stratégies précises axées sur les patients : améliorer la santé de la population; améliorer l'accès aux services de santé; augmenter la qualité et la variété des ressources humaines en santé; et garantir la responsabilité et l'imputabilité du système de santé envers les patients.

Qu'est-ce que cela signifie ?

I want to read some and highlight some of the key investments we plan to make in our health plan: renewed commitment to 24/7 access to primary health care wherever New Brunswickers live, enhance ambulance services to meet Canadian standards, establishment of new community health centres, recruitment retention strategies for health professionals, more physicians, more nurse practitioners, more nursing seats, new primary health care collaborative practices sites, establishment of new surgical access management programs and new provincial cancer care networks.

Une stratégie améliorée de gestion des maladies chroniques, l'élargissement du programme de vaccination pour les enfants et les jeunes, l'amélioration des soins palliatifs à domicile, des soins actifs des services de santé mentale, des investissements dans le système de dossier électronique du patient, des investissements supplémentaires dans le domaine de la recherche de santé, une mise en oeuvre d'une stratégie du mieux-être, une illustration contre le tabagisme, l'amélioration du programme provincial des soins cardiaques, et j'en passe.

Des engagements concrets, précis, contenus dans un plan détaillé que nous allons livrer à la population du Nouveau-Brunswick.

But it will also mean something else. It will mean choices about hospitals and beds, choices that we are implementing now to give us the flexibility we need to reinvest every single dollar right back into front-line health care and services. We have made the tough choices and, as we speak today, I can say there is people in New Brunswick that are not happy with those

choices, in fact, they are blocking a road today, but those are real choices, hard choices, that we make to reallocate resources and funding to improve care to patients. These are difficult choices for people to experience, and I understand that.

Mais ce sont des choix nécessaires pour améliorer notre système de soins de santé et le mettre sur la route de la viabilité.

Nous avons clairement dit aux gens du Nouveau-Brunswick que, si nous voulons conserver notre système de santé, il faut le changer. Nous devons changer notre façon de vivre en commençant par adopter un mode de vie plus sain. Nous devons changer notre façon de livrer les soins de santé en mettant davantage l'accent sur les patients et les collectivités que sur les hôpitaux et les institutions.

And we must change the way we invest in health care by putting more money where it is needed the most: front-line services, not bricks and mortar.

Our vision is clear: a patient-focused, community-based health care system that delivers the right care at the right time by the right provider at a cost that taxpayers can afford and in New Brunswick that also means in the official language of your choice.

C'est uniquement de cette façon que nous pourrons préserver l'héritage du régime de soins de santé pour la génération suivante.

Le gouvernement fédéral a la possibilité de devenir un partenaire à part entière dans l'objectif que nous nous sommes fixé de répondre aux besoins et aux attentes des Néo-Brunswickois et Néo-Brunswickoises et de tous les Canadiens en matière de soins de santé.

Vous pouvez devenir un précieux partenaire en collaborant avec nous à la préservation et à l'amélioration du système en investissant à long terme dans la santé de notre régime de soins de santé.

By providing significant new funding, that is predictable and sustainable, into the future; by addressing equalization concerns, to ensure provinces can meet the constitutional objective of this program to allow Canadians, no matter where they live, to receive comparable levels of health care at comparable levels of taxation. This morning we heard from Aboriginal leaders that there are big differences in our country in terms of health outcomes. We live in a country where we

believe under our Constitution that Canadians, whether they live in Edmunston, New Brunswick or in Edmonton, Alberta, are entitled to comparable health care. We are not meeting that objective today and this is our chance to change that.

A generational fix should not be a one-time fix of funding today, but gone tomorrow.

A generational fix should not be higher expectations now, with declining federal share after two years.

As Premier of New Brunswick, I am prepared to work with you, Prime Minister, I am prepared to work with all my colleagues, along with health care providers in New Brunswick and across Canada, to put our health care system on the right track so it is truly sustainable in the future.

There are a lot of similarities between the priorities contained in our provincial health plan and what was contained in the targeted investments that you have targeted in your election platform.

I believe this is a basis on which we can move forward together, but choices we must make.

Nous aurons des choix difficiles à faire sur le plan financier pour investir plus que jamais dans les système de soins de santé, même si nous devons consacrer moins à d'autres priorités importantes.

Nous aurons des choix difficiles à faire sur le plan de la prestation des services afin de porter notre attention davantage sur les patients et sur les collectivités.

And we will continue to make the difficult policy choices, to speak honestly and openly to New Brunswickers about our health care system in the years ahead.

Today, I am asking you to work collaboratively with all of us, to support the choices that we are making, to invest in real change and reform, to provide the long-term sustainable financial support that all Canadians want and only the federal government can provide.

Let's translate commitments into action that will place our health care system on a more solid footing. There is a lot of work to do, but there is a lot of goodwill around this table and, more importantly, there is a lot of goodwill across this country.

I believe that if we work together and we focus on the patients, we can overcome the obstacle and really put health care on a solid footing.

Thank you. Merci.

RT. HON. PAUL MARTIN (PMO Canada): I would call on the Premier of Manitoba,

HON. GARY DOER (MB): Thank you, Prime Minister. Thank you for this First Ministers' meeting. It is indeed an honour to be in this historic room. The last time I was here wasn't a successful occasion as an observer and I come here with the thought and the memory -- not memory but realization, people like Ed Schreyer, the Premier of our province before who brought in the first home care program sat at this table dealing with the great visions of Canada that made us a better country.

Coming to this meeting, I ran into lots of people with lots of advice, as we all do, but there were three particular people who wanted to relay directly their patient stories to me on Friday.

The first one, a friend, had been waiting for over six months for a hip operation, hip replacement surgery in Manitoba, and was indeed suffering quality of life because he could not participate in walking and golf and other exercises that he felt were very, very important for him.

A second person I ran into was a contractor who told me that seven months ago he went in to the emergency wards with some heart pain, chest pains, and 12 hours later, after many operations later over a weekend, he is now feeling great and he feels that the health care system was there when he needed it.

I ran into a third acquaintance who said, "Don't -- I won't repeat the language, but in terms of this meeting -- don't get it wrong at this meeting. My family friends in the United States just lost their job and they lost all their medicare coverage. In fact, their only option if they ever got any health care challenges is to move back to Canada.

Now, nurses can talk about the stress in the emergency wards and doctors and family doctors can talk about the stress that they have with high patient workloads. Canadians know we have a good thing with medicare, but they know there are a lot of stress, as everybody has indicated. They know that and we know that.

Now, how did we get here? I think we all share some responsibility for getting here. Provinces reduced the number of spots in medical schools. It takes a long time to change that. We changed and reduced the number of nurses that we

trained in the early 1990s. Again, it takes a long time to make that up.

We also had a situation -- Jean Charest, the Premier of Quebec mentioned this as well, and I will be blunt -- I was curious when you chose 1999 as starting point for recent history.

1995, the federal budget that did reduce and eliminate the deficit in Canada. Its cuts in Manitoba were the equivalent of closing down every rural and northern hospital in that province. So we have been on a treadmill with these yearly sessions in 1999 and onward, and partly what we are dealing with is our own responsibility and partly what we are dealing with is a federal responsibility, and so we have a lot of work ahead.

What are we doing about it? In terms of our first strategy, it is human resources. We are at a competitive North American market. We compete for doctors in the United States and we compete, quite frankly, with each other.

We have increased the medical spots not in 2003 but in 1999 by 30 per cent in Manitoba. We have tripled the number of nurses that we are training and graduating and returned the RN training program back to Manitoba. And we have introduced an Aboriginal training program which we welcome you will to join, and we have introduced a francophone training program for the citizens of St. Boniface and southeastern Manitoba to provide those services.

Seventy to 80 per cent of the costs in health care are not a black hole. It is salaries of doctors, nurses, diagnostic staff medical aids, cooks, home care workers, psychiatrists, psychologists. That is why the cost side has been driven up by a supply side that we have all been part of. To some degree all of us are making progress in training more people.

In Manitoba, our second part of our plan was to deal with wait lists, but we started with life and death wait lists. We sent 500 people to the United States to get cancer treatment because the waiting time was eight weeks. We are now down to one week for cancer treatment.

We have reduced the cardiac surgical waiting list by 40 to 50 per cent, but if a person needs life and death surgeries, they get it right away. But I would say even with increasing the number of MRIs, the procedures, we have double the number of machines, we have doubled the number of procedures, we have only lowered the waiting list by a third.

In areas of hips and knees and cataracts, we have reduced the numbers and we have reduced the waits, but there is still intolerably long waits for citizens. Why? Because we start with life and death procedures first. That might be wrong, but that is the only way we can allocate our resources and do it effectively in our province.

We practice innovation, tele-health, reducing administration, children's cardiac care, which I should point out it was in Manitoba and in the 1990s 12 children died of preventable deaths. We have now, in western Canada, combined all of that surgery in Edmonton in a cooperative way so that we can get the density and the critical mass to provide better operating services for those kids, in a cooperative way with other western provinces.

On the other side, we can bought a gamma knife for neurosurgery in Manitoba, and I know they have now in Sherbrooke, Quebec. We are now moving citizens back from Cincinnati and Pittsburgh and all across Canada to have the vital surgeries and neurosurgeries with neurosurgeons being attracted with the gamma knife in Manitoba.

We are practising wellness policies. We have a smoking ban in Manitoba. We should be doing more on fitness and youth and we have kids health as public discussion. We brought in healthy baby program for young children. And we are looking at, because parents are way ahead of us on issues and policies on transfats. A lot of parents are banning all foods in their schools that have those products. Congratulations to the federal government for labelling that food, but the Canadian public is way ahead of all of us in terms of the next steps they want to take in terms of phasing out those products.

We have practised the first home care program in Canada with the home care program started by Ed Schreyer. We spent over $202 million on home care. It is a program that is probably the most comprehensive in Canada, and with the reform package of the federal government we added palliative care home care drugs so that patients would not have to be in a hospital to get those drugs. They could be home closer to their family.

We have a pharmacare program of $277 million. I like the national pharmacare program proposed by nurses. I think taking advice from nurses is a good thing for all of us, a good policy to follow. We will talk a lot more about that tomorrow, but I actually like their proposal and their costing, not the federal

government's costing. I will always go with the nurses when it comes to costs. Probably good advice.

You go with the nurses, good. We have a plan now. We just got a plan. That is a very good deal. The nurses have come through for us again.

But let me look at the issue of pharmacare. Your quote -- I have a couple of quotes from you in your presentation:

> "Both orders of government must do its part on pharmacare." (As read)

In Manitoba, the federal investment in pharmacare is $12 million. Our provincial costs of a co-payment, costs in hospitals and personal care homes, is $277 million. I ask you: Who is doing its part in this very, very important area, an area that was promised in 1997 and again in 2004.

The same numbers could be used in home care.

Primary care, I agree with you. We have to train more doctors, provide more services closer to community. The $30 million we put in in 2003 we are using to train more doctors. We needs more family docs, we need more people in the community on primary care. We need a strategy to get there, but we are catching up. We have a lot of catching up to do.

Where do we go from here? We are not dealing with Fyke, Kirby, Romanow or any other report here today, we are dealing with the federal mandate that was given by the Canadian people to the federal government in the election of June of 2004. Let me give you some examples.

The Kirby report doesn't deal with Aboriginal people. I think it is a Senate Committee but it doesn't deal with Aboriginal health. We dealt with that this morning. We have gone beyond these reports.

The Romanow report has a different evaluation of the issues of waiting lists compared to the platform and program put forward by you. We have to we are dealing with the five point plan of the federal government that has received a democratic mandate that we have a democratic responsibility to implement.

Let me go over it for you because there are a couple of elements of the plan and the reality. Jean Charest, the Premier of Quebec, talked about the reality gap and other premiers have talked about that. One-time only money can't get us there. I am not interested in having a short-term hiring of a cardiac surgeon. I am not interested in hiring a neurosurgeon in the short run because we can't do it. We can't higher nurses and

train them for the operating rooms you need. I can't go to a hardware store and rent a MRI machine for a couple of years. We have to put capital investments in in hospitals and other community-based facilities and other primary-based facilities and we have to make long term commitments.

We have talked before, we can't put up a MASH medical tent for short-term money. It is not that way in health care. Other Premiers have said that and I want to mention it over and over and over again. We can't do it.

It also is very expensive. In Manitoba when we look at your promises, $1 billion is a lot of money nationally. It is a huge amount of money. We see these headlines every time we come in for a health meeting. I don't know whether the headlines land before the planes or whether the plans land just simultaneously, but these huge headlines.

One billion dollars or $4 billion over five years is $27 million a year in Manitoba for wait lists. Twenty seven million dollars is about $80,000 a day. That will buy you -- buy us, rather, I'm sorry, buy Canadians -- it will buy us 10 hips or 10 knees or four cardiac operations. It is very expensive.

I suggest to all of my federal friends that we have to cost the federal platform very precisely because that is how we have to budget our hospitals, our primary health care units, our home care, our pharmacare.

Premier McGuinty has already well laid that out, the costing. We accept the numbers from Ontario of the cost of the federal platform so far. And he challenged you, and us, all of us, for independent verification on that.

We believe that there is the political will but we have to be honest with the Canadian public. We cannot promise something we can't deliver. That for me is the worst possible outcome of this meeting. We have to be able to have a plan, have a cooperative way of implementing a plan. We are committed to doing that and we have to make sure we can get on with it to fix health care for a generation, because quite frankly next year at this time I would like to be back here talking about the need for a skilled economy, tying education and training into the needs we have across this country so we can talk about growing our economy, not just talk about health care year after year after year.

We have an opportunity to achieve this. You were successful in slaying the deficit. You were successful in developing a long-term critical path on the Canadian pension plan. We need the same kind of determination and detail to get it done here at this conference.

I have to say that all of us have to not only fix this for this meeting, but for the generation you are talking about. I don't know who is going to be Premier in Manitoba in 2009, but I think it would be irresponsible of me to let down the patients in 2009 by not having a long-term block funding sustainable agreement.

When I talk to the Manitoba public, in conclusion, they say to me: Why are you people arguing? What do you want? I say 25 per cent of the costs, home care, pharmacare, costs. Well that shouldn't be too complicated. What is wrong with that?

I think we have the way to get it done, and I think we have the will to do it. I am certainly willing to be part of it.

Thank you very much.

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

Premier of British Columbia. Gordon.

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

Like my colleagues, Prime Minister I would like to say thank you for bringing us together to engage in this meeting.

I come to the meeting with a sense of optimism and a sense of hope because I believe that we can find a way to sustain health care in the long term. I believe that we can find a way to improve health care for Canadians across the country.

I come with that conviction because of the time I have spent in the last three years since I took on the responsibility as Premier of my province with other Premiers from across the country. From coast to coast to coast, from every political party, people are committed to solving the single-most important challenge in the lives of Canadian that we face today. And that is the health care challenge.

Our system today that we both enjoy and benefit from and that we also see as a challenge is the result of past actions, both wise and measured, and in some cases not so wise and not so measured.

Over the last three years I found that each of my colleagues around this table -- and I believe you share this commitment -- are strong advocates for public health care in

Canada. I have found that they are willing to do virtually anything to meet the health needs of Canadians. Each of us as Premiers has had to make and face very difficult decisions. Every Premier here can tell you that health care reform is tough. Health care reform takes time. It takes effort and it frankly takes a significant toll.

We chose that difficult path, Mr. Prime Minister, because we believe that over the long term it will result in better health care, more secure health care and a better quality of health care for Canadian families in this country.

Like any path in life, the way is always less arduous when you have a reliable partner. Success in health care can only be built on the foundation of true federalism. We know that because we know the opposite is true. Unilateral decisions in the past have undermined our health services today.

This week true partnership between provincial, territorial, federal and governments and Aboriginal leadership can be forged. As I have worked with Premiers from every region of this country, from every political party, or as I have met with Aboriginal leaders, I know there is a common purpose; there is a common objective. There is a common goal that we each share. Canadians are ready for us to act together and we can't let them down.

I have been pleased today, as we have had our meetings at the Conference Centre, that we have been joined by Steven Harper and by Jack Layton who equally share our commitment to the long-term success of providing a foundation for the future in health care in Canada.

As we examine the details of any health plan that we put forward, I think we have to keep a couple of things in mind.

Number 1, Canadians are already sending enough money to their governments, federal and provincial, to sustain and improve health care for a generation. Federal and provincial dollars, it has been said around the table, come from one wallet. It is the wallet of the hard-working Canadian.

We are obviously being judged by how wisely we invest each dollar and how we invest that in our priorities and the priorities that Canadians have set.

Mr. Prime Minister, I want to directly address the issue of accountability because as a provincial Premier who prepares report after report and information after information, I believe the provinces are accountable. We are accountable to Canadians.

We are accountable to taxpayers. We are accountable to one another. This is the extent of the reports that are available to any federal official who would like to read them, Prime Minister: 1039 pages. Each year we lay out a service plan of what we are trying to do, how we are trying to do it, where we are going to invest the dollars to meet the needs of British Columbians. We are in fact accountable. And I think it is important for Canadians to recognize that.

Make no mistake, we have some challenges in health care. We recognize that as well. But the challenges come, I think, sometimes when we set out expectations that cannot be met or when we are not straightforward with Canadians about the challenges that we confront.

Health care is the number 1 priority of Canadians. It is the number 1 priority of every provincial and territorial government. We in British Columbia invest 42 cents of every tax dollar that comes to the province in providing health care to the people of British Columbia. On the other hand, the federal government invests about 15 per cent of their resources, or 15 cents of each one of their dollars.

So as we strive to provide modern and effective health care services, provinces and territories are facing escalating health costs. There are tidal waves of change that are on our horizon, Prime Minister. We can all see them: the tidal wave of aging; the tidal wave of technological change; the tidal wave of pharmaceutical change is coming in our direction. They are predictable. We can handle those waves with a predictable, long-term financial partnership that recognizes those pressures and that recognizes that together we can ride those waves.

But we cannot maintain the fundamental services that society calls for without appropriate financial resources.

I want to underline this because I do think that one of the things that happens as soon as we come to these meetings is people start talking about the provinces are asking for this for themselves or the federal government is asking for that for itself. I think we should be clear about this. The provinces do not come to this table asking for 25 per cent of all health costs for provinces. We are asking for 25 per cent of all health costs for Canadians, for the people that we serve. And it is important to note that when we make this request on behalf of Canadians, we are ready to invest it in stabilizing the

system, in equalizing the system and then in modernizing the system.

What does that mean? It means that we must ensure that we can afford the health services that we are now delivering before we start talking about additional commitments that will add additional costs that we frankly cannot afford at the provincial level.

The commitment that we have heard to date of a 2 to 3 per cent increase in federal funding is certainly welcome. But Prime Minister, I ask you to consider this: we already know that health care costs are growing at 6 to 7 per cent. We need annualized, in other words one-year funding that is predictable and that is long term.

Everyone has mentioned that our populations are aging. Let's remember that aging has an impact on more than simply the patient population. It has an impact on physicians. I understand that Dr. Hamm is a little older this year than he was last year. It has an impact on nurses, although I have never found an individual nurse who is getting any older, Prime Minister. But we have an impact on nurses.

Our professionals are aging. It is going to require a major initiative for us to train enough nurses and physiotherapists and doctors to meet that aging challenge. We can do it. And already in provinces across the country we are doing it. In British Columbia, we have added 5,000 nurse training spaces across our province in colleges and university. We have doubled the number of physicians that we are training, Prime Minister, and I want to use this as an example of why it is so important we have long-term funding.

We made an announcement before our election in 2001 that we were going to double the number of physicians. We were elected in June. We made the decision to invest in that in August, within two months. We started the building process, the capital process so we could build the classrooms and facilities required for those doctors at the University of British Columbia in Vancouver, at the University of Northern British Columbia for rural and remote medicine, at the University of Victoria for geriatric medicine. We made those investments. That was three and a third years ago. The first students enter this year. It will be four years before they get their medical degrees. It will take two years of residency before those doctors that we

need are actually on the floor of the hospital in communities working, sharing their expertise with each of us as Canadians.

You need long-term predictable funding to deliver that. I certainly couldn't say to those people who I wanted to be physicians: Come on in for a couple of years and we will see whether we can afford to keep you there after that. We do need that funding.

So, Prime Minister, we have made a number of choices in our province, as other provinces have. We have reduced the health care costs, the administrative costs, significantly over the last three years. We have actually saved approximately $100 million from administrative restructuring which has all gone back to patient care. As we did that reform, we took those resources and we tried to meet a number of needs for British Columbians.

In terms of wait list reduction, which we all share as a primary goal, we have actually provided 38,000 additional procedures. Our wait lists keep growing.

As our doctors and our nurses and our administrators keep working to find savings within the system, they have actually found over the last probably four months an additional 20 to $25 million for cardiac wait lists, for hip replacements, for knee replacements, for 13,000 diagnostics that we are working every single day -- and I think that is what is so critical to understand. Every day we work on providing better health care to Canadians, and every day we are under more and more pressure.

We face long-term challenges of obsolescence in our physical structures, and we face the demands for increased facilities and increased equipment, technological equipment, to meet the needs of people across our province that live in more rural and remote British Columbia as well as our urban centres.

I want to take my hat off to the people of Nunavut who have done such a great job in terms of building their telehealth infrastructure. We want to continue to do that. We have started to do that. But each of those reforms requires investment.

Today I think we have to remember that with the costs of health growing, the costs of health growing at 7 per cent a year, we need to establish a partnership that builds a strong foundation for the future.

Our goal is simple. It is to meet the needs of Canada's families.

You said in your opening remarks, Prime Minister, and I want to echo this: We want no second-class citizens in Canada. We want no second-class health services in Canada.

So I have a question: Which one in this room wants to choose which children get the immunization they need and which children in Canada we decide we are going to leave at risk? Which one in this room wants to decide which families in Canada are going to have the pharmaceutical regime they need and which ones aren't going to quite be able to afford it?

I believe that the spirit of this conference is, in fact, the spirit of Canada. The spirit of Canada is bigger than saying we are going to leave some people out. The spirit of Canada is a generous spirit. The spirit of Canada says we can do things for one another when we commit ourselves to doing things for one another.

We have been elected to provide leadership. Premiers have risen above our political differences and worked together in a comprehensive way. If you look at the plan that premiers have put together, it covers almost 10 different objectives that we have set for ourselves and we can move forward, learn from one another and build for the future. We have risen above regional disparity. We have work to forge a national vision that is sustainable and affordable and that builds on the strengths of Canadian federalism.

Let's embrace that spirit for all Canadians. We have an opportunity to do what is right for patients. We can get to a long-term strategy that will secure our public health system, but the new foundation for health care won't be built by pointing fingers or by rejecting ideas that have been brought forward by those who deliver health care.

And Prime Minister, you know this and I know this, it is the provinces that deliver health care. The foundation we seek will be built by listening, by learning and by opening our minds to new possibilities. It won't be built by skirting the real issues that matter to Canadians; it will only be secured when we confront them.

There is not one idea that will sustain us in our goals. There are many ideas. It won't be found with a two-percentage-point lift in funding over six years, with a six-year funding formula fixed for decades or for a generation. The fix for a generation will be found when we demonstrate respect for each other and for the roles that each of us play in

delivering care to Canadians. The fix for health care will be found when we acknowledge that other critical priorities, like education, services for children and families, have had to suffer through negative impacts because of the challenges that we face in health care. I want to stress this, Prime Minister. The fix for that generation in health care will be found when we show a true commitment to both flexibility and to funding.

The premiers have proven there is indeed real progress being made and more progress will be made as we listen to each other and embrace practical solutions. There are 13 premiers around this table who are coming to this meeting united in support of creating the kind of foundation for the future that Canadians want. We are looking forward to working with the federal government as we provide the care that Canadians need in their communities across this country.

It is amazing to me, when I think that we can build a consensus coming out of not just the platform that your government brought forward in the spring but out of other initiatives that have been taken across the political spectrum over the last number of years.

Canadians deserve equal access to prescriptions and to immunizations they need. I, for one, don't care much about what the mechanism is. I do care about the results. The issue is how we extend the vision for a truly national health care system where basic drug coverage is available, including catastrophic drug coverage for every Canadian.

We have models that we have already invented, like the Canadian Blood Services, where we work together, we learn from one another and we benefit substantially, both in terms of quality and costs.

Prime Minister, we believe that there could be a national purchasing agency for drugs, a national formulary for drugs, a national efficacy testing that would be improved and speeded up for the benefit of patients across the country and we are willing to work with the federal institution in providing them. We also believe that we should be ensuring that every Canadian, regardless of whether they are living in the far north, the far west or the far east, should have access to equitable immunization programs that prevent illnesses that are already avoidable.

The issue for all of us is: How do we take that national program, how do we take that national objective and use it to

reduce costs, to reduce wait times and to reinvest in those savings to improve health services to people across the country?

In British Columbia, Prime Minister, just to close, let me say this: between 2004, today, and 2006, we expect our health budgets to go up significantly. In fact, since the year 2000, our budget will be up by $3 billion in health alone, which is a 35-per-cent increase. While we have reduced the administrative costs, as I have said, we have watched as, consistently, the demands for services has gone up. We have instituted a 24-hour nurse line, which has reduced demands. We have instituted pharmacist support. We have introduced multi-lingual professional support to people on those lines because we do want British Columbians to have access to top-quality health care.

Prime Minister, we can solve this problem. We can solve the problem by recognizing that to sustain the current health care system it is going to require a true new partnership, with 25-per-cent funding from the federal government on real costs of health care for all of us. We can solve the problem and we can move forward by looking for the opportunities of equalization, which my colleagues have identified, and we can solve the problem by looking for new opportunities to reduce the costs of pharmaceuticals to people across this country and refocusing those resources on the health needs of families in every provincial and territory of Canada.

I want to close by again thanking you for coming here. I am sure that three days with the premiers was at the top of your list, but I can tell you that three days for Canadians of us working together to find a solution is at the top of their lists. We can find a solution. Canadians are sending enough resources and our country is strong enough and smart enough to lead the way and deliver the top-quality health care system that every Canadian deserves.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier. Premier of Prince Edward Island.

HON. PATRICK G. BINNS (Prince Edward Island): Thank you very much, Prime Minister. And I will ask you, if my voice is a little bit gravelly. I had a bad cold. I really need a doctor. I am shot sure if I can afford one or not, but we will keep John Hamm close by to make sure nothing happens. Thanks, Ralph, for the mints. A fishermen's friend.

--- Laughter / Rires

HON. PATRICK G. BINNS (Prince Edward Island): As Premier of Prince Edward Island since 1966, I have had the opportunity of attending a number of First Ministers' Conferences and I have always found that the people who sit around this table may differ in approach, but I do believe, strongly, that all have worked hard to better life for Canadians and that we now, specifically, have the opportunity and are committed to fixing our health care system.

I was born in Saskatchewan in 1948, about a year after hospital insurance was first introduced in Canada. At that time, national health grants began and Ottawa became a significant health care partner in providing those grants. I have been fortunate to live with some form of medicare all my life and, in truth, the medicare systems we have today have been several generations in the making.

Therefore, I believe that we have the opportunity over these days to commit to solutions which will put Canada's health care systems on a firm footing. But we have arrived at a critical juncture: we have the ability to rise to the challenge or we can allow this golden opportunity to slip through our hands and, in doing so, continue to put the very foundations of Canada's health care system at risk.

Health care for Canadians is a shared priority. It has been for some time. All leaders want to reduce wait times, increase the number of health care professionals, improve critical services like pharmacare and home care. In fact, in our province we worked in partnership with your government and with health care providers in the communities to improve access and make reforms. We have recently added more health professionals, like doctors and nurses, than at any other time in our province's history. We have invested in our hospitals and have enhanced services to the regions. We have established our first cancer treatment centre and we have provided new investments in equipment in human resources. The acquisition of our province's first MRI has meant that thousands of Islanders no longer have to travel out of province for important diagnostic services. A new $55-million hospital in Prince Country is now providing first-rate, state-of-the-art service to Islanders.

This progress in coming up to a Canadian standards -- and I say "up to" because we were not there and we are not there now -- has meant significant investments in the face of

competing demands for provincial resources. But because of these investments, our health care expenditures rose to 8.8 per cent of GDP, the highest in the country.

Colleagues, since I became Premier, the Government of Prince Edward Island has increased what it spends on the health of Islanders by more than 66 per cent. Since 2000, those costs have escalated by 37 per cent. By contrast, the total federal transfers to Prince Edward Island have decreased -- that is right, decreased -- by 2.2 per cent over the last three years.

In the face of all this, our focus over the next three days must be on maintaining, sustaining and reforming our health system, but to do so we have to address in a meaningful way the fair and equitable sharing of the costs of providing health care to Canadians.

For several decades Ottawa paid 50 per cent of the average Canadian cost of medically insured services. Successive changes have unfortunately reduced this share. Federal transfers were reduced in 1986, when Ottawa imposed a growth limitation on transfers. The formula became GDP minus 2 per cent. In 1990, important transfers to the provinces for health, social services and education were frozen -- frozen for four years, but health care costs were spiralling at the same time. Then in 1995, the Government of Canada actually cut the Canada health and social transfer by $6 billion. More importantly, the amount of money in CHST transfers became discretionary and no longer tied to a formula.

To make matters worse, in 1995, equalization payments began to fluctuate wildly and lost their historic GDP relationship. I would point out, Prime Minister, that reductions were made by both Liberal and Conservative governments. Since 1999, I would also recognize that some reinvestments have been made by the federal government, but not nearly enough to keep up with increasing costs and escalating demands.

I know there is full consensus around the table that inequitable division of costs is not reasonable and I acknowledge, with thanks, your recognition, Prime Minister, of this fact, as well. But I want to speak further of equalization. The principle and purpose of the equalization program has been entrenched in the Constitution of Canada since 1982. This is a defining feature of the Canadian confederation and to me it reflects the very underpinnings of what it means to

be Canadian: equity, fairness, and regardless of where you happen to live or what your economic station may be.

Section 36.2 of the Constitution Act commits the Government of Canada to, and I quote:

> "The principle of making equalization payments to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation".

This fundamental requirement of the Canadian Constitution has not in recent years been adhered to. As illustrated, provincial health services costs continue to escalate, while federal transfers are nowhere near to keeping pace.

While reinvestment since 1999 by the federal government in the CHST -- and now CHT -- have been made, these investments have been offset by a steady erosion of the equalization program. In 1999, the decision was made to reduce user fees to 50 per cent over five years and this has weakened transfers to the provinces. In fact, in 1982 to 2004, equalization entitlements fell from almost 1.3 per cent of Canada's GDP to just over 0.7 per cent, and this chart -- and know you won't be able to see it well -- illustrates that decline, particularly since 1995, where it drops off drastically.

Failing to address this erosion is failing to live up to the basic tenants of what makes our country unique and socially prosperous and I would humbly suggest that total Equalization Program funding must be restored to 2000-2001 levels as a first step in overhauling equalization.

And the reasons, Prime Minister, that I have chosen 2000-2001 is because in September of 2000, four years ago, when we met with your predecessor, Prime Minister Chrétien, he made a commitment to us, it was part of a deal, to fix equalization for the future. We never expected that fixing would mean decreases.

Prime Minister, I applaud your commitment to fix health care for a generation. This is a powerful statement and Canadians are expecting a lot of us. In fact, it may be tough to live up to some of their expectations. There has been a suggestion that a federal investment of an additional $13 billion to health care over the coming six years will be made. We remain to see the final numbers.

To many Canadians, that may appear to be a significant investment, but in terms of individual contributions, the $13

billion can be boiled down to about $66 per Canadian per year. On Prince Edward Island, we spend about $2,500 per year. Such an increase would be a small percentage of expenditures for a system that is so underfunded. It is important for my province that we shore up our basic health are system. We have many reforms under way, but we cannot continue to add new programs or expand services without better cost-sharing.

As in many other provinces and territories, health care spending in our province is rising much faster that revenues and the long-term forecast is not optimistic. Our population -- as is referred to by Quebec -- is older than the Canadian average and that aging population increases the demand for health service. That is why straight per-capita transfers are neither fair or appropriate.

Our collective approach must be responsible and sustainable for the long term. We cannot afford to raise expectations unless your government is prepared to adequately share the costs. Change does not come easily and there are many obstacles which can serve to prevent true reform and progress. Let me remind everyone in a lighter way that while we belong to different parties and can be separated by thousands of miles, that we all share the same moonlight.

As First Ministers let's rise to the challenge and demonstrate to Canadians we are serious about working with health care professionals in addressing the number one priority. Canadians will rightly judge whether we seize the opportunity to maintain, sustain and reform the healthy care system and they will not, I believe, accept the status quo, the status quo defined by federal-provincial struggles over the financing the health care system in desperate need of commitment from the federal government. There is a plaque in the historic Province House in Charlottetown where the Fathers of Confederation first debated and deliberated the construction of Canada back in 1864, and it carries the following inscription, I quote: "They built it better than they knew".

Prime Minister, I believe we now owe it to all Canadians to build a better health care system today.

Thank you.

RT. HON. PAUL MARTIN (PMO Canada): The Premier of Alberta.

HON. RALPH KLEIN (AB): Well, thank you very much, but Saskatchewan is a little older by about five minutes, so, Prime Minister, I will defer to Saskatchewan.

RT. HON. PAUL MARTIN (PMO Canada): They reversed my order.

You see, that is what the federal officials do.

--- Laughter / Rires

RT. HON. PAUL MARTIN (PMO Canada): I just can't believe it.

You have the Premier of Saskatchewan.

HON. LORNE CALVERT (SK): Thank you, Prime Minister. I can assure you that Saskatchewan would never let federal officials change the order of Confederation.

And while we are discussing this matter, I am sure, on behalf of the Premier of Alberta, I would want to invite all of our colleagues in the room and friends from across the nation to visit our two great provinces next year in 2005, as we celebrate our joint centennial.

Mr. Chair, Prime Minister, thank you for this opportunity. Thank you for bringing us together on this very significant issue.

It seems to me, Prime Minister, that I would like to spend my time this afternoon trying to describe some of the context of our meeting, as we meet and open here in the nation's capital. And as I consider the table at which we sit and all of the diversity that is represented at this table, our political diversity, regional diversity, jurisdictional diversity, we have one thing in common: all of we First Ministers, we are today the stewards of medicare.

Medicare does not belong to governments. For that matter, medicare does not belong to health care providers. Medicare belongs to Canadians. And we who sit at this table are but the stewards of medicare for our time. And it is not our task to invent medicare. It is our task to sustain and to strengthen, to reform, to transform, to innovate, to ensure that we leave Canada's most social -- most treasured social program in better shape than when we first came here. And as medicare stewards, we are accountable to those who elect us -- all of us.

Medicare was born on the prairie, in Saskatchewan, based on a very simple principle: the principle being that your access to health should not be determined by the size of your wallet, that your access to health care should be determined by your need. That is the principle.

Now, Premier Doer talked about some folks he met coming into the meeting or coming down to the meeting. Well, I can report to colleagues that yesterday, here in Ottawa, I met a

women who I would guess to be about the age of my mother and she looked me directly in the eye and said, and I quote: "Now, you boys..." -- and she was kind enough to call us "boys" -- "Now, you boys save medicare". She grew up on the prairie. She has memory of a time there was not medicare in Canada. And in Saskatchewan, today, there is an entire generation of elders who remember a time before medicare and they remember this little radical experiment that took place in the southwest corner of Saskatchewan. And they remember what many of us forget today, that when this radical notion was proposed and when the struggle was engaged, there was a tremendous amount of fear and trepidation about this idea and there was much opposition. But those who had a dream persisted and they fought the battle and once established on the prairie, a decade later -- not even -- it became a national program.

So Prime Minister and colleagues, we do not need to reinvent medicare, but as its stewards today, we are charged to sustain it and strengthen it, to change it and reform it and preserve its values.

Now, obviously, our health care system today is much more than the doctors in hospitals of a half century ago. Technology has advanced, pharmceuticals have advances. Health care providers today have skills and knowledge that would simply amaze some of their predecessors. And we have learned the value of home care, we have learned the value of community-based care, we have learned the value of primary health care, long-term care, public health care, we have learned the value of wellness and preventative health care. But through all of the years and through all of the changes, we have preserved the values -- the values of a public health care system, the values of shared citizenship, the collective responsibility we accept to care for each other, the value of equity, that no matter where we live in Canada we should ensure, enjoy a similar level and access to health care services and the fundamental value that our care should not be dependent upon our wealth, but upon our need, no matter our birth, our wealth or our place in the nation.

So today, as we begin the process of meeting together, as First Ministers, today as the stewards of medicare, where are we? Well, as you identified, Prime Minister, I believe, and others have mentioned, we have, today, the tremendous advantage of all the work that is now going on in our provinces, we have all of the experience of the reforms that are happening. In

each and every one of our jurisdictions, we bring that to the table.

We have the tremendous advantage of all the work that has gone on in the various studies. You mentioned Fyke in Saskatchewan, the Kirby, the Romanow. All of that work, all of that discussion, the volumes are available to us and conclusions have been drawn. And I would argue today that the challenges are pretty clearly defined, the challenges of providing health care providers in adequate number, in healthy workplaces and matching the right provider with the right need at the right time, the challenge of the provision of pharmaceuticals, the challenge of building toward a national plan to address drug costs, the challenge of the need to reduce wait time and to improve access, the challenge of home- and community-based care, the challenges of primary care, of wellness, the challenge of governance and accountability.

And while our experiences are somewhat different and while the reports differ in some detail, you know there are some very striking similarities in all of the work and in all of our experience. In our own case, in Saskatchewan, with the Fyke Commission, when that commission finished its work, we concluded in Saskatchewan that, based on all of the evidence and all of the values, that a publicly funded and publicly administered plan was still yet the right thing for Saskatchewan and the right way to sustain and renew the system. And we knew then, and we know today, that we had to concentrate on four primary areas providing better access to health care services, doing more to promote wellness, addressing the shortages of key health care providers and ensuring long-term sustainability through greater emphasis on quality, efficiency and accountability.

We have been at work in Saskatchewan, as we have across the country, and so we are establishing the primary health care teams across the province. We have expanded the diagnostic care in Saskatchewan. We have more than doubled the number of MRI tests. We are building the nation's first real surgical registry and patient waiting list. We are trading more providers. We have implemented a tobacco reduction strategy. We have implemented a health line. All of those we will discuss in the days to come.

Today, I would like to come to conclusion by identifying what I believe are the four, the four over-arching policy challenges that are sitting before us at this convention.

Firstly, how do we ensure, in our time as the stewards of medicare, that all Canadians, despite the size of their wallet and despite where they live, how will we ensure they have access to a reasonably similar standard of care while ensuring enough flexibility that the unique needs of our different populations are met and the diversity of need is respected?

You know, it is a fact that today, in Canada, some of the key elements of health care are not universal or equitable in drugs, in home care, in mental health services and access to other services and preventive care. To better achieve equal access for all Canadians seems to be our first challenge.

Secondly, how will we sustain confidence in a publicly funded administered medicare system to deliver access to those areas of care in a timely way? If Canadians lose confidence in our system, it will soon spell the erosion of our system and all of its values.

Thirdly, as we discussed this morning, how are we going to meet the challenge of responding to the poor health outcomes experienced by Aboriginal peoples right across Canada?

And fourthly, how are we going to put medicare on an adequate, sustainable and predictable financial foundation for the future? Ours is a publicly funded system where, through our governments, we pool our resources to provide our care.

The funding question is therefore elemental and fundamental. If we fail to build the adequate predictable and sustainable foundation financial for medicare in Canada, those who believe that our health care solutions are to be found in the marketplace will have their case significantly advanced.

I do not believe the solutions to our health care futures are to be found in the marketplace. I do not believe in for-profit health care. I believe the solutions to health care are to be found in our community and our Canadian community and in our provincial communities.

Therefore, it is so essential. That is why I believe the Premiers at this table believe it to be so essential that we establish in these three days the path forward to adequate, sustainable and predictable financing. For now, for months now years, we have talked about that being set at 25 per cent of health costs being delivered by provinces, all in. We need to find the path of progress to reach that goal if we are going to assist, if we are going to build that financial foundation, that will ensure the future of medicare.

I want to close by saying it is not money alone. It will not be money alone that will build the sustainable medicare for the future to meet our challenges. It will mean change. It will mean change in how we deliver health care. It will mean change in the roles of health care providers. It will mean change in the determinants of health. It may in fact mean change in our expectations.

As the stewards of medicare today, we need the wisdom, the strength and the foundations and the courage and the vision to change for the future.

Prime Minister, there is an old proverb that says we are all afloat on a stormy sea and we owe each other a terrible loyalty. I don't think we owe our first loyalty to each other, but we owe a terrible loyalty to those Elders who pioneered medicare in our country, and even more substantial loyalty to our children who will inherit our work. We have work to do.

Thank you, Mr. Chairman.

RT. HON. PAUL MARTIN (PMO Canada): Well said, Premier.

To the Premier of Alberta.

HON. RALPH KLEIN (AB): Thank you, Prime Minister, and thank you for hosting this conference, and colleagues.

First of all, I want to make it quite clear that health care renewal is not something we are here to start. It is something that all provinces and territories have been pursuing for as long as I have been the Premier. That is almost 15 years now, and long before that.

Of course, the federal government has been involved as well in trying to improve the system, as the Prime Minister so aptly pointed out.

Health renewal or reform is, as Lorne pointed out, first and foremost about people. It is about the Marthas and Henrys and the Mr. and Mrs. Grundys. It is about those people who want to make sure that the system is there for them when they need it, when they are sick or injured. The public system, as envisioned by Tommy Douglas, that is there for them when they are sick and injured so they don't lose their home and their family and their dignity because of the costs of medicare, when they are sick or injured.

It is also about the people who provide the services, the doctors and the nurses and the housekeepers and the paramedics and so on.

With that in mind, I want to talk about what we propose to do as a province, a province with the constitutional responsibility to deliver health care services. I want to talk about our goals in health care, our recent achievements in health renewal and what we look for from the federal government.

As I said at the outset, all across Canada provincial and territorial governments have worked very hard to maintain and improve their health care systems. That is our constitutional responsibility and we are meeting it.

In Alberta, a few examples of these successes include negotiation of Canada's first long-term primary care arrangement with physicians and health regions, and as a result of those negotiations innovative primary care centres are opening or being planned across the province.

Introduction of an on-line wait list registry so physicians and patients can, in essence, shop around to get treatment faster, all within the publicly funded system. So if a hip replacement is not available in Calgary, they can shop around and get one in Medicine Hat or Lethbridge or Red Deer or Edmonton or Grande Prairie or Peace River;

the launching of a provincial electronic health record program, so physicians, pharmacists and emergency rooms can have instant access to the best health information for better care decisions and better quality care where everyone's records are on computers;

the introduction of a high profile prevention program to reduce diabetes -- I mentioned that earlier -- tobacco use, heart disease and injuries. This hopefully will result in better health and lower demands on health services over time;

expansion of the health link telephone information line province-wide, so Albertans in every part of the province can have free confidence advice from medical professionals without having to go to the doctor, to simply get it on line;

expansion of the tele-health clinical services program to provide more specialized services to clients in small communities through tele-conferencing;

the establishment of new multi-disciplinary clinics for better access to specialized services in community settings;

expansion of provincial immunization programs to combat communicable diseases amongst all age groups. It is one of the most cost-effective ways of improving Albertans health; and

financial commitment to building new world-class facilities, including a heart health centre of expertise in Edmonton, a bone and joint centre of expertise in Calgary, and a new full service children's health centre in Calgary.

We did this to build knowledge expertise and care for Albertans and all Canadians. Of course steps have been taken amongst the Premiers to coordinate health care activities across Canada and to achieve efficiencies.

So what I have outlined are a handful of steps taken by our province over the last few years that have helped achieve one or more of the goals for the health system. There are many other examples of course.

Statistics prove that access is improving. Some wait lists are being reduced, even while other wait lists are growing. The number of services has greatly increased and victories are being won in the battle against unhealthy lifestyles and habits. We see a lot of advertising and hear a lot of advertising about healthy living and that is starting to pay off.

When I say "we have done this or that" I don't mean the government. To the contrary, I mean the province as a whole and in this context I mean Canadians. In fact, successes in health care services in our province have been achieved largely because of dedicated health professionals, skilled managers and support staff, universities and colleges that train good skilled people, but mostly because of the people themselves who want to achieve a healthier lifestyle.

But that doesn't mean that we don't have to plan for the future. We are indeed planning for the future, understanding that health care is a provincial responsibility and we have a constitutional responsibility and the constitutional authority to deliver health care.

With that in mind, we launched a three-pronged program.

The first part of the program, unfortunately, was to increase spending on health care to address many pressing issues in the system. We increased our health care budget to $9.1 billion, albeit Canadian dollars but significant nonetheless. That was a $700 million dollar increase. That was the largest mid-year spending increase in any budget category at any time in the province's history. But the goals for the reinvestment were very specific.

First of all, we had to make the system pure. That meant eliminating all the deficits of our health authorities. It

meant recruiting doctors and other health care givers to allow the performance of more than 1,200 orthopaedic surgeries. It involved putting more money into reducing wait times for certain heart surgeries from nine weeks to two weeks. It involved the fast tracking of the addition of 600 new acute care beds in Calgary in the capital region, as well as accelerating completion of other capital projects in the province. It involved putting more money into reducing waiting time for MRI procedures.

The second phase of the program -- and we are about to enter into that phase -- is an international symposium that will draw the best health care minds in the world. Because I wonder without going to the expense of sending people all over the world why there are other countries and other states and other provinces in the world that are deemed to do better than Canada. There are many, I believe, successful strategies and practices beyond the borders of North America. Notwithstanding Shirley Douglas, who is campaigning outside, it is not just a choice between Canada and the U.S. There are other jurisdictions we ought to be able to look at to find out what works and what doesn't work.

In the third phase we will take all the ideas and all the reports that you alluded to, Prime Minister, and all the reports that are out there, and all the best practices in other jurisdictions, and we will take this out to the public. We will find out what Albertans want in terms of health care delivery systems. I have always been a believer, you find out which way the parade is going and then you get in front of it.

We are going to find out which way the parade is going relative to health care. That renewal will proceed only in discussions with Albertans, because they are the people who pay and use the health care system.

I can tell you that unlike probably every other province, the health care budget has more than doubled in the last 10 years. A decade ago health care took 25 per cent of the Alberta budget, now it is almost 40 per cent. Over the same period the federal governments share of health care dropped to about 16 per cent from about -- I think it was close to 50 per cent at one time.

More money. The 25 per cent of the total health budget we have been talking about for years would help. It would help immensely. But, as I have said, it is only one part of the

puzzle. 25 per cent would be a bigger part of the puzzle. What we see now is a small part of the puzzle. The puzzle probably has a hundred different pieces, a hundred different pieces, and it all has to come together.

The federal government has indicated it will provide an additional $12 billion in funding over the next six years, or 13.4 over the next five years to support health care. It sounds like a lot of money and it is. As Pat put it, it amounts to about $66 per Canadian. Our figuring shows it at about $64. You must have been figuring in American dollars.

But $64 or $66 per person will not buy reform. It will not buy sustainability. It will buy a very small corner of the puzzle. So that says we must continue our efforts to innovate and improve the system.

And besides, now I have been on this money treadmill for close to 15 years, this more money treadmill. There is an old saying about treadmills. They are a great machine for politicians because you run like hell and you get nowhere.

We do, however, appreciate the opportunity to work with other governments on long-term solutions to challenges such as wait lists, and home care and access to health services. In Alberta, as I have mentioned, we will undertake public consultations on health care and do what is right for Albertans.

Our objective of course is an effective sustainable system for Albertans and one that delivers better access and higher quality. This is the road that we will continue to drive, notwithstanding what we believe is a serious federal government shortfall in funding.

It is Alberta's view that the true level of Ottawa's commitment to the partnership can best be demonstrated by addressing the long-standing health funding inequity that has been one of the biggest single challenges facing the provinces, without doubt.

Having said that, it is quite obvious we need a new and more imaginative approach for the future.

Thank you.

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

Newfoundland and Labrador.

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

What a spot I find myself in, having to follow one of the most colourful Premiers in the history of the country. There is

probably not a viewer or a reporter who still has his or her television set on now, as I start. So I just want to thank my mom and my family and my cabinet for continuing to watch as I present.

The cabinet are only watching because I said there would be a test on my presentation when I got back.

I want to thank you, Prime Minister, particularly and personally for having the courage actually to face this group of 13. I am sure as the afternoon goes on you are probably even questioning the wisdom of all that. But I certainly admire you for doing it, and we are all very aware that you have the hammer coming home. Thank you for having us here and giving us an opportunity to express our views.

I am certainly pleased to be here today in my capacity as a First Minister of this great country. But I am proud to be here as a voice for Newfoundlanders and Labradorians; as a voice for the patient in the hospital bed or the individual sitting at home waiting desperately for their turn to see a cardiac or cancer specialist; as a voice for the care giver who has dedicated their life to helping others, often at the expense of any real life for themselves; as a voice for the administrator who sits at their desk frustrated by the bureaucracy and inefficiencies in the system which result in health care delivery that does not live up to the tremendous expectations that are placed upon them; and a voice for family and friends who watch as their loved ones suffer in a system that is not always capable of being there for the patient.

The value of our health care system is not lost on Canadians, nor is it taken for granted. My grandson Gabriel, born 16 weeks premature, at one and a quarter pounds, is today a vibrant, healthy and precious four-year-old because of services that we rely on, services that I certainly do not take for granted.

Four members of my family are cancer survivors whose lives have been saved by the surgical skills and advanced treatment methods of health care professionals.

Nurses, doctors, technicians and other health care professionals work day in and day out to deliver the best that we can afford to provide. We are doing something right.

I recently had the great pleasure of visiting a nursing station in the most northern region of Labrador. There I met some of the pillars of our health care system, nurses Goldie

White and Joy Barrett. I was struck by the professionalism, compassion and dedication of these individuals, who probably work with less but do more than many of their counterparts in urban areas. They provide real frontier medicine and a full menu of services to their patients, including dental work.

I didn't stay for any work, by the way. I was afraid of an extraction because of the tough policies we have in Labrador these days.

Their only request to me was a new ambulance to replace the old truck so that their patients could be transported in greater comfort and safety. And you had to see this truck. Instead of complaining about all that they did not have, they focused on what they did have, and only requested something that would enhance their patients' most basic quality of care. What a testament to the professionalism of our health care workforce.

In all of the discussions of health care going on around this country, the human face of health care is too often forgotten and neglected. We read endless commentaries and listen to panel discussions about wait times, and access, and shortage of doctors and nurses, and most of all we hear about funding. All very important, very, very important, but where is the human face?

Indulge me for just a moment to tell you about Tommy. Tommy is a 10-year-old boy diagnosed with cancer living in rural Newfoundland and Labrador. For Tommy, his very survival means he will have to leave his family and community to seek treatment hundreds of kilometres away in St. John's. Tommy's mother is the primary care giver for her elderly father, who is showing the early signs of dementia and requires fulltime care. Tommy's father works hard to provide for his family to the best of his ability with seasonal employment. They are victims of underfunded health care and limited employment opportunities.

So Tommy's mom is torn. She can't afford to pay for home care to support her elderly father, nor can she afford the expense of travelling and living in the city during the course of Tommy's treatment. Tommy's dad can't afford to stop working, so Tommy's mom must make the horrendous decision to send her 10-year-old child to face his battle with cancer alone in a far away city.

This is the 21st century but in Canada this is the human face of health care in my province. This is my reason for being here today.

The picture can be quite grim. However, I do not want to undervalue the progress we have made collectively and individually in the provinces and territories in recent years. Real, meaningful steps have been taken toward improving our health care system.

Whether we are sitting around this table today or in our homes watching these proceedings, I believe that there is a common objective for the vast majority of all Canadians. Regardless of political affiliation, education, socioeconomic background or geographic situation, Canadians and Newfoundlanders and Labradorians want more than anything to improve our health care system and, more importantly, to ensure we have a sustainable system well into the future.

In Newfoundland and Labrador our challenges are varied and often unique. However, at the core our resolve to provide excellent, affordable and accessible health care is equal to any of our provincial or territorial counterparts.

I sit here today united with my colleagues. As leaders of our provinces and territories, we have been on a journey for the past number of years which if left unchecked is unsustainable.

In each of our jurisdictions, we have rigorously and to the best of our abilities delivered one of our most important mandates: the provision of public health care to our citizens.

While some of us have the good fiscal fortune to deliver a wide variety of services and drugs, others of us are struggling on a daily basis to deliver the basics in a system that continues to demand more and more of our precious fiscal resources.

In Newfoundland and Labrador, Prime Minister, we have a very serious financial situation, as I know you understand and can appreciate. Our province is facing sustained deficits of $1 billion per year on total revenues of $4 billion and accrued interest on debt of $1 billion per annum. We have had to eliminate jobs, reduce services, reconsider our program offerings, and our public sector employees have a two-year wage freeze.

Our situation has been compounded by a steady decrease in federal support. In the case of Newfoundland and Labrador, our expenditures for health care have grown $480 million over the past five years while the total federal contribution toward all social programs has declined by $10 million -- a clear case of the rich getting richer and the poor getting poorer.

As a consequence, we are borrowing to fund our existing health care services and would require $300 million just to achieve financial stability on a current basis. To put that in perspective, we only receive $16 million, or three days of health care costs, for each $1 billion of federal health care funding. This would only solve 5 per cent of our problem.

Health spending currently represents 45 per cent of program spending in Newfoundland and Labrador. We have only 4.7 per cent to go toward economic development and growing our economy. In four years it will be 1.47 per cent, and in 10 years there will be no more money available to develop our economy.

This, Prime Minister, will only exacerbate our highest out migration, unemployment, child poverty rates in the country, and the lowest income rate in the country.

We are spending in my province more than we can afford but we are still not yet adequately meeting the needs of Newfoundlanders and Labradorians. In a province of a half million people the wait list for our only MRI contains the names of 1,906 people and routine wait times of 270 days.

We have 700 communities spread out across a vast interior and 18,000 kilometres of coastline. Cancer radiation treatment is only available in St. John's, requiring drives of thousands of kilometres to and from for some patients.

Put simply, we have a health care funding crisis in Newfoundland and Labrador. Our system is so underfunded that we are not able to fund our existing programs, let alone accept or consider new programs that require cost sharing or targeted new funds.

The people of our province are doing their part in helping our government achieve fiscal health, but we cannot and we should not be expected to do this in the absence of federal participation.

We are not asking for help. We are not begging for money. We are a proud people. We are asking the federal government to live up to their responsibility and obligation to this great Canadian federation.

Running this country, just like our health care system, must be a partnership. The people sitting around this table today must never lose focus of one important point: we all work for Canadians. Governments, provincially and nationally, are the public trustees for all Canadians. Surpluses or deficits,

we manage their money and we must be accountable and ever mindful of that reality.

While the provinces and territories manage our individual jurisdictions, the federal government answers to and works for all Canadians. Well, Canadians have spoken and they are demanding that more of their money is invested into a system which they know is fragile and in desperate need of support. Canadians have spoken and today they are waiting for the federal government to respond.

Our country's health care system is a national institution which sets Canada apart from many other developed nations. Our publicly funded universal system makes us the envy on the world stage. Little do they know the practical reality of life on the front lines in health care in Newfoundland and Labrador.

As leaders in this country around this table, we collectively and individually have a responsibility to ensure that this national treasure is in fact there for our children and our grandchildren. However, we must also ensure that it is affordable and relevant so that our decisions today do not mean financial burdens tomorrow.

Prime Minister, we must embark upon a journey today to ensure this for the people of this great country. Canadians expect it and we must deliver it. I believe that our health care system is at a turning point, a fork in the road, and we must decide which path to take. In the process we will talk about a lot of issues: sustainability, affordability, wait lists, policy and funding.

I must say today, Prime Minister, I chuckled at the news conference when one of the reporters suggested that we were bickering, and I was too hungry to intervene, to jump in and try to help you on that one. I think it is unfair to say that we are bickering. It makes it seem that this process is petty, and I think they tried to lay the blame on your shoulders that you were not able to solve the bickering. I don't see what we do at this table or in the back rooms or when we meet or when we talk or when we talk to the media that we are bickering. This is serious business. We are entitled to discuss it and you are entitled to have a position and we are entitled to have a collective position and individual positions.

We are entitled to argue. I understand you love an argument. I love an argument too. There is nothing wrong with that. That is good. That is healthy. And we all have a common

purpose here. We are all here to make sure that we get the best possible achievable, affordable, reasonable health care system that we can get for the people of our country. So we are all on the same wavelength. We are all protecting our own territories, but we are in this together. We will listen to each other and hopefully at the end of these three days we will achieve a compromise and we will agree on certain terms. There may be some terms that we are unable to agree upon, and if we have to we will set those aside and we will deal with those another day.

I don't want the media to get the impression it is just a crowd of people that can't get along together; that they are petty and they are nitpicking and everything else. That is the process, people. That is what it is all about.

I am confident. I have had it shaken, believe me. I think we should have started this a week ago privately and been at a more advanced point now, but I am confident we can reach a deal here. But we will all have to hold our collective noses. No proper compromise or agreement is ever acceptable to either party, so I am confident we can achieve that.

Excuse me for digressing. I am just about to wrap up.

The complexities and the details will sometimes seem insurmountable, which is why we must also keep at the force of our deliberations the basic fundamental core of our health system: the people who deliver it and the people who need it most, the people who receive those services.

Today we are here to make deliberate, thoughtful and progressive decisions on behalf of all Canadians. Action is demanded and action is required. As we proceed with our deliberations over the next three days, I would suggest that we take to heart the words of a great leader, John. F. Kennedy. It was he who said: There are risks and costs to a program of action, but they are far less than the long-range risks and costs of comfortable inaction.

Let us not be leaders of comfortable inaction. Rather, let us take a stand for our health care system and for the people of Canada. We will find a way.

Thank you, Prime Minister.

RT. HON. PAUL MARTIN (PMO Canada): Well said, Premier.

Premier of the Northwest Territories. Joe.

I don't know if I am rewriting history again. I have you first, followed by Dennis, followed by Paul. If I am rewriting history, I am not the first one at this table.

HON. JOSEPH L. HANDLEY (NT): Thank you. With Premier Fentie's agreement, I will proceed.

Prime Minister, I also want to thank you for calling and hosting this very important conference.

On behalf of the people of the Northwest Territories, I am pleased to participate in this important meeting and to contribute our knowledge and our concerns in helping to gain a greater understanding of the health care challenges we face and the solutions we must pursue.

I want to take a moment to express profound appreciation to the legions of health care professionals and front line health workers across this country, and especially those in the North who labour with dedication and commitment to care for our citizens. In the next few days, we must work together to reach the agreement required to build an effective, sustainable national health care system for all Canadians, one that all Canadians can count on no matter where they live.

I believe we will accomplish this goal, because anchoring our meeting is a commitment by all leaders at this table to the most important principle: that not a single Canadian should be left out or left behind in building a better health care system, not because of the region they live in or because of their economic circumstances.

That is why I bring to this table a determination to ensure that the people of my region get access to the quality care they need, when they need it, and the tools and resources to exercise their individual responsibility. As a government we want to help citizens live healthy productive lives.

Ensuring adequate health care for Northwest Territory citizens has never been a bigger priority or a more daunting task. This is particularly true in our efforts to improve the health conditions of Aboriginal people.

We are coping because we are resourceful and creative but to develop long-term solutions we need adequate, stable, long-term funding.

The Northwest Territories is home to 42,000 people. 50 per cent of our people are Aboriginal: Dene, Métis and Inuvialuit. We live in 33 communities, most very small in size and spread out over a vast area.

Transportation needs are met in most of our communities, exclusively in some of them, by boat, by winter ice roads and by tiny short gravel strip airports. My fellow Premiers in the

west know this firsthand from their recent attendance at the Western Premiers Conference in Inuvik.

These are times of immense change in the Northwest Territories. From our diamonds and oil and gas, we are creating wealth for the nation and jobs for Canadians from all parts of the country. At this time of change we are also facing unprecedented challenges. Large scale, rapid developments bring the potential for social, environmental, health and safety issues which affect our communities.

Many of our 33 communities are inhabited primarily by Aboriginal people. Many of these are communities without doctors, where patients are flown out for the majority of medical treatment and disease diagnosis. Servicing sparsely populated geographically isolated communities means few opportunities for economies of scale and program and service delivery.

Recruiting health care professionals to relocate to small remote communities is becoming increasingly difficult. Only five of our 33 communities have a resident physician. Physicians visit most of the small communities on a rotation, usually once a month. If no physician lives in the community, patients must either see a community health nurse or travel to a larger centre, often outside of the Northwest Territories, and this can mean weeks away from home.

Reducing waiting times across this country is a pressing urgent issue. While we share the concern, the challenge in the North has a much different character. For an elder from Lutselk'e, a tiny community at the east end of Great Slave Lake, who has tuberculosis, his wait time begins at the community airport. It means flying to Yellowknife, possibly to Edmonton, for a long stay without his family or community, for specialist care and treatment not readily available in the Northwest Territories. Our goal is to deliver this care closer to home.

Home care is a major concern in every part of Canada. In our small communities we lack trained personnel, hospitals and facilities to provide this type of care. As well, the tradition of care giving in Aboriginal families is becoming increasingly difficult because of overcrowded and inadequate housing.

Lack of funding means you are focusing on today's urgent needs without being able to deal with the long-term issues causing these urgent needs.

These issues include the lack of adequate housing, clean water and disease prevention and health promotion programs. Northern homes are crowded with more people per house than the rest of Canada. As well, many northern houses have serious environmental, health issues. Overcrowding leads to spread of disease. We have high TB rates and devastating outbreaks of respiratory illness primarily affecting children.

Pregnancy and child birth, normally a joyful family time, can be dramatically different in the Northwest Territories. During labour, a surgeon and an anaestheologist must be on call. Only two communities in the Northwest Territories have these specialists on staff. This means that women from every other community must leave their families during their seventh month of pregnancy and fly to Yellowknife or Inuvik. Women stay in boarding homes, giving birth alone in a strange community where they may not know anyone and where they have to communicate in English, which is often their second language.

Their partners are rarely able to attend the birth because air travel is so expensive and, if they have children, they must make arrangements for others to look after them while they are away from home.

The Medevac system is crucial during pregnancies and childbirth. Smaller communities are currently unable to handle situations like premature births or specialized neonatal care. The cost of an air ambulance flight between Yellowknife and Edmonton, where many of our people go, is over $7,500. This cost is much greater if a patient is from one of our small communities.

Although registered midwives will soon be able to practise in the Northwest Territories, those women with high risk pregnancies will still have to travel elsewhere to larger centres.

To forge an effective, affordable, sustainable national health care system, we need to be creative and innovative, not just at the national level but regionally and locally.

The Northwest Territories has established a culturally appropriate coordinated home care program available to all our residents. It is developed with the involvement of Aboriginal partners and families. In just two years the range of service options designed to assist individuals avoid unnecessary admissions to facility based care has been increased. We have

increased home support services by 100 per cent and doubled the number of home support workers.

One of our biggest pressures facing health human resources in our region is the ability to attract and retain nurses, especially community health nurses. Our community health nurse shortage is significant and growing. On June 30th of this year across our system, 35 per cent of community health nurse positions were vacant.

We are working to develop initiatives aimed at recruitment and retention of nurses, social workers and other health professionals. Where we are working to grow our own health care professionals. We are working to grow our own health care professionals. Our northern nursing program has produced 84 graduates between 2000 and 2004. We have funded nine northern medical students to complete their medical studies and one northern student has graduated from the Family Residency Program.

As much as we do our small part, I believe we need a national priority on training health professionals. We intend to expand our health human resources planning to recognize and encourage traditional healers and train staff in the broad reach of traditional medicine.

As we all know, staying healthy depends on a person's state of mind. Traditional healing support brings comfort and indeed courage to Aboriginal people, most especially our elders.

Our neighbours in the Yukon have a traditional healing wing in the Whitehorse hospital. This is the leading edge initiative we want to learn from.

We must work together, share efforts and find new approaches and we must proceed with flexibility. Flexibility is pivotal to our success in building an effective national health care system.

One size does not fit all. Indeed, in my mind flexibility defines Canada and should guide our public policy.

I want to commend you, Prime Minister, for your recent remarks recognizing health care solutions require flexibility. Just as bigger jurisdictions must construct a health care system to meet their particular needs, so too must the North, with its unique circumstances.

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

HON. DENNIS FENTIE (YT): Have we worn you down yet, Prime Minister?

I would like to begin by thanking you, Prime Minister, and all my colleagues for the opportunity to speak to you today on behalf of all Yukoners, to provide Canadians with a brief glimpse of what the situation is in the Yukon, the realities and the challenges we face with our health care system. Whether we are Aboriginal or non-aboriginal Yukoners, we need to have access to the same basic level of health care as every other Canadian enjoys.

One of the main challenges in this area is the fact that it costs more to deliver those services to our people. We have made progress in this regard with our establishment of the Northern Health Fund, but we must do more.

Because of the unique challenges we face, we are focusing on what will help improve our health care system and, in turn, make for healthier people and healthier communities in the Yukon.

Sustaining existing services is vital and the Yukon will continue to ensure adequate funding is in place to support our core health care services, plus we will continue to invest in innovative health care services such as our tele-health and at a distant diagnostic service. This allows more services to be provided locally and helps manage medical transportation costs.

We will continue to invest in health promotion and illness prevention, reducing smoking, obesity, substance abuse, combined with increasing physical activity and healthy living will help us achieve greater sustainability over the long term.

By addressing many of the issues affecting the health status of our overall population, we can make health care more affordable in the Yukon.

Another major challenge is the recruitment and retention of health care professionals. Getting these professionals to live and work in the smaller communities of the remote Canadian north has become increasingly difficult in a highly competitive southern marketplace. The Yukon will continue to increase its investments in this area. We must also continue to invest in infrastructure, including upgrading, replacing or building facilities. Equipment and housing must be added and of course investment and basic information and technology infrastructure.

We will continue to invest in the health care of our Aboriginal people. This is a national challenge.

One of the requirements that we must address is the adequacy gap, the delivery of health care or any other program or service in the North depends on the adequacy of our formula financing agreement. Federal restraint measures significantly and permanently compromise our capacity to provide adequate programs and services to our people. Without immediate restoration, territorial governments cannot sustain the escalating cost of health services, nor can they continue to divert funds from infrastructure, social and education programs to health care. Without restoration of this funding, existing and new resources will have to simply be focused on sustaining existing core services. This will result in the Yukon falling further behind each year as the cost of health care escalates.

Another requirement is flexibility. Because of our unique circumstances, sometimes our needs and priorities are different than those of the rest of the country and sometimes it simply does not make sense for us to do the same thing as they might do in the Province of Ontario for example. It wouldn't make much sense to have a MRI in the Yukon. It would be more expensive for us to operate a MRI than it would be to send people to another jurisdiction to get the same diagnostic service.

We still need highly skilled community nurse practitioners working in our communities. We need doctors who can work in and understand varied circumstances, from supporting medical care in bush camps and medevac situations to provide care in the local clinics. We need a wide range of other skilled health professionals who can work well in the Yukon environment. We need to continue to invest in prevention, education, nutrition, housing, economic development, and human resources. These are of the highest priority for the Yukon.

Health funding that is earmarked for specific purposes may prevent us from focusing our resources on the issues and priorities that would best support long-term improvements to the health status of our people. Healthier people leads to long-term sustainability for health care and indeed for our citizens in the North.

With our existing resources, Prime Minister, we are working hard in the Yukon to improve the health status of our people, to come up with innovative ways to deliver our health care programs and ensure sustainability. We have increased services to rural and remote areas this year by adding three new communities to our tele-health network. We have increased resident and

visiting specialist services to Yukon residents, including another obstetrician for example. We are adding emergency room physicians and we now have a specialist in internal medicine. We have also now added an orthopaedic surgeon who can do knee replacements in Whitehorse instead of sending our patients to other jurisdictions.

We continue to work on tobacco cessation awareness campaigns and we are focusing on prevention and promotion initiatives on providing residents with more health information on which to base good health decisions and choices.

Prime Minister, the Yukon has not come here today empty handed. We are demonstrating we are doing our part. What we are asking is that our partner, the federal government, does its part. In considering that health care is of the highest priority for all Canadians, we feel that it is not asking too much.

Thank you.

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

The Premier of Nunavut. Paul?

HON. PAUL OKALIK (NU): Merci, Monsieur le Premier Ministre, for Nunavut.

I don't want to talk too long, I believe we are ahead of our schedule, I mean in terms of a little late.

In Nunavut, I represent 25 communities and 30,000 residents, 85 per cent of which are Aboriginal. We have one hospital to speak of to service those communities so we send most of our patients to other jurisdictions. Actually, we send most of them here to Ottawa. That is the fact of health care in Nunavut.

We have maybe doctors in three communities and the rest have to rely on nurses. We have had to invest in technology to compensate for that. By the end of this year, every community in Nunavut will be connected with tele-health technology. That is an investment we made earlier on to reduce our travel costs. We are trying to do our best to meet the challenges that we face in health care.

Early on in our mandate we also cut health boards. We felt that the better expenditure could go toward delivering health care, not administering health care. Those are choices that we have made already to try to offset a lot of the operational costs in our territory.

We are also looking at reducing -- finding ways using our traditions in delivering babies for instance, introducing midwifery in our territory. We are trying to continually look for ways of reducing costs of health care.

We are building a new hospital to increase more services to our residents to offset some of the travel costs that is we incur. We are building additional health centres in a number of communities to introduce more doctors so that we do not have to fly more of our patients.

Those are just a few of the services that we are providing. We are training our own nurses, Inuit nurses, so that the majority of the people in the territory get health care in their language and actually get it in their communities and get long term assistance in that area. Those are just some of the areas that we are working on.

In the last few years we have had to cut a lot of the services that we provided in the past just to deliver basic health care to our residents. I believe we cannot afford to continually do that as we have the least amount of resources in the country.

So I would ask for your help and support in delivering basic health care to your fellow Canadians in Nunavut.

Thank you.

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

I have taken extensive notes and -- j'ai le choix maintenant de prendre la prochain trois heures pour vous répondre.

--- Rires / Laughter

However, I think if I did that I would severely jam the emergency room of some hospital.

So forgive me if I don't deal with every issue, but let me deal with this in a summary way, because tomorrow obviously we will be going into a great deal of the detail on a lot of these issues.

First of all, I recognize very much where you are coming from. I recognize very much the pressures.

Je comprend très bien les problèmes que vous soublissez au point de vu de financement, and we will obviously come back to this issue. In fact, I will mention it a little further on. This is Wednesday's agenda.

But this meeting -- notre réunion ne doit pas se préoccuper que du financement. Il faut aussi parler des réformes, des réformes que vous êtes en train de prendre. Les réformes que la système a besoin.

We also have to talk about other issues. We have got to talk about accelerating the process of reform which you have all begun. I am not here saying that the federal government has suddenly discovered the need for reform. And I'm not saying that you have done nothing. I recognize -- in fact the examples that I choose that we should be able to do nationally are in fact the very initiatives that you have undertaken.

We are in the middle of a huge change in society because of aging and because of these new technologies the fact that these cost the are going up it is nobody's fault. It just happens to be the way that our society is evolving.

So it is very clear that if we are going to deal with these changes, fundamental reforms on an ongoing basis are going to be required to deal with them.

Today most of the discussion has taken place on the basis of the reforms that you have undergone. I would hope that in tomorrow's discussion, which is going to be much more detailed, we can hear from you all on the reforms that should be undertaken. Where are we going? Because health care for a generation is the generation ahead and what we should be doing there.

I also would make the point about accountability. I hope we can talk about that. Let me just make the point.

On ne parle pas du culpabilité des bureaucrats du governement canadien. We are not talking about accountability to federal officials. We are talking about accountability to Canadians, province by province. We recognize a great deal of the reporting that has been done. We are talking about doing it on a way that reflects benchmarks. We are talking about doing it in a way that allows Canadians to take that province by province reporting and understand the health of the health care system nationally, because this is a shared value and Canadians have an interest in the national situation.

Having said this, one would have to be deaf not to have understood that funding is a concern. So let me simply say -- not deaf in actual terms, deaf simply to the reality of what you are raising. That is very true, very, very true.

But if you look at what we have proposed, yes, we have proposed a wait times fund. We proposed a wait times fund because the best advice that we have received is that in fact you have to break the back of it and that that is a short-term basis.

I think of the words of Dr. Naylor who essentially said attack waiting lists directly, prevent queuing. Get at it and once you have broken its back the odds are with the right structural changes you will be able to keep it that way.

That is the purpose after wait times fund. But I understand full well what you are saying when you say you want long term financing.

Je suis entièrement d'accord avec vous que ce que vous voulez, c'est un financement durable.

That is why we are talking about a ten-year plan and that is why what we have said was our goal will be, as we discussed at the January meeting, to meet the Romanow gap and then to build an escalator into that so that in fact the funding rolls up year after year over the course of a decade.

It is why we also responded to your request to deal with equalization, because we recognize that if equalization went down at the same time that health care funding was going up that this was going to be very difficult obviously for a number of provinces, recognizing as well that the reason that equalization goes down at the present time is not a decision by the federal government, it is the way the formula simply works because of the relative values of the tax capacity of individual provinces.

So you said give us an equalization program that will not reduce, give us an equalization program that is long term. And we are prepared to respond to that. And we recognize how integral that is to the health care system. And, so, when you say to me, what we want is long term funding, let me say that is a message which we have received. Our proposal is designed to provide that long term funding.

Now, some may say why Romanow? Well, let me just take a look at what -- and fortunately this meeting has not degenerated to this -- but what could happen.

First of all, federal government's funding was never 50 per cent. It had a high of 40 per cent. Our funding is not now 15, if you include research and development, Aboriginals, public health and equalization, the federal government -- and I could

take you for hours and proving as an ex-Finance Minister how, in fact, it is somewhere between 36 and 40.

Let me tell you, if we get into that kind of a debate, we all understand that we are into an ever-, you know, an ever-descending spiral, and none of us wants to have that.

It is the reason that when you look at all spending -- because if you look at all provincial government spending, you have to look at all federal government spending -- and I will tell you, I don't think anybody wants us to continue this constant battle of finance departments in terms of what it is. That is why we have Romanow was an independent commission basically established a way of looking at that and that is why it is the architecture which we have adopted.

We want to provide you with long term funding that is not susceptible to the ups and downs or the vagaries of the economy or in fact the vagaries of the federal government's decision because we understand how important it is that you plan on it. So the point that you are making is one that we accept fully.

Il n'y a aucun désaccord sur la nécessité d'avoir un financement à long terme, et si nous avons un fonds à court terme dans notre proposition, c'est que les experts nous disent que pour vraiment faire une attaque frontale contre les délais d'attente, c'est ça que ça va prendre.

Notre rôle, maintenant, est de trouver l'idéal, la réalité de notre système de santé pour une génération à venir et pour la suivante.

Et, comme ceux qui nous ont précédé, nous allons avoir ce débat. Nous allons avoir quelquefois des divergences. Cela, je le comprends. Mais, après cette session, j'espère que nous allons trouver un terrain d'entente. C'est cela que la population canadienne s'attend de nous.

Tomorrow, we will get into more details of the material that has been brought up. Let me just really close by saying the following, and I think I have essentially picked up what a number of you said, but perhaps picking up what came from the Premier of Newfoundland and Labrador.

We are going to have our differences around this table. And we are going to argue about them. And we are going to argue about them because we each reflect the national interest and I believe that all of you, provincial Premiers, also reflect the national interest as you see it.

The Canadian government reflects the national interest, perhaps from a larger base. Those kinds of discussions have to take place. And they have to take place -- and they probably should have taken place in much greater depth much earlier.

At the end of this, at the end of this, we have got to walk out of here with a long term plan so that we don't come back and argue about a bunch of numbers, but in fact what we are talking about is building for the future which a number of you have said, and that is very much my goal.

Let me just close by going back a little bit. I happen to have a fairly strong personal family history in this particular debate and, if there had been a debate among provinces and the federal government 40 years ago, 50 years ago, about this issue, there would have been none of the unanimity about the importance of medicare.

There would have been none of the unanimity about the importance of a public system. There would have been none of the unanimity that is expressed at both the provincial and the federal level about the responsibility to the generations to come in the way that it was.

And if any of you ever have the chance, you should read those old debates because they show a Canada and and sense of values that would be very, very strange to each and everyone of us. So, we have our differences. Hopefully we can bridge them. But I have got to tell you that those differences are nothing compared to the differences that existed 40 or 50 years ago, and that has got to make us feel pretty optimistic about where this meeting can go. Thank you.

--- Whereupon the meeting adjourned at 1837 /

La réunion est ajournée à 18 h 37