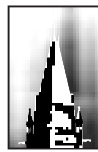

THE HILL TIMES

HEALTH ISSUES - POLICY BRIEFING

'We cannot afford to wait any longer'

Health Minister Anne McLellan says all levels of government need to invest more in public health

By PACO FRANCOLI

In many ways, Health Minister Anne McLellan could be considered one of Cabinet's luckiest members. Whenever the strings of the public purse loosen, she seems to get a big chunk of the pie, if not the biggest.

That's what happens when you're in charge of Canada's No. 1 priority.

Then again, given the state of public health in Canada, it seems that no amount of money is enough to satisfy the enormous demands placed on her department.

Though she received the lion's share of the last federal budget, which set aside $34.8-billion over five years to fix the health-care system, today she is under the gun to find new dollars to solve emerging health problems that will require the recreation of two new national agencies.

"It's a large portfolio. It covers a wide range of areas," she admitted recently in an interview in her Hill office.

"I have certainly enjoyed the challenges in this department. I would be lying if I didn't say there were frustrations also involved. Sometimes things don't move nearly as quickly as I would like them to move. Sometimes we don't have nearly the resources we need to do things as quickly as I would like."

Ms. McLellan (Edmonton West, Alta.) is currently in the process of laying the groundwork for a new Health Council to monitor health policy and accountability which could cost the federal government $10-million yearly.

She is also poised to pitch to her Cabinet colleagues the idea of creating a new national federal centre to oversee public health emergencies such as SARS. She stressed that all levels of government in Canada "cannot afford to wait any longer" to take action.

Ms. McLellan made those comments in the wake of her blue-ribbon panel's findings that Canada desperately needs a new national agency for disease control as well as $700-million in new money to manage a public health crisis such as the SARS outbreak.

Headed by Dr. David Naylor, the National Advisory Committee on SARS also stressed that a major reason the country badly met the challenge posed by SARS is because of lack of collaboration between the federal and provincial governments.

Photograph by Jake Wright, *The Hill Times*

SHOW ME THE MONEY: HEALTH MINISTER MCLELLAN IS LOOKING FOR NEW DOLLARS TO CREATE A NEW NATIONAL PUBLIC HEALTH INFRASTRUCTURE AGENCY.

While Ms. McLellan told *The Hill Times* she intends to brief her Cabinet colleagues soon, she could not say when such an agency would become a reality or how much it would cost. She said she may model the new institution on U.S.'s Centres for Disease Control and Prevention (CDC), a federal agency based in Atlanta, Georgia, for protecting the health and safety of people.

The health minister also indicated that she needs more money for her department's Pest Management Regulatory Agency which was recently criticized by Environment Commissioner Johanne Gelinas for failing to properly manage pesticide use in Canada.

Help, though, appears to be on the way. Last week, Finance Minister John Manley (Ottawa South, Ont.) indicated he would provide an extra $2-billion in health-care money to the provinces if the federal surplus topped the $3-billion set aside for emergencies.

THE HILL TIMES: Recently the federal government and provinces reached an agreement on the creation of a 27-member National Health Council. But Ralph Klein doesn't seem to be on board. Where are the talks today?

ANNE MCLELLAN: "Well, we're pushing ahead. I have asked a wide range of stakeholders to nominate anyone they might like in terms of possible non-government representatives. Each of the 13 provincial and territorial governments plus ourselves can nominate up to four non-governmental reps. That creates a very large list for 13 positions. And then ministers will choose 13 non-governmental reps from that pool of names making sure we represent the diversity of the country.

"What I want and what I will have is a fairly large pool of names from which we will be able to forward as many as four nominees. Now if any of them are ultimately selected will depend on others who are nominated and the diversity of representation we hope to achieve. My guess is that actually there will be a high degree of coincidence in terms of the names that provinces and territories and the federal government actually come up with. But that remains to be seen."

HT: But the council itself. It's not a reality yet, is it?

MS. MCLELLAN: "No, a commitment to create the council was made by all first ministers in the February accord. So what we are doing is moving forward on that and we will present to provincial and territorial premiers, when they meet together in October, the framework which ministers agreed to in relation to the Health Council, as well as names for a possible chair and 26 other members."

HT: And the process for striking the council. Can that happen unilaterally by the federal government?

MS. MCLELLAN: "Well, the first ministers made a commitment to the Health Council. Therefore I presume all premiers will live up to that commitment."

HT: Would you move forward without provincial consent? Say, if Ralph Klein is not happy…

MS. MCLELLAN: "Well, I've never believed you need all the provinces on side to move forward. But I do believe that to be useful in the long run one does need significant provincial agreement."

HT: And do you have a timeframe in mind for when you want this thing up and going officially?

MS. MCLELLAN: "We have indicated – when I say we, I mean provincial and territorial health ministers coming out of our meeting in Halifax – that premiers would be presented something for their consideration at their meeting in October. And we will move forward from there."

HT: As far as the mandate is concerned, how much of the council's time will be spent handling the Primary Health Care Transition Fund struck in September of 2000?

MS. MCLELLAN: "Well, that's certainly part of it. The mandate is set out in

Continued on Page 24

Health Council now appears pointless

Designed to deceive Canadians into believing Liberals are interested in protecting public medicare

By NDP MP SVEND ROBINSON

Nearly one year has now passed since the *Report of the Romanow Commission on the Future of Health Care in Canada* was tabled, and little has changed. Many of the concerns outlined in the report remain unaddressed: Canadians are still forced to contend with waiting lists for surgeries, diagnostic services, specialists, treatments, and even to get a family doctor to see them; public hospitals are still closing while private clinics and hospitals replace them; and nurses and doctors are still over-worked and in desperately short supply.

In February of this year, Minister of Health Anne McLellan, appeared to have adopted one of the Romanow Report's key recommendations: the creation of an arm's-length, independent council to oversee the performance of the health-care system, to provide strategic advice and analysis to health ministers on important and emerging policy issues, to seek ongoing input and advice from the public and stakeholders on strategic policy issues, and to act as a collaborative mechanism capable of driving reform and modernization of the health care system. At that time, Prime Minister Jean Chrétien secured the agreement of the provincial and territorial premiers to create the Canada Health Council (although its mandate, principles, and composition were left unaddressed) within three months (i.e. by May 5).

Well, May 5 came and went, and the minister hadn't taken action to establish the council, and she then suggested that it would take shape in the coming weeks. May turned into June, the House of Commons rose for its summer recess, and still no word from McLellan on the council. Late last month, the minister finally announced that the provinces and territories had agreed on the composition of the council: 27 members, of whom 13 would represent the provinces and territories, 13 would represent non-government organizations, and one chairperson.

As Mike McBane of the Canadian Health Coalition pointed out, a 27-member board is so large as to be unworkable. "It's designed to fail," he stated.

The Romanow Commission had recommended a 14-member board, consisting of seven representatives of government, three representatives of the public, and four representatives of the provider and expert community recognized for their competence in health policy and practice.

Apart from its unwieldy size, the council as envisioned at this time would lack all legitimacy as a government watchdog, since no member would be appointed without the consensus of the federal and provincial governments. The minister has already broken her promise to Canadians that the Canada Health Council would be in place by May, and now she's betrayed them again by breaking her promise that the body would be "independent" from government.

The First Ministers are scheduled to meet this month to discuss the mandate of the council, and there is little hope among Canadians who care about our health-care system that the body will be endowed with any meaningful responsibility or authority, as recommended by the Romanow Commission. The fact that the provinces and territories have been asked to submit names for the membership of the council without knowing what the council will be tasked with accomplishing suggests that the whole exercise is lacking in serious intent. Just as the commissioning of Romanow to lead a study and write a report recommending steps to improve health care seems to have been a means for the Liberals to procrastinate while the system crumbles, so too does the Health Council now appear to be a pointless effort, designed to deceive Canadians into believing that the Liberals are interested in protecting public medicare.

Photograph by Jake Wright, *The Hill Times*

ROBINSON: MAY 5 HAS COME AND GONE AND THE MINISTER HASN'T TAKEN ACTION.

Sadly, not only is Liberal apathy eroding our national health-care system, but so too is the federal government's continuing infatuation with corporate globalization. By promoting incessant liberalization of international trade, the Liberals are jeopardizing not only our citizen-based democracy, but even our personal health. Free trade agreements like NAFTA, GATS, and the proposed FTAA risk compelling us to open our publicly-funded and delivered health services to competition from private, foreign corporations, which would inevitably result in a two-tiered health care system. As more and more health services are contracted out to private companies, a door to foreign competition is being forced open which will not be easily shut.

Again, the Romanow Commission's report was clear that this threat is real and must urgently be opposed: "In almost every one of the Commission's public hearings, as well as the regional roundtables, concerns were expressed by experts and citizens alike that Canada's health care system should be protected from the impact of international trade agreements." The report recommended that the Liberals ensure that health care in Canada remains a "public service," and that Canada's position that the right to regulate health care policy should not be subject to claims for compensation from foreign-based companies, is reinforced and stubbornly maintained.

Next month, governments from across the Americas will send their representatives to Miami for the next ministerial meeting to negotiate further the terms of the proposed FTAA. The draft version of the agreement already contains rules that could open up the Canadian health care markets to foreign corporate service suppliers, while making it difficult to expand public medicare to include prescription drugs or homecare. Furthermore, the draft FTAA contains provisions which go further than the WTO's TRIPS agreement on pharmaceutical patent protections, making it even more difficult for governments to grant generic drug makers licenses to produce affordable medicines.

More than 50,000 Canadians from across the country have already signed petitions and postcards calling on the Liberals to acknowledge that "the FTAA is Hazardous to Your Health," to stop the negotiations of the FTAA and all trade agreements that put profits before public well-being, and to listen to Canadians who demand that universal publicly-funded and delivered health care services be preserved. These signatures will be joined in Miami with hundreds of thousands of others collected throughout the Americas, and presented to the trade ministers meeting there. We can only hope that the Liberals will finally choose to stand up for medicare and indeed for all Canadians, and say no to the FTAA.

Our cherished health-care system has been sorely abused and neglected by the Liberals during the Chrétien era, and particularly the years when Paul Martin, as Finance Minister, was so intent on slashing much-needed federal funding for medicare. Now, as Martin assumes *de facto* authority as Prime Minister, there is little reason to expect any improvement. Already we have seen John Manley hinting broadly that $2-billion in promised federal health care funding to the provinces in early 2004 will not be forthcoming. It seems that so long as the Liberals remain in power, Canadians will be denied a fully funded, fully accountable, and fully public medicare system.

NDP MP Svend Robinson is his party's health critic and represents the federal riding of Burnaby-Douglas, B.C.

The Hill Times

"I BELIEVE RESEARCH WILL KEEP MY FAMILY TOGETHER."

For many Canadian families, new innovative medications can't come soon enough. All too often, these promising treatments get tied up with provincial drug plans – even after Health Canada has approved them. For the people who put their lives on hold every day, it's too long to wait. They need access to these new innovative medications as quickly as possible. And it's up to all of us to make it happen. To find out more, visit our web site at www.canadapharma.org

Because with all they're going through, waiting shouldn't be the hardest part.

Canada's Research-Based Pharmaceutical Companies

Research makes us better

Quality health care: where do official languages fit in?

By Liberal MP
MAURIL BÉLANGER

As Canadians continue the national debate on our health-care system, the phrase "quality health care" is a refrain repeated by many. It's what everyone wants, but how is it defined? Quality means different things to different people. Timeliness, thoroughness and accessibility are widely viewed as essential elements of "quality health care," and as such, are enshrined in the Canada Health Act. But what about other aspects of "quality health care" not included in our act? Last March, the House of Commons adopted a motion referring the subject matter of Bill C-202, An Act to amend the Canada Health Act, to the Standing Commons Committee on Official Languages. This was my own private member's bill, which aimed for the addition of a sixth principle to the Canada Health Act, that of respecting Canada's linguistic duality.

The Government of Canada is mandated by Sec. 41 of the Official Languages Act to preserve the use of English and French throughout the country as well as promote and protect official language minority communities in all areas within its scope. Though health-care delivery falls within the provinces' jurisdiction, the Government of Canada is a primary player in terms of health-care funding. Moreover, Canadians' linguistic rights are protected and promoted by the Government of Canada. So how can linguistic rights and right to health care be combined to eventually translate into improved health-care delivery for Canadians from both official-language communities?

The committee has heard several answers to this question:

•The Government of Canada already specifies certain conditions under which it will transfer health-care funding to the provinces. It could add the respect of our linguistic duality to the list of already-established criteria (the five principles) needed to be met to obtain funding, along with a set of guidelines for meeting that sixth condition. From a legal perspective, this solution seems quite feasible, but there could be a number of reactions, particularly from the provinces.

•The Government of Canada could invest more in health and official-languages research and development, as well as continue to provide funding to post-secondary education institutions and programs designed to train health-care professionals who could work in official-language minority community settings.

•The Official Languages in Education Program, managed by Canadian Heritage, is a valuable tool used by the Government of Canada to direct funds to the provinces for a variety of official-language initiatives relating to education, another provincial jurisdiction, thus directly benefiting Canada's official-language communities. In concert with the provinces, the Government of Canada could establish an "official languages in health program," perhaps managed by Health Canada, that would see funds flow from the federal to provincial governments to ensure health services are provided in official-language minority communities.

These are only a few possible avenues that the Standing Committee on Official Languages has been considering in the course of this study. One thing is certain: there is a need for greater "quality health care," and for many Canadians, that translates into health-care services in the language of his or her choice. It is the Committee's hope that the Government of Canada will adopt policies that meet this need.

The committee's report, once adopted and tabled in the House, will be available at www.parl.gc.ca/lang.

Liberal MP Mauril Bélanger represents the federal riding of Ottawa-Vanier, Ont., and is chair of the Standing Commons Committee on Official Languages.

The Hill Times

Powerful pharma companies opposed to humanitarian aid

By Tory MP
GREG THOMPSON

It's not surprising that one of the most important health-care considerations facing Canadians these days is also the most complex and difficult to explain, let alone resolve. This is the world of prescription drugs, a medical necessity for millions, subject to intense regulation by government, the object of study by the bureaucracy and a Parliamentary committee and subject to a political debate, the outcome of which could be the salvation of the African sub-continent beset by the AIDS epidemic.

The rising costs of essential drugs, ways of controlling prices and approving new drugs, misuse and addiction, monitoring adverse effects and advertising practices are some of the issues before the House of Commons Standing Committee on Health.

Generally, the generic versions are priced as much as 35 per cent lower than the equivalent brand name drugs, but Canadians are apt to pay considerably more for the generic pills than are charged in many other countries with the exception of the United States.

A study by the Patented Medicine Prices Review Board of Canada shows that prices for generic drugs can be 26 per cent lower in the United Kingdom than the Canadian equivalent, 32 per cent lower in Australia, 68 per cent lower in New Zealand and 24 per cent lower in Germany.

Surprisingly, the study was unable to determine a comparison with the United States where prices for drugs used by government agencies were 69 per cent below their Canadian equivalents, but in lists of prices available to the general American public, their prices were as much as 248 per cent higher than in Canada.

Another growing, serious matter raised in our committee's Western Canadian meetings involves the growing cross-border internet pharmacy business. We heard testimony that internet pharmacy companies are diverting at least $1-billion worth of Canadian drugs to the United States, a practice that is creating shortages in some areas of Canada, shortages that include even life-saving cancer drugs. We were told that the internet drug business has already resulted in one Canadian manufacturer raising its prices and it could be only a matter of time, unless this trade is curtailed, that Canada's drug prices will rise to match those paid in the U.S.

As the bureaucratic and Commons Health Committee studies proceed, the government is moving towards changes in the patent laws so that the cheaper generic drugs can be provided to Third World countries to help combat the spread of HIV and AIDS. The powerful pharmaceutical companies have been opposed to these humanitarian efforts because of fears that the cheaper drugs could eventually find their way into the richer countries and erode their patent protection. However, public pressure and the realities of the world-wide threat from HIV/AIDS will likely overcome those roadblocks. When one considers that more than 34 million adults and children are living with HIV/AIDS worldwide, almost a million in North America but almost 25 million in sub-Saharan Africa, the obvious need should outweigh all other considerations.

Any discussion of drug pricing and availability in Canada brings to mind the various Liberal Party Red Book undertakings for the implementation of pharmacare, the universal program proposed when that party was campaigning to become the government. Just another of those wonderful promises which seems to have fallen off the priority list because of the costs and the complexities of the real world.

Tory MP Greg Thompson, represents the federal riding of New Brunswick Southwest, N.B., and is his party's health critic.

The Hill Times

Thank you for making the CACDS Pharmacy Day on Parliament Hill an outstanding success!

We're pleased that so many of you were able to experience why more than 95 per cent of Canadians say that professional pharmacists' services improve their health and well-being.*

On October 8, our ***Beyond the Counter*** interactive pharmacy event demonstrated why Canadians **value** the health and wellness **services** and **information** their community pharmacies provide every day.

To ensure the continuing health of communities across Canada, CACDS is committed to working with our partners in government to create the health care solutions of today and tomorrow.

Beyond the Counter: The future of community pharmacy in Canada

* *A Survey of Canadians and their Pharmacy*, POLLARA, September 2003

Merci d'avoir contribué à faire de la Journée CACDS de la pharmacie sur la Colline du Parlement un succès sans précédent!

Nous sommes enchantés de constater, que vous avez pu, en si grand nombre, profiter des services professionnels des pharmaciens qui, selon 95 pour cent des Canadiens, améliorent leur santé et leur bien-être.*

Le 8 octobre dernier, notre pharmacie interactive ***Au-delà du comptoir*** a clairement établi pourquoi les Canadiens **apprécient l'information** et les **services,** associés à la santé et au bien-être, que leur procurent leurs pharmacies communautaires au quotidien.

Pour garantir en permanence la santé des diverses communautés du Canada, la CACDS est déterminée à collaborer avec ses partenaires gouvernementaux dans le but d'améliorer les solutions de soins de santé d'aujourd'hui et de demain.

Au-delà du comptoir : L'avenir des pharmacies communautaires du Canada

* Sondage POLLARA : *Sondage des Canadiens et de leurs pharmacies*, septembre 2003

We welcome your thoughts.
Please contact us at
(416) 226-9100 or visit **www.cacds.com**

Vos opinions sont importantes pour nous.
Veuillez communiquer avec nous au
(416) 226-9100 ou nous visiter à **www.cacds.com**

The Voice of Community Pharmacy in Canada / Le porte-parole des pharmacies communautaires du Canada

CIHR and health research: exceptional value, says Bernstein

Excellence in research is fuel driving the engine of discovery and mobilizing research

By Dr. ALAN BERNSTEIN

Health research is transforming our lives and our health-care system. From understanding the most intimate molecular secrets of the cancer cell, to the sequencing of the SARS virus genome and the development of a SARS vaccine, to the discovery of new drugs and transplantation procedures to prevent or cure diabetes, to a scientific evaluation of which clinical procedures work and which don't, to addressing the poor health outcomes of Canada's aboriginal peoples, to documenting and addressing adverse events in our health-care system, to post-traumatic stress disorder, to structural genomics and proteomics, to understanding the genetic and psychosocial conditions that predispose to schizophrenia, to research aimed at understanding how our nervous system works — CIHR is funding all of this and much more.

In just three short years, our 13 institutes have developed their individual strategic plans and CIHR has developed an overarching national strategic plan, or blueprint, for health research, a plan built on excellence in research. Excellence in research is the fuel that is driving the engine of discovery and mobilizing research to improve the health of Canadians, build an innovative and cost-effective health system, and develop the knowledge-based economy for the 21st Century.

Our institutes have rapidly developed and implemented many new programs that encourage problem- and outcomes-based multidisciplinary and multi-sectoral approaches to the health challenges facing Canadians and to the scientific opportunities that are opening up daily.

CIHR has also launched innovative new programs to encourage and catalyze the commercialization of research, including our hugely successful Proof of Principle program, which allows researchers to add value to their discoveries prior to going to the marketplace for funds.

Over the past three years, CIHR's institutes have developed new partnerships with federal departments, provincial research agencies, industry and health charities in Canada and abroad. We have signed major collaborative agreements with partners in the United States, the United Kingdom, France, Germany, Mexico, Australia and New Zealand to conduct research collaboratively on genomics, tobacco addiction, heart disease, HIV/AIDS, diabetes, Aboriginal health and training, to name just a few. These new partnerships have already resulted in more than a doubling (to almost $100-million per year) of our partners' contributions to CIHR-sponsored research.

CIHR's blueprint for health research building on these successes and following broad consultations with our stakeholders, CIHR will focus on five broad areas over the next five years.

We will:

1. Continue to build the base of health research excellence in Canada;
2. Develop major national research initiatives and platforms to address the health challenges facing Canadians;
3. Develop and implement a balanced research agenda that includes research on disease mechanisms and fundamental biology, treatment, prevention, health promotion, population determinants of health, and the capacity of our health care and public health systems to deliver the services Canadians want and need;
4. Harness research to improve the health of vulnerable populations; and
5. Support the renewal and strengthening of Canada's health system and economy through innovative new programs that bring together the creators and users of new research knowledge, including the public, patients, caregivers, decision-makers, and industry.

The benefits

The benefits for Canada of CIHR's Blueprint are clear and significant. They include:

- improving the health of Canadians through new understanding of disease, development of new diagnostic technologies and treatments, new approaches to the delivery of health services, evidence-based health promotion and changes to public policy;
- developing a leading edge, evidence-based and cost-effective health system;
- strengthening the Canadian economy through programs that build the human and knowledge capital that are critical to success in the competitive global market place; and
- branding Canada as a country of excellence in health research.

The future

The creation of CIHR by Parliament in 2000 has transformed the health research enterprise in Canada, and almost overnight, has catapulted Canada to become a significant player internationally in health research. With generous support from the Government of Canada and our partners, we are together building an organization that has already become a model for the world. But we have a way to go. CIHR requires a bold, up-front, multi-year growth in our budget from its current level of $620-million to $1-billion per year, starting in 2004.

CIHR and the health research community have demonstrated the excellence, outcomes and impact that Canadians expected when CIHR was launched. In three short years, we have built a strong foundation on which to build for the future. The Canadian health research community has more than delivered on our commitments over the past three years, and are poised to deliver more in the coming years.

Now is the time to be bold. Now is the time to build a Canada for the 21st Century, a Canada built on excellence, a knowledge-based economy, a leading-edge and innovative health system, and a productive and healthy population — a country where our young people have opportunities to pursue rewarding and satisfying careers.

Alan Bernstein, OC, PhD, FRSC, is president of the Canadian Institutes of Health Research www.cihr.ca Dr. Bernstein is known internationally both as a researcher and as a scientific leader. His pioneering research in the area of cancer, hematopoiesis and gene therapy remain landmarks in their field.

The Hill Times

Canadian College of Health Service Executives

Robert Zed, Chair announces the appointment of Dr. John H. Hylton as President and CEO of the College.

Prior to joining the College, John held a number of senior positions as a public servant, a university educator, trustee and consultant.

The College is a member-driven, not-for-profit association committed to excellence in the management of Canada's healthcare system.

Canadian College of Health Service Executives
Collège canadien des directeurs de services de santé

Kirby's Senate Committee looking into mental illness and addiction

By Liberal Sen. MICHAEL KIRBY and Tory Sen. MARJORY LEBRETON

Thank you for inviting the chair and deputy chair of the Senate Standing Committee on Social Affairs, Science and Technology to provide an overview of their work in the important field of health and health care. The committee has been very busy over the last three years dealing with critical issues surrounding health and health care.

From March 2000 to October 2002, the committee held, as part of its study on the health of Canadians, some 65 public hearings, heard from 433 witnesses and reviewed several hundreds of briefs. We tabled six different reports with the Senate: one in March 2001, one in September 2001, two in January 2002, and one respectively in April 2002 and October 2002. Many of the recommendations contained in our last report (or volume six) were approved at the 2003 First Ministers' Accord on Health Care Renewal and proposed in the 2003 federal budget. These include namely: primary health-care reform with access to an appropriate health-care provider on a 24/7 basis; increased investment for medical equipment; catastrophic prescription drug coverage; short-term acute home care, compassionate care benefits under the Employment Insurance program; electronic health records; and enhanced accountability through public reporting. Overall, we are very pleased by the impact our work has had on decision-makers in this time of health-care reform and renewal.

Following the release of volume six, the committee decided to undertake a study on mental health, mental illness and addiction. We are struck by the high prevalence of mental illness and addiction — approximately one in five Canadians. As such, nobody is left untouched by mental illness and addiction; this affects individuals, their families, schools, communities, the workplace, society as a whole. What is worse is that, despite this high prevalence, there remains largely unmet needs. Statistics Canada's latest Canadian Community Health Survey revealed that 21 per cent of Canadians suffering from mental illness and addiction do not receive the services and support that they need. Only 37 per cent use some type of health care or community resource.

There are many barriers that impede appropriate access to needed mental health services and addiction treatment, including: diverging philosophical approaches to mental illness and addiction; stigma and discrimination; system fragmentation, little integration and lack of coordination; and inadequacy of funding for mental health services and supports, addiction treatment and research.

What has also struck the committee is the full extent of the impact of stigma and discrimination. This discourages Canadians from seeking needed treatment, leads to government underfunding of research, treatment and support services and perpetuates outdated treatment methods within the health care system itself. It has been said that mental illness is an "orphan child." One witness to the committee preferred to profile it as the "last taboo." He stressed that, interestingly, in the years to come, where mental over physical performance is a key to the country's and individual's quality of life, we have yet to address mental illness and addiction in a convincing way. What can be possibly done? Maybe policy will have to change before attitudes change. Maybe we will have to work on them both simultaneously.

Continued on Page 23

Paul Martin's shameful health-care legacy: Merrifield

Consequences of Martin health-care cuts are still very much with us today

By Alliance MP
ROB MERRIFIELD

As Paul Martin prepares to move into 24 Sussex, Canadians have noticed a distinct lack of clarity as to where he stands on the key issues of the day. It falls, then, to look back on his record as finance minister and right-hand man of the outgoing Prime Minister for a possible preview of what a Paul Martin government might look like.

When it comes to health care, undoubtedly one of the most important public priorities of Canadians, the prognosis is not promising. Martin's legacy on health care is one of chronic underfunding, soured federal-provincial relations and patient dissatisfaction.

In his now infamous budget of 1995, Paul Martin announced massive, unilateral cuts to federal transfer payments for health, social services and education. Under Martin's new block fund, the Canada Health and Social Transfer, federal transfers to the provinces were slashed by almost $4-billion in two years — from $16.6-billion in 1995 to $12.6-billion in 1997.

The cuts caught the provincial governments completely off guard. Martin was credited for trimming the deficit but the provinces were left holding the bag.

Provincial governments tried to make do with their own spending increases and experiments in alternative service delivery, the latter for which they were sometimes scolded by Ottawa. Nonetheless, the financial shortfalls forced the provinces to lay off health professionals and cut health services.

What followed was a long season of federal-provincial squabbling over money and general acrimony between Ottawa and the provinces on a host of issues. As the cuts trickled down to ordinary Canadians, wait lists lengthened, many health professionals sought greener pastures south of the border and doctor shortages intensified.

In a study of national health care systems, the World Health Organization ranked the performance of ours a dismal 30th. Hardly "the best health-care system in the world."

The Martin cutbacks continued for the rest of the 1990s and into this decade. In response, the Official Opposition called for an immediate infusion of $4-billion into the CHST in 1997. We called for entrenched five-year funding agreements — negotiated with the provinces — in the *Canada Health Act* in our 2000 election platform. Clearly, the provinces must have a reliable and stable source of federal funds in order to plan for the health-care needs of their citizens over the long term.

Martin and Chrétien cynically pumped billions of dollars back into the CHST on the eve of the last federal election — the opportunity to use health care funding to bolster the Liberals' electoral prospects apparently too good to pass up. But it wasn't until fiscal year 2002/03 that the CHST climbed back to 1994 funding levels.

All told, a cumulative total of $25-billion (in real terms) was removed from the CHST between 1994 and 2001. At the same time, Martin left in place some $16-billion per year in questionable grants and contributions.

The consequences of the Martin health-care cuts are still very much with us today. In a recent survey, one in four Canadians said the quality of care had worsened in the past two years. The respondents cited a shortage of health professionals and hospital beds as the biggest problem, followed by waiting times. According to the College of Family Physicians of Canada, 4.5 million Canadians had trouble finding a family doctor in 2002.

The health accord reached in February 2003 by the premiers and the outgoing prime minister was needed to undo some of the damage caused by Paul Martin. The Canadian Alliance welcomed the accord as a commendable effort to move health care reform forward on the national agenda.

The accord reflected a number of our own priorities, including restored funding for core health services, flexibility for the provinces in the implementation of new services and flexibility on delivery options within the public health care system.

We also supported the adoption of a dedicated health transfer, needed to provide greater clarity on Ottawa's actual health care contribution, which had been obscured under Paul Martin's CHST.

The Canadian Alliance is firmly committed to our universal health care system. We are committed to timely access to quality health care, regardless of ability to pay.

Paul Martin's record on health care is a poor one. He slashed billions of dollars in health care funding while he was finance minister, leaving provincial governments in a cash crunch and Canadians on wait lists.

The provinces deserve a more reliable partner when it comes to health care funding. Canadians deserve a prime minister who will work hard to safeguard publicly funded health care. Why should we trust Paul Martin now? Mr. Martin is the cause, not the cure, when it comes to health care.

Canadian Alliance MP Rob Merrifield is his party's senior opposition health critic and represents the riding of Yellowhead, Alta.

The Hill Times

Canada doesn't have a national action plan for mental illness

Kirby, LeBreton say there are no national standards to guide funding and delivery for mental health

Continued from Page 22

The committee also heard that, unlike many other developed countries, Canada does not have a national action plan for mental health, mental illness and addiction. Various levels of governments are all involved in the funding and delivery of mental health services and addiction treatment. Perhaps more importantly, there are currently no national standards to guide the funding and delivery of mental health and addiction services and supports. In fact, the *Canada Health Act* expressly excludes hospitals or institutions "primarily for the mentally disordered." Should mental health care be covered under the *Canada Health Act*?

Similarly, psychologists' services are not insured under medicare in any province. If individuals have the money or private insurance, they have access to high quality psychological services, often within days or weeks. If they are dependent upon the publicly funded health care system, they will encounter long waits for the available psychological services, if they can even find them. Accordingly, should all psychologists be paid with public funds, as doctors are? These are all crucial questions that the committee intends to examine.

We wish to stress that the Romanow Commission did not address mental health issues in a comprehensive way. The commission limited its recommendations to case management of home mental health services. Further, there is currently no national forum to discuss these issues other than the committee study. Thus, we believe that the committee study is important. But the involvement of the whole mental health community is critical and essential to the success of the committee's work.

Making a difference is the goal of our study on mental health, mental illness and addiction. Our timetable includes a report on findings and options for reform in the fall 2004; this will be followed by a set of national public hearings. Then, a report on recommendations for reform will be tabled to the Senate in the spring 2005.

Last June, our committee received a mandate from the Senate to study public health governance and infrastructure in Canada. So far, we have heard from federal officials from departments and agencies, provincial public health officers, public health experts/researchers, and national health organizations. The committee has also heard from Dr. David Naylor, who chaired the National Advisory Group on SARS and Public Health, and will soon hear from the United States Centre for Disease Control and Prevention. Our intention is to release a report on the issue of public health in the first week of November.

Senator Michael Kirby is chair and Senator Marjory LeBreton, Deputy Chair of the Standing Senate Committee on Social Affairs, Science and Technology.

The Hill Times

In just 10 years, the number of MRI scanners in Canada has grown by nearly %.

In January 2003, Canada had a total of 147 MRI (Magnetic Resonance Imaging) scanners, which is about **400**% more than the 30 machines the nation had in 1993. On a per capita basis, there are 4.7 MRIs for every million Canadians. This ratio has improved slightly from 4.2 in 2001.

To learn more about the **supply of imaging technologies**, visit www.cihi.ca to get your copy of the *Medical Imaging in Canada* report.

Our job is to fill **information** gaps

Canadian Institute for Health Information
Institut canadien d'information sur la santé

BETTER HEALTH INFORMATION FOR BETTER HEALTH

Health Minister McLellan to brief Cabinet on Naylor report

'What we need to do is have a national focal point,' says McLellan, but not a 'CDC North'

Continued from Page 19

the accord. An actually business plan for the council will only be developed when the council is in place. And that business plan would ultimately be approved by health ministers."

HT: Will this be a permanent council?

MS. MCLELLAN: "What we envisioned at this point is that the council would be reviewed at the end of five years."

HT: What is the budget of this council?

MS. MCLELLAN: "We have on the table up to $10-million a year. But I think it's safe to say that most of my provincial and territorial colleagues believe it can be done for less. And so do I quite truthfully."

HT: Turning to SARS, what do you make of Dr. David Naylor's report? He said Health Canada was almost invisible during the crisis.

MS. MCLELLAN: "No, that actually isn't what he said. Unfortunately, for example, in relation to that specific statement, that we sent our epidemiologist to Toronto and unfortunately because of the situation on the ground, which is controlled by local public health officials, our epidemiologists who are highly-trained scientists ended up pretty much shuffling paper. And therefore a number of them left, as any sensible person would if what you are doing is shuffling paper as opposed to being put into a public health system on the ground where you are using your skills.

"In fact, as the Naylor report pointed out, there is necessity for all levels of government to work much more closely together and create an integrated response to this kind of challenge in the future."

HT: What did you learn from his report about what Canada should have done more of that you didn't know before?

MS. MCLELLAN: "I guess perhaps, when you are in the middle of a situation like that and dealing with daily challenges, it may be only later that you realize that your systems of surveillance, your data collection, which is then analyzed and sent to the [World Health Organization]... that those things are simply not up to the challenge. And that doesn't mean that people hadn't thought about those things.

"But I think Dr. Naylor's report, because he talked to everybody at all levels on this, I think part of what strikes me is the fact that all three levels of government need to work together in a much more integrated and cohesive fashion to ensure that we are doing the surveillance, we are doing the data collection, we are doing the analyses... And then that information in real-time can be sent back to the front lines to the emergency rooms, and can be sent up the line to the WHO, the [Centres for Disease Control] and other countries."

HT: Did it strengthen your resolve to create a "CDC North?"

MS. MCLELLAN: 'I don't use the expression CDC North. I think something like the CDC. I think that there does need to have a national focal point. Now various provinces have entities that provide some focus for public health. It may be primarily infectious diseases or more broadly based. British Columbia has a centre for disease control. Quebec has a fairly-developed system of public health. Different provinces are at different places.

"What we need to do is have a national focal point. We need to clearly delineate the roles of the three levels of government so that everybody knows what they are supposed to do. Everybody knows what there responsibilities are in terms of data collection, data dissemination, data analysis. Everybody knows who communicates on what issues and when. And I think those kinds of things need in my mind a national focal point.

"But what I envision is that while there is a national focal point that one has a network, a virtual network, of existing, and perhaps to be created, entities that deal with disease control and/or public health more generally. For example, Ontario is talking about developing a centre of some sort that would form part of our national network."

HT: How far along is this in being a reality, this focal point?

MS. MCLELLAN: "This is very early days. I have indicated that this is very important. I will probably go to Cabinet colleagues in the next few weeks and give them the overview of Dr. Naylor's report and talk to them about options in terms of moving forward. I think it will probably be sometime in the new year when final decisions are made around exactly how we move forward.

"But I think the thing that is important is that we cannot afford to wait any longer. As Dr. Naylor has pointed out, as virtually everyone in the area of public health has pointed out, all three levels of government have known for over 10 years that we are not investing enough in public health. And that we need to built that national public health infrastructure."

HT: So does it come down to a question of just more money? Because it seems as if your department has a lot of the things that this focal point would do. It has surveillance, laboratories, infectious disease control and so on. And it has a public health branch and a centre for emergency preparedness, which are both in your department. A lot of the infrastructure already exists at Health Canada.

MS. MCLELLAN: "Some of it does. But what it has to be reconfigured, coordinated and integrated with the infrastructure of the provinces and the local governments. If you are going to develop a national focal point for public health it should be more about just infectious disease. Public health experts will tell you that in fact if you are doing public health in has to be about infectious disease, chronic disease, injury prevention... a whole host of things."

HT: The first ministers are meeting this month. Do you expect they will ask for more money for health care?

MS. MCLELLAN: "Well, I don't know because I don't know anything about their meeting other than the fact this is their first meeting to discuss the [Council of the Federation] that was agreed to in Charlottetown in July. The only thing I know is that federal, provincial, territorial health ministers agreed to present for premiers' consideration when they meet with a package on the health council for their consideration."

HT: Much of last budget was dedicated towards health care. And the government has maintained it won't raise taxes to meet these goals. How much of a strain has this meant on the public purse?

MS. MCLELLAN: "I don't think that has been a strain. What has strained the public purse in the sense of unexpected expenditures are things like SARS, BSE, mad cow, fires in British Columbia, power outage in Ontario, and hurricanes. Those things have placed unexpected demands on available dollars, but certainly the dollars for health care were clearly delineated in the last budget over five years. So that's all accounted for."

HT: What happens if down the line there is a deficit? Is that going to affect the way the health-care system is funded?

MS. MCLELLAN: "As I say, there may be unexpected things, but this government has been very clear about the fact that we are not going back into deficit. We do know that health care is Canadians No. 1 priority. We have a funding profile over the next five years as it relates to health care and we will deliver on that but we will do so within our means, and if that means that dollars have to be reallocated from one place to another than I guess that will happen."

HT: I also want to touch on the Environment Commissioner's report that came down on Oct. 7. It didn't get too much attention with everything else going on but she made some interesting points directed at your department. She said in particular that Health Canada does not understand the health impact of pesticides. Do you agree?

MS. MCLELLAN: "No I don't. I think the Environment Commissioner made some very important recommendations and I take her concerns very seriously. We have new legislation that was passed late last year, in December 2002. The regulations in relations to that legislation are in the process of being worked on now. The new legislation and the regs will be in full force in the spring of 2004. We certainly know that this is an area that has been underfunded in the past and the whole area has been transformed through new legislation which as I say will come into affect in the spring of 2004.

"We have put additional

Continued on Page 25

"If not now, after SARS, when?"

National Advisory Committee on SARS and Public Health, Oct. 7, 2003

"Science and health protection must trump politics!"

Dr. Sunil Patel, CMA President, to the Senate Standing Committee on Social Affairs, Science and Technology, Oct. 8, 2003

Parliamentarians realize they must unite and show political leadership by fixing our patchwork quilt public health system.

We have a blueprint for urgent change for public health in Canada.

The health and safety of Canadians cannot wait.

On October 21, the CMA is making a house call. Talk to your doctor.

cma.ca

One in eight couples challenged with infertility, numbers to rise

McLellan says Bill C-13 is about providing a regulatory framework for infertile couples

Continued from Page 24

resources into this area, but myself and my minister of agriculture. We are certainly aware of how important this is. And if you look at the legislation it provides some of the policy framework to do some of the things that she specifically talks about. For example, ensuring that we understand the affects of pesticides on children, that we understand accumulative affects, and these kinds of things.

"There is no question that we need to reevaluate the existing pesticides, those that came on the market before '95. We have begun that process. We need to move with greater speed in relation to the reevaluation process. We also have to get new pesticides on the market because virtually all new pesticides have less harmful or less environmental risks associated with them. So it's very important that we not only reevaluate the old pesticides, and either get them on the market as we have already done, or change the instructions in relation to use or strength of dosage or whatever. But it's also important for us to get new pesticides on the market because they are based on the best science of the day and invariably have less impact on either human or animal health or the environment."

HT: Do you think your department's Pest Management Regulatory Agency can keep on top of all these pesticides?

MS. MCLELLAN: "Well, it will once it has the new legislation and once it has increased resources. Yes."

HT: But as it stands. Is it staying on top of it?

MS. MCLELLAN: "If you look at her report, she is pretty clear in terms of thinking we should be moving faster on the reevaluation of old pesticides. Right? Well, it is a question of resources. We are working as effectively as we can, based on the resources we have. We are also doing things like working with other countries, so that we don't duplicate work that's done... That is an important global endeavour which we hope will provide greater efficiency and timeliness in doing things like reevaluations. And as far as that goes, also evaluating new pesticides."

Photograph by Jake Wright, *The Hill Times*

NO. 1 PRIORITY: HEALTH MINISTER ANNE MCLELLAN, PICTURED IN HER CENTRE BLOCK OFFICE WITH HT'S DEPUTY EDITOR PACO FRANCOLI, SAYS 'SHE IS FRUSTRATED THAT SOME MPS DON'T SEE THE IMPORTANCE OF BILL C-13 AND THE NEEDS OF THE INFERTILE COMMUNITY IN THIS COUNTRY.'

HT: On the issue of MRI shortages, there seems to be a shortage especially here in Ontario. Do you think that in some cases the Canada Health Act is being violated because not all Canadians have equal access to these facilities?

MS. MCLELLAN: "Well, the Canada Health Act requires reasonable access to medically necessary services, and obviously some of the challenges is to determine appropriate waiting times for various kinds of procedures, including diagnostic procedures. And clearly I know that with the previous [Ontario] government, and I'm not exactly sure whether there will be a change in this area with [Dalton] McGuinty, but certainly the previous Ontario government was intending to increase the number of MRIs here in the province quite substantially.

"I presume Mr. McGuinty will continue with that, whether in exactly the same way as the previous government had indicated, I don't know? But certainly if you look at the additional money, the $1.5-billion that we put on the table, for this next phase of the medical equipment fund, there is money available there for the province of Ontario, not only to provide for more MRIs but we've also indicated in this round that if provinces wish to, they can take some of money and use it for the training of technicians or radiologists."

HT: The Ontario Association of Radiologists has called on you to launch an investigation into the Ontario government's failure to provide "consistent and appropriate" access to medically necessary diagnostic tests for the province's residents. How do you respond?

MS. MCLELLAN: "I certainly understand the radiologists' concerns. I've had the opportunity to talk to them on various occasions. They certainly need to take up their concerns with the new government of Ontario. As I say, the Canada Health Act speaks to reasonable access to medically necessary services."

HT: But it doesn't warrant an investigation from your end?

MS. MCLELLAN: "I have not received anything at this point that an investigation is warranted. I mean, all provinces struggle with the challenge of providing timely access to needed health care. I think that's why we put more money into the medical equipment fund. If Ontario wants to use that money, and as I say the previous government had indicated it wants to use some of its allotment for more MRIs and other kinds of high-tech diagnostic tools, obviously if they're used well and if their efficiency is maximized, if they are utilized to their full capacity one presumes that that will have some impact on the waiting times presently in Ontario."

HT: Are you discouraged somewhat by the way your bill C-13 on human reproduction has been received by members of the opposition and the government?

MS. MCLELLAN: "No, discouraged would be the wrong word. I am disappointed that there are some Members who don't understand the importance, or appear to be willing to ignore the needs of the infertile community in this country. One needs to focus on what this legislation is about. It's about the challenge of infertility. It's about providing a framework, a regulatory framework in which those couples who are otherwise unable to have families can have those families. And it is about ensuring the health and safety of donors of sperm of eggs. It's about ensuring the safety of mothers and their children. So people need to understand presently there is virtually no regulations in the area of in vitro fertilization. And what this legislation will do is provide a regulatory regime and for the first time require licensing of in vitro clinics, monitoring of these clinics, regular inspection of these clinics, data collection in relation to these clinics. So we will know a lot more about how they operate, things like success rates, the number of surplus embryos... all this kind of thing which we really now only have on an ad hoc basis or an anecdotal basis.

"So this is very important. One in eight couples in this country today are challenged by infertility and all our numbers tell us, and global numbers tell us, that that number is going to rise, and it is going to rise pretty dramatically over the next 20 to 30 years for a host of reasons. Therefore there are going to be more and more people who wish to have families and we have to make sure that we are protecting everybody involved and we acknowledge the integrity of human life."

HT: One last question on your portfolio. You've been at it for two years now. How have you been enjoying it and would you want to keep it under a Paul Martin government?

MS. MCLELLAN: "I have quite enjoyed being health minister. These past two years have been very busy ones, dare I say even tumultuous ones in some respects, with the Romanow report, Kirby, so many provincial reports and health care being the No. 1 issue consistently for Canadians.

"It's a large portfolio. It covers a wide range of areas. And I have certainly enjoyed the challenges in this department. I would be lying if I didn't say there were frustrations also involved. Sometimes things don't move nearly as quickly as I would like them to move. Sometimes we don't have nearly the resources we need to do things as quickly as I would like."

HT: It makes you the subject of many more editorial cartoons as well, I guess.

MS. MCLELLAN: "Well, that's right (laughing). I guess you could never have too many editorial cartoons. I don't know. But certainly health is central to Canadians' agenda and therefore it's been a very exciting time to be minister of health. But it does obviously, as you pointed out, put you in the line of fire, whether its in the minds of editorial cartoons or others."

francoli@hilltimes.com
The Hill Times