Ottawa, Ontario

--- Upon resuming on Tuesday, September 14, 2004 at 0930 /
La réunion reprend le mardi 14 septembre 2004 à 0930

RT. HON. PAUL MARTIN (PMO Canada): I would like to call the meeting to order. J'aimerai vous rappeler à l'ordre. I think that is the signal for you guys to go, yes.

It has just been pointed out to me that when we met Sunday night we didn't necessarily bring Mike Weir all the luck that we wanted. We are meeting tonight. There is a hockey game which I suspect will take up a bit of our time. I hope we do a lot better.

J'aimerais vous suggérer un changement dans notre façon d'opérer, dans notre façon de travailler aujourd'hui. Hier, je pense que notre réunion a bien fonctionné, sauf qu'il y a eu beaucoup de discours préconçus et ce n'a pas été vraiment une discussion informelle comme d'habitude.

I would like to make just a bit of a change in the way that we work today. Yesterday's meeting I think went very well, but I think we all know that we all essentially gave speeches, gave remarks which we had prepared, and that that is not the way that we would work behind closed doors.

Essentially, I believe the way we would work is that I would open with a very, very few brief remarks. I would not make a big speech. I have one prepared. It is brilliant prose that may be well lost forever to history. After those remarks, we would essentially turn it over to a Premier who would make a presentation and then the rest of us would engage in the discussion. I would like to suggest to you that we operate in that way.

So let me just simply make a few brief remarks from very rough notes which you have just set here and then turn it over to you, Lorne, if I could.

Pour moi, les délais d'attente sont importants pour plusieurs raisons. Certainement, le stress qui arrive lorsqu'il faut attendre des semaines ou des mois pour une intervention chirurgicale, par exemple, peut avoir un effet vraiment très néfaste sur la santé de quelqu'un.

The second reason why I believe waiting times are so important is that essentially the targets that are involved will drive the process. That driving of the process, focusing it whether on human resources or on managing the queue and how to do it, I think that fundamentally gives us the opportunity to really make the system evolve and strengthen.

So how do I see wait times? Essentially, you begin with the necessity of providing information province by province to its own residents.

Alors, c'est très clair que l'information qui doit être

fournie par un gouvernement doit être fournie à ses résidants.

That information should be provided indicator by indicator, so that the citizens, the residents of any single province, can know exactly how they are doing.

Then that information should be compared, should be compared to other provinces, and also should be compared against science-based benchmarks on how well the system is performing.

Alors, il y a deux comparaisons. Il y a une comparaison avec les autres provinces -- peut-être même des comparaisons internationales -- et deuxièmement, des comparaisons avec des points de repère établis scientifiquement.

Then you establish these targets are what will really drive the meaningful reductions. Those targets are established province by province. They are not established by anyone else. Taken together, that is to say the targets established by the provinces, the information prepared by the provinces, then compared to others against science-based benchmarks, I believe taken together will really give us the opportunity for real change and for real strengthening.

Many examples of this. I am not telling you anything that you don't know, that you don't do. The Western Canada wait list project is a tremendous success. What it has done is, given the tools to professionals to manage wait lists. I think that is the kind of innovation and it is happening in other provinces as well.

Let me just close on this by giving you my own personal example in an area a long way away from the one we are dealing with here.

Fundamentally, the reason that Canadians got behind the great deficit fight across the country is that at the federal level, and in many, many provinces, we established deficit targets and then we beat them. Just think, if Canadians could get behind something like the elimination of a national deficit, how much more they could get behind a great national objective like strengthening the health care system.

That is why we are all here today. It is on that basis that I think that our discussions are so important in terms of the various elements of reform, and it is on that basis, Lorne, that I turn it over to you.

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

I agree, and I'm sure we all agree, that we today hopefully can engage in more dialogue with less of the perhaps lengthy formal presentation.

We start with what is clearly one of the most significant issues to Canadians, I would say to all of our provincial jurisdictions for the reasons that you identified, Prime Minister, and there is, I'm sure, common agreement about the need

for us to tackle some of the waiting list issues.

It is that issue which in many Canadians' minds will define the strength of the system. Access is a question in many minds of the strength of the system. If there is good access there is confidence in the system. So there are the very specific needs and then there is the broader need of the health of the system.

I thought what I would do, understanding the hour and understanding the agenda that we have before us, is keep my comments as brief as I can, share perhaps a little bit with you, Prime Minister, and with Premiers, First Ministers, some of the things we are doing in Saskatchewan, because we have, I think, over the last number of years, taken a novel -- not a novel, but an innovative approach to assessing our wait time and building a wait time strategy, to say a few words about where I believe that we go from here.

In terms of our own circumstances in Saskatchewan -- and we have had a challenge with waiting lists and waiting times, particularly for some of the orthopaedic surgeries, the cataract surgeries, and in some areas of diagnostic testing. That, too, may be shared by many of us in the room.

We believed that we needed to take a province-wide approach for the very first time; not a community by community approach, not even a health region by health region approach, but a province-wide approach. So we have put in place what we describe and call the Saskatchewan Surgical Care Network.

What this network has done is to bring together an advisory group of specialists, general practitioners, managers, health care managers and others, to make certain that the system is working for the patient; and to make sure that the patient within the system understands and has knowledge of the system. Because, in my experience, one of the worst circumstances is when a patient does not have the understanding of just what is happening in his or her own medical care. So we bring together in Saskatchewan this group of medical professionals and managers, the specialists in the field.

We then have set out a target time, a list of target times for surgeries in Saskatchewan so that we have very measurable goals to achieve. So the people to start giving us the sense of organization to the system then target times and very clear goals.

Then we have -- I think it is the first in Canada at this extent -- we have created what we call the Surgical Patient Registry, so that everyone who is awaiting a surgical procedure in Saskatchewan now is part of the registry. That registry very carefully tracks and monitors progress through the system.

The in some ways unique perhaps component here is that as a patient I can access that registry. I can see where I am in the

process of receiving my surgery or diagnostic care. In that, there is a tremendous education. In that, patients also can be made aware of where opportunities for that particular treatment or surgery may exist beyond their own home community and the ability to access that.

I share your view, Mr. Prime Minister, that in organization of the queues and the waiting lists and better utilization of our existing facilities we can make a difference in the wait times.

But that said, we also recognize in Saskatchewan, and I'm sure we recognize it across the country, that it takes more than just the organization and the efficiency of existing, and we have had to add new resources to deal with the wait lists in our circumstance.

So in our circumstance, for instance in terms of diagnostic testing, over the last five years we have increased CT scans by 85 per cent.; we have increased MRIs by -- we have doubled the number of MRI tests in our province over the last five years. We are now up to a circumstance where we are providing about 90,000 surgical procedures every year in Saskatchewan. Remember, we have a population of a million, and so that is about 10 per cent of the population receiving those surgical procedures.

We have made change. We have more day surgeries and that sort of thing, but it has meant the investment of new resources and new health care providers. If we are going to complete the work of addressing the waiting list issue in Canada it will mean some new resources. It will mean new providers and some new technological investments. There is no escaping that.

We will, later this day, of course, be talking about health care providers. At the end of the day, of course, it is a matter of having the right person with the right technology to provide the service.

We can't imagine or draw with pencil an MRI without a technician. There is no use having the machine if you don't have the staffing. There is no use having the surgical suite if you don't have the surgeons and the nurses and the anaesthetists and the after surgical care. So we will need further investments. This is why we welcome your initiative to provide more investment to dealing with the waiting list time. We welcome that.

At the same time, I think a concern that I have and a concern that is shared by Premiers is that as we invest in dealing with the waiting lists today with new facilities, new technologies, new professionals and health care providers, that at the end of the four-year term if the funding then is removed we are left to maintain the base without the funding.

So the long-term nature of the health care dollar is crucial, I believe, in dealing with the waiting lists today, but in dealing with that waiting list in future, because the last

thing we would want to do is take significant measures now that can bring our waiting lists down to a reasonable circumstance, but then in just a few years' time see those waiting lists start to grow again.

We are making progress. We welcome the initiative. Working together I think we can make a significant difference to Canadians across the country in their access to diagnostic and surgical care.

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

Premier Binns.

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

I largely agree. I don't disagree with anything that Premier Calvert has suggested.

When you talk about waiting times, you are really talking about the continuum of care. Let me give an example. If you have diagnostics quicker, then you will put a demand on surgical activity perhaps, and once you do that, then you need to quickly move to rehabilitation services. As you speed up and reduce wait times in one area, it has an impact on the whole continuum.

I think we all have to recognize that meeting one component of this problem will lead to continued demand in increasing the other areas.

I know all provinces are making investments, as we are. We are investing in diagnostic equipment. We added a new MRI recently, another CT scan, the linear accelerator for cancer treatment, but we need to continue to develop our electronic health record so that we really can determine what is needed in the future.

I'm not going to take that a lot of time, but I want to say that flexibility, as in other things, is important here. Because of our population, there are some services we will never provide on Prince Edward Island. So we have an arrangement with Nova Scotia-New Brunswick to send Prince Edward Islanders next door. Of course, we are intertwined then with their wait times. If they have a wait time for cardiac surgery, then our people have to somehow fit in. So we need the flexibility to be able to deal with that.

I guess I would say that in all of this the best way to reduce wait times is to continue to put money into health promotion, and your government has done a very good job in partnering with us in that area. If we can reduce pressure on doctors' offices and on hospitals by healthy living and exercise, and better diet, then a lot of things are preventible. Up to 50 per cent of cancers are preventible.

Wait times is a very comprehensive area, and I think the strategy is right in that we are investing up front in trying to

reduce the demand and in the long term that will pay off. So it is important to continue to invest here and it is important to have flexibility.

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

L'HON. BERNARD LORD (NB) : Merci beaucoup, Monsieur Martin.

Je crois que la discussion que nous avons, ce matin, sur les temps d'attente est très importante, et c'est certain que les Canadiens et les Canadiennes veulent que les gouvernements s'attaquent à cette question, et vous avez raison de mettre de l'importance là-dessus, parce que nous aussi, on a mis de l'importance sur cette question.

I want to start by commending the work that Saskatchewan has done on wait times. The reason I say that is we are copying a lot of what Saskatchewan has been doing because we feel it is a great model. I believe this is a perfect example of how the federation actually works; that when there is flexibility in provinces to try something new, to try something different, that we can do it on our own to meet our needs, other provinces will learn from those examples.

We have learned from what has been done in Saskatchewan. We are taking it. We are adapting it to New Brunswick, and we are putting in place to make sure we reduce wait times and to make sure that we are more efficient in how we deal with wait times in the Province of New Brunswick. It is a critical component of our New Brunswick health plan because we know that patients need to have access to services on a timely basis. That is what we want to provide New Brunswickers.

Everyone knows it requires investments. It requires human resources. It requires planning. It requires funding as well. We are putting those components in place. We are going to put in place a surgical patient registry. We will have a standardized patient assessment process. We will have target times for surgery. We want New Brunswickers to know what the targets are so they will be able to judge are we meeting the objective or not. These targets will be set not by us but by the experts to make sure that it fits within what is medically acceptable and reasonable for patients.

We will publicly report the results, because I believe that if we want to move forward we need to set clear objectives, let the public know what the objectives are, and let them know if we have met the objectives or not. If we did, great; if we didn't, then we need to look at how do we make sure that we meet the objectives next time around.

This approach that we are taking in New Brunswick, certainly, c'est une approche qui se marie bien avec certains objectifs que vous vous êtes fixés, et c'est pour ça, lorsque je disais hier que dans les choses que nous proposons et que nous

mettons en place au Nouveau-Brunswick, il y a beaucoup de similitudes avec certaines choses que vous avez avancées, et je crois et je le redis, qu'il y a terrain d'entente qui existe entre les provinces et entre les provinces et le gouvernement fédéral, et c'est un exemple d'objectif commun, et nous sommes prêts à mettre les efforts nécessaires afin de réduire les temps d'attente pour les patients et, au Nouveau-Brunswick, nous nous sommes déjà engagés dans cette procédure.

RT. HON. PAUL MARTIN (PMO Canada): Gary?

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

It is fitting that we are starting with this very, very important priority this morning.

Some of the solutions that you are suggesting we would concur with. The Western Canadian Strategy basically cedes some of the authority from an individual doctor to a collective group to put the patient's priority higher in terms of medical need. In western Canada also now, with Quebec's purchase of the gama knife, we are developing centres of excellence. We don't have the critical mass to deal, for example, with children's paediatric cardiac care, but having all the surgeries in Edmonton has allowed for a group of experts to be developed for that waiting list.

And similarly with the neurosurgery and the gama knife now in Sherbrooke and now in Winnipeg, we are reducing that waiting list and attracting and maintaining physicians that were located in the United States to Canada.

Some of the issues of waiting lists require a long lead time for human resource training. A lot of MRI machines and CAT scans should be operating longer hours to reduce the lists, but we have to train the sonographers and other technologists in a longer lead time to be able to do that. Some of us are doing that now and some of us are trying to catch up.

Having targets -- we can have targets, like a budget. You can have targets for volume. We have doubled the number of MRI machines in Manitoba and doubled the number of procedures, but that hasn't reduced as a target the number of people on the waiting list. It has only reduced it by a third because more people are being added. I think you will find in provinces with even higher numbers of MRI machines per capita you have similar evidence.

There are other complications for waiting lists as well. You have a situation even in the medical community where some doctors will practise rehabilitation for a knee injury, as opposed to other doctors who will immediately put you on a waiting list for a knee replacement. So some of these issues are much more challenging, not impossible to deal with, than others.

I think provinces in general have reduced the waiting lists

over the last four years with some of the reinvestment from the federal government and our own major reinvestments on life saving issues.

Cancer treatment has gone down from about eight weeks to one or two weeks or sometimes zero weeks in British Columbia for a wait, and cardiac urgent emergency life and death surgery has gone down quite a bit as well in Canada. But there are still really long waiting lists even with the reductions in the numbers.

We cost each procedure on how much it costs. So we priorize life and death first as a target, and then the other quality of life issues are really, really important. We have costed every procedure in every day with every dollar that we allocate into our budgets.

I am just curious to ask whether in terms of the commitments we are making today, have we costed it out by procedure, by waiting lists, by province, by community, by day, by procedure? Do we have that kind of detail so when we have the kind of budget metaphor that we are using now for waiting lists we have that same kind of critical path for cataracts, for cardiacs, for every procedure in Canada, every day? How much can we afford? What can we promise and what can we deliver collectively?

I really think that we have to make sure that whatever we commit to here, we can deliver when we leave here. That is I think the challenge still that we have.

RT. HON. PAUL MARTIN (PMO Canada): I think that is quite right. I think that one of the advantages in fact of setting targets is it forces you to do that kind of costing so when you set your targets they are well founded.

I have Premier Charest, Premier Williams and then Premier Campbell.

L'HON. JEAN CHAREST (QC) : Merci, Monsieur le Premier ministre.

Dans la foulée des remarques du premier ministre Doer, je veux d'abord féliciter la Saskatchewan pour le travail qu'ils ont fait dans ce domaine-là, parce que, effectivement, chez nous, nous avons observé ce qu'ils ont fait et je pense qu'il est juste de dire qu'ils sont en train d'innover pour ce qui est de toute la question de la façon dont on doit aborder deux sujets, en fait, les listes d'attente et les délais d'attente, ce qui est mon deuxième sujet, sur lequel, je crois que, nous devons faire un minimum de pédagogie pour que la population puisse bien comprendre ce dont il s'agit.

D'abord, la première chose, je pense, que nous devons préciser, c'est qu'il y a une distinction à faire entre les listes d'attente et ce qu'on appelle les délais d'attente.

D'abord, des listes, il y en aura toujours. Il y aura

toujours une personne qui arrive, puis quelqu'un qui arrivera après et après et après, et en soi, on ne veut pas des listes qui soient trop longues, mais par définition, il y aura toujours dans le fonctionnement d'un réseau de santé des gens qui reçoivent, dans l'ordre, des soins médicaux.

Les listes, on les veut les plus courtes possible et on veut qu'il y ait le moins de gens possible qui attendent, mais l'enjeu réel, l'enjeu-là qui est vraiment névralgique, c'est toute la question des délais d'attente. Les délais par rapport à quoi? Les délais par rapport à ce qui est médicalement requis.

Ce qui est médicalement requis n'est pas décidé de manière arbitraire, surtout pas par nous, ni par nos fonctionnaires, mais c'est une détermination qui est faite sur le plan médical. C'est donc dire que les gens qui ont une formation scientifique, qui sont les médecins à qui nous faisons confiance, c'est à eux à qui revient la responsabilité de déterminer dans quel délai une personne doit recevoir des soins pour que nous puissions lui prodiguer les soins nécessaires pour sa santé. C'est vrai en oncologie. C'est vrai pour d'autres types de soins, que ce soit des chirurgies cardiaques ou autrement.

D'ailleurs, je vous souligne, dernièrement, on a été témoin d'une épisode qui a attiré l'attention du monde entier : Le Président Clinton a été opéré, a reçu une opération cardiaque. J'étais très heureux de lire dans les journaux québécois dans les jours qui ont suivi que si monsieur Clinton avait suivi le même malaise au Québec, qu'il aurait été traité, selon -- pas selon moi -- selon les intervenants du milieu de la santé québécois, il aurait été traité, effectivement, dans les mêmes délais, compte tenu de l'organisation de notre système. Son cas aurait été identifié; il aurait été opéré.

C'est donc dire qu'il faut distinguer entre les deux. Et pourquoi la distinction est importante? Je vais vous donner un aperçu de l'expérience québécoise.

Nous, on a investi dans la première année 47 millions $ pour s'attaquer à ce problème-là des délais d'attente. On a réinvesti la deuxième année, également. Les résultats sont quoi?

Globalement, on a réussi à réduire les listes d'attente de l'ordre de 10 pour cent. Alors déjà, on a -- pardon, 4.6, mais les délais d'attente ont réduit d'un nombre d'un chiffre plus important -- oui, j'ai les chiffres à l'envers. C'est-à-dire les listes ont réduit de 4, mais les délais ont réduit, dans l'ensemble...

TRÈS HON. PAUL MARTIN (CPM Canada) : Non, non. Les premiers ministres ont toujours raison.

L'HON. JEAN CHAREST (QC) : Oui, je le sais qu'ils ont toujours...

--- Rires / Laughter

L'HON. JEAN CHAREST (QC) : Ça adonne bien que vous disiez ça parce que je suis à veille de parler de vous.

--- Rires / Laughter

L'HON. JEAN CHAREST (QC) : Je vais vous dire...

TRÈS HON. PAUL MARTIN (CPM Canada) : Avec la même conclusion.

--- Rires / Laughter

TR. HON. PAUL MARTIN (CPM Canada) : Avec la même conclusion.

L'HON. JEAN CHAREST (QC) : Votre introduction est bonne, j'arrive à mon autre sujet.

--- Rires / Laughter

L'HON. JEAN CHAREST (QC) : J'arrive exactement à mon...

Donc, on a réduit l'ensemble des listes de 4, mais les délais d'attente, eux, ont réduit de 10 pour cent. Je vais vous donner des cas précis-là.

Sur les listes d'attente là, on a réussi à réduire les listes en hémodynamie, angioplastie (ça touche le coeur), cataracte, genou, hanche, chirurgie avec hospitalisation : Tout ça a baissé sur les délais maximums -- ce qu'on appelle les délais maximums -- cataracte, genou, hanche, chirurgie avec hospitalisation.

Mais il y a des domaines où malgré les efforts -- ce sur quoi je veux conclure, c'est que malgré l'investissement puis les efforts, il se peut très bien que le nombre de patients qui soit au-delà des délais ait diminué mais que la liste ait allongé. Et pourquoi? Bien, parce que les besoins auront augmenté plus rapidement que la capacité du réseau de pouvoir les combler, et ça c'est attribuable à plusieurs choses, et entre autres, le phénomène de vieillissement de population, mais aussi parce qu'il n'y a plus de médecins. Sur la foi des investissements, on va envoyer des gens dans le système. Alors, c'est une chose qu'il faut garder à l'esprit.

La deuxième chose sur le plan pédagogique que je pense est très important pour ceux qui nous écoutent, c'est de garder à l'esprit qu'il y a au Canada non pas un système de santé nationale, il y a 13 systèmes de santé à travers le Canada qui adhèrent aux mêmes valeurs sur lesquelles nous nous entendons en terme de fonctionnement, de principes et de valeurs.

Pourquoi il y en a 13 au lieu d'un? Est-ce que c'est bon ou c'est mauvais? Au contraire, c'est une chose que nous devons recevoir positivement parce que cela signifie que nous sommes en mesure de répondre plus spécifiquement aux besoins de nos populations respectives.

L'exemple le plus important que je pourrais vous donner, Monsieur le Premier ministre, c'est la première partie de notre réunion d'hier. J'ai trouvé ça intéressant. Il y a une dimension de la réunion d'hier qui était également pédagogique.

On a dévoué beaucoup de temps à reconnaître les besoins spécifiques des populations autochtones, avec raison. Ils ont, dans le fond là, tracé le contour de l'importance d'avoir une approche qui est différente d'un endroit à l'autre, parce que le problème du diabète dans les populations autochtones est beaucoup plus aigu, plus important que la population en général. Encore faut-il que nous puissions être en mesure d'y répondre plus spécifiquement.

Il y a donc 13 systèmes de soins de santé, ce qui m'amène à vous dire à quel point nous, nous croyons que l'approche proposée par le fédéral de fixer des délais d'attente et des fonds spéciaux est une approche qui doit être mis de côté. Pourquoi?

D'abord, une autre question de pédagogie. Je pense qu'il y a une chose qu'il faut différencier dans vos remarques d'ouverture. Lorsque vous parliez du déficit et de la dette et de l'engagement qu'avait pris la population canadienne, ça c'est une chose qui relevait de votre niveau de compétence. Vous l'avez fait. Il y avait un niveau de compréhension. Mais je vous dis sincèrement que notre lecture à nous, c'est que dans l'appareil fédéral, je ne crois pas qu'il y a une appréciation de la culture -- il y a une culture différente, disons-le comme ça, pour ce qui est de l'opération de l'administration publique, et je vais vous dire pourquoi.

Nous, dans notre gouvernement, à notre niveau à nous et dans le réseau de la santé, 80 pour cent des dépenses que nous faisons vont en salaires et en fonctionnement, et je n'ai pas le chiffre à portée de main. Quel pourcentage du budget fédéral va dans le fonctionnement dans les salaires? C'est autour de 15 pour cent peut-être, maximum 15 pour cent, ce qui m'amène aux délais d'attente et votre volonté à vous de vous attaquer à ce problème-là.

Lorsque vous exprimez la volonté de fixer des priorités, ce qu'il faut savoir, c'est que, ultimement, sur le terrain, ces décisions-là vont se prendre avec les gens qui font fonctionner le réseau, ce qui représente 80 pour cent de nos coûts.

Qui sont ces personnes-là? Pour donner un exemple dans le concret, c'est des technologues qui travaillent dans les hôpitaux québécois, qui sont régis par des conventions collectives, qui travaillent à l'intérieur d'un établissement avec une administration, pour lesquels il peut y avoir de l'équipement médical, qui ont des horaires fixes ou des horaires variables, qui sont représentés par différentes unités d'accréditation à l'intérieur de l'hôpital, avec qui nous sommes en lien et avec qui nous travaillons intensément pour que nous puissions justement organiser le travail autour des besoins des patients.

Alors, cela relève directement de nous.

Mon inquiétude, Monsieur le Premier Ministre, c'est que vous

allez fixer une attente avec la population du Québec pour leur dire « En 2007, on va avoir réduit les délais d'attente de telle façon et de telle façon », mais les décisions qui relèvent directement de nous et qui vont nous permettre d'atteindre un résultat sont hors de votre contrôle, et moi je ne contrôle pas ce que Gary Doer va pouvoir faire au Manitoba, je ne contrôle pas ce que Gordon Campbell va faire en Colombie-Britannique, je ne le décide pas. J'ai, par contre, une pleine compétence sur l'administration du réseau québécois.

Ce qui ne nous empêche pas de poursuivre les mêmes objectifs, de reconnaître les mêmes problèmes, d'échanger, soit dit en passant, de l'information. Là-dessus, je veux être clair, le Québec est prêt à échanger de l'information. Nous souhaitons, nous voulons, on veut se comparer aux autres. C'est souhaitable qu'on se compare aux autres pour qu'on puisse savoir où nous en sommes.

Mais, quand le gouvernement fédéral nous dit « Moi, je vais faire un fonds spécial et puis il faudrait atteindre tel résultat et tel résultat », je vous dis qu'il y a là un danger que les priorités fédérales causent des distorsions très, très, très importantes dans le réseau de la santé.

D'ailleurs, je pense que même le Rapport Romanow -- c'est Gary Doer qui nous le disait hier -- vous recommande de ne pas faire ce type d'initiative-là, d'où l'importance de respecter les compétences, à défaut de quoi on va se retrouver avec une proposition qui, franchement, ne tiendra la route.

Alors, là-dessus, on s'attaque avec beaucoup de vigueur au problème. Pour ce qui est du *gamma knife* qui est à Sherbrooke -- et je suis très fier de Sherbrooke. Soit dit en passant, Sherbrooke forme, Monsieur le Premier Ministre, les étudiants francophones du Nouveau-Brunswick. On a une excellente entente avec le Nouveau-Brunswick, ce qui témoigne de la collaboration qu'on a.

On a une entente avec un hôpital à St-Boniface, au Manitoba, et on a le *gamma knife* à Sherbrooke qui devrait normalement être, il est disponible pour des patients de l'Atlantique, qui pourront recevoir des soins. Cela est le type de coopérations sur lesquelles le Québec est très ouvert et que nous trouvons souhaitables.

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

Simplement pour répondre à un de vos points, soyons clairs, on respecte, il y a un respect total des compétences des provinces. Et on sait fort bien que c'est les provinces qui gèrent leurs hôpitaux. C'est les provinces qui livrent les services dont nous sommes en train de parler.

Et ce n'est pas le gouvernement canadien qui va établir les

cibles. Les cibles vont être établies par les provinces. C'est vous qui allez établir vos propres cibles.

Tout ce que je demande -- et moi je suis résident de votre province. Je paie mes impôts à votre gouvernement. Je ne demeure pas tellement loin de vous.

Et je peux vous dire que, comme citoyen de la province du Québec, c'est vous qui allez établir les cibles. Comme résident, j'aimerais bien savoir comment est-ce que les cibles du Québec se comparent avec d'autres, comment est-ce que les résultats du Québec se comparent avec d'autres et comment cela se compare avec, par exemple, des points de repère qui sont scientifiquement établis.

Cela, je pense que, comme citoyen, on veut l'avoir, et vous aussi vous voulez l'avoir. La seule chose que je vous dis, c'est que c'est vous qui allez établir les cibles. C'est simplement l'information dont on parle.

Mais, en ce qui concerne le respect des compétences, je suis entièrement d'accord avec vous. Je suis aussi entièrement d'accord avec vous lorsque vous dites que nous avons des valeurs en commun. C'est pour cela qu'il y a un intérêt national, et c'est pour cela que nous sommes ici aujourd'hui.

Premier Williams.

HON. DANNY WILLIAMS (NL): I forgot what I was going to say, Prime Minister.

--- Laughter / Rires

RT. HON. PAUL MARTIN (PMO Canada): Then you will say it very well.

HON. DANNY WILLIAMS (NL): I am going to try to be brief because we have a lot of people around the table, and this is a very, very important topic and we would all like to have a lot of time on it, but I think in the interest of expediency, I think we have all got to try and get our message across clearly and succinctly.

Thank you for addressing this very important issue. I think the federal government is to be commended for recognizing this is a top priority for Canadians. It is the priority for Canadians. I have polled by own people, checked with my own people in Newfoundland and Labrador. Over 80 per cent of them consider this to be their top priority.

As I said yesterday, a couple of examples, and I won't belabour the point, but, you know, one MRI in the province has a waiting list of 1,906 people. Mammographies can take up to nine months in order to be checked. Just a couple of brief examples of the situation.

I think it is appropriate that we opened with Premier Calvert, the leaders in the country, I think what is so good about this whole exercise that we have gone through -- and we may

step back and some people may criticize the process -- but I think what it has done is we are looking at best practices around the entire country. I think that is very worthwhile. We are sharing information.

Newfoundland and Labrador can learn a lot from the people around this table. We lope to basically take all your good ideas and put them together in Newfoundland and Labrador and make our system more efficient, and I thank premiers like Premier Calvert and other Premiers around this table who have been pioneers in certain areas. So that has been very, very helpful.

From our own perspective, as I said, it is a big issue in Newfoundland and Labrador. Again, it comes back to us being able to provide a level of service in a timely manner on the basis of affordability.

I do notice that in the draft that you released yesterday on the improved access and reduced waiting times, the summary of the federal proposal, you referenced a report called "Taming the Queue", which is a wonderful name, by the way. I think it was a great name for the Canadian Medical Association. I had the opportunity to meet, before I left my province, I met with the members of the Newfoundland Medical Association. They referred me specifically to this document and I read it, and it is a very good document. Two things struck me in the document -- or what I refer to as the 3Ms -- they talk about and the whole issue of waiting times and wait lists, better measurement, monitoring and management. For Newfoundland and Labrador I think that is the right approach. I think those are the rite criteria but they all cost money.

And that is the problem. Of course, the target that has been set by the federal government with regard to publishing wait times by December 2005 would be a significant challenge for my province in order to meet it.

One statement which appears throughout "Taming the Queue", which struck me and I wrote down as I read it, the key elements in planning long term solutions to waiting time problems are "needs-based planning for the provision of evidence-based care and sustainable resourcing" (As read)

From my perspective, that priority is sustainable resourcing. I think Premier Campbell has made the point that one-time funding is not the answer when it comes to wait lists. That it has to be sustainable. It is a huge problem now. It will be a problem forever. We will address it, but it will require sustainable resourcing and I would suggest to the federal government that they consider that their wait list money be on a permanent basis as opposed to one-time funding.

The final thing that I would like to share with you is a comment by the NLMA, I always have trouble saying that, is that

they describe the situation in there, and Premier Hamm would certainly appreciate this, they described a perfect storm which is being created in their profession. They said it is a combination of an aging workforce.

Get-a-lifers, people who finally decide that they need a life style, rather than practice medicine, they have made sacrifices that our physicians make across the country, and as well as escalating disease rates.

I would add to that perfect storm the funding problem that we have in this country, and I think it is very important and we are dealing with it. But the perfect storm does describe did. There is a combination of factors that are moving together under some various areas here, and I think we have to address it.

So I think the federal government has taken the right approach, has taken the right step, is addressing a component of the perfect storm that is occurring in it country, and I commend you for that.

The big point from Newfoundland and Labrador's perspective is we need the money to implement these great ideas.

Thank you, Prime Minister.

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

I have Premier Campbell. If I might ask you, Premier Campbell, at some point in your remarks, Premier Doer mentioned and you in fact talked to me about this last week, how you got cancer waiting times down to virtually nil. I would think some of us would -- I would be very interested if you could elaborate a little bit on how that happened, how you did that.

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

Let me start by saying I think that for almost the rest of the day, regardless of whether the topic is wait times, we are talking about wait times.

Wait times are the result of human resource strategies, of diagnostic strategies, of capital improvement strategies. They are all part of what we are trying to accomplish.

So, for example, you talk about in British Columbia and what we have done with our cancer treatment. Our cancer treatment centre is properly funded. It is not just properly funded in terms of the physicians and the nurses and the equipment; it is properly funded in terms of the research that has gone on with regard to it.

We have very explicit measurements that is we use in terms of patients when they come in. Virtually all our emergent patients in the entirely system in Canada are dealt with immediately and I think that is one of the things that Premier Charest talked about.

So we have been able to both invest in cancer -- we have invested in preventive care. We have invested in testing. We

have invested in diagnostics in cancer across the province. We have travelling clinics and mammography that takes place across the province, as well as the stable decentralized testing systems.

It is really the people that have made that successful with the software that we have put in place to measure the lists and to measure the timing. I do think we have to recognize that that is really what has taken place. It has been a significant investment.

I should point out in Ontario there is virtually no wait times for cardiac surgeries. So while five and five to be candid sounded great, we should recognize in Ontario cardiac surgeries are not one of the big wait times, they are not one of the big issues and in British Columbia cancer treatment wait times is not one of the big issues.

One of the points I wanted to make any time we set a plan called a wait strategy plan, you immediate live start to fill out application forms and have bureaucracy and, instead of dollars flowing to the bedside right away, you don't.

So it is critical, for me at least, in terms of where we are going at the provincial level, is for you to understand this: we have been working on wait times for a number of years now. The Western Canada wait lists project is not something that we have just started. It is something that has been ongoing for some time. It is a sharing of information.

One of the challenges we have is when people don't know how to access information they say there is no information. So we should all know that Stats Canada does one of the best surveys that there is with regard to access to health services.

Wait times may be something that sort of in the news-type wait times like cardiac surgeries, There could be wait times to yet an audiology tests. There could be wait times for cochlear implants.

I don't know, Prime Minister, if you have ever experienced this, but if you go to a facility where, as we did the other day, where a young boy who is seven years old has just had a cochlear implant and he is just now hearing for the first time? That is a pretty phenomenal thing that we can do if we recognize that that is a kind of wait time as well in a selective surgery.

There is one other thing that I would say, we have put a lot of time and effort into establishing a National Health Council. The National Health Council right now is looking at wait times and how we deal with wait times.

One of the things that is clear is that when you are doing all of the emergency issues, and when it is life threatening you are taken care of. So the question is how do we schedule, and when we talk about scheduling, it is not unusual for an emergency

situation to push a scheduled procedure off.

So we have to look at, I think, building capacity in the system, which is long term capacity as well. So, wait times are about nursing shortages, about physician shortages. I mentioned yesterday that we have just invested about $27 million in the last fuel weeks in reducing cardiac wait times, hip and knee replacements, diagnostics. I can tell you the issue there was not whether we had the resource, it is whether we had the people, the facilities that we could actually flow that resource effectively through to the patient who needed it.

And that is I think one of the critical things that we have to do. We have seen from the Western Canada wait list project. We have all had the information from Saskatchewan which they have been very open with, what is working and what isn't, what the standards are we are striving for and what we are not.

So, I think we are making progress on wait times. We have got to continue to work on wait times. And I would echo Premier Williams. I think focusing on wait times is good, but you have to focus on them long term.

Because the fact of the matter is, Prime Minister, in British Columbia, for example, in the last three years, we have done 38,000 additional procedures and in some cases lists have grown and sometimes times have shortened.

The aging population is going to drive additional demand. We have to run to catch up to today's demand, as well as to anticipate tomorrow's demand and it is going to carry on for some time. So there will be institutional changes. There will be informational opportunities that are created and there will be service opportunities that are created with the proper funding, and I think that is what is going to be critical as we move through this.

RT. HON. PAUL MARTIN (PMO Canada): Thank you, Premier Campbell. Just a couple of comments.

First, I very much appreciate your comments about the health council. I think it can play a very important role in all of this.

On your comment about the five and five, again, I very much share your view. The five and five, whether it was heart, cancer, hip replacement, vision, was arrived at simply because this is where the medical profession said that the concentration should be. No doubt there are some provinces such as yours or Ontario who have done very well in certain of these areas. The five and five shouldn't be a limit. We should be able to add to the five and five. So I very much agree with what you have just said.

I have Premier McGuinty and then Premier Handley.

HON. DALTON McGUINTY (Ont.): Thanks, Prime Minister.

I think you will have gathered that there is a very strong consensus, firstly and most importantly among Canadians, and certainly among the 14 of us in this room with respect to the need and the determination to attack wait times. I think you also will have gathered that we have each made significant inroads with respect to addressing wait times, each in our own way.

I wanted to emphasize as well that we have taken the opportunity to bring together our finance ministers and our health ministers to take a look at best practices with a view to ensuring that nobody is doing something somewhere from which somebody else might profit from that particular experience.

I think it is important to be clear-eyed about this. We are not talking here about eliminating wait times entirely. To raise that level of expectation would be dishonest on our part, and I am sure there is nobody here suggesting that. I think what Ontarians and Canadians are certainly looking for is progress with respect to reducing those wait times.

We have some real challenges at present in Ontario and throughout the rest of the country. One of those is we don't have in place the sufficient infrastructure for gathering data with respect to how long people are waiting for. Most of that information is kept by doctors, individual hospitals. Some of them make it public. They have a Web site.

We have advanced, particularly in the area of cardiac care. You made reference to that, and there is more to be done there.

I agree absolutely that we should set some targets for ourselves. I think first we should begin to have as targets for ourselves increased volumes and then beyond that to target specific waiting times.

One of the issues -- and I had a chance to chat with you about this before. The reason I like targets is because I think they drive change. I think it is important for our bureaucracies, those in the broader public sector, to begin to experience a bit of success in our health care system. We owe it to them to construct a few successes and to pick a few areas where we are going to focus our efforts. We have done that in Ontario: cardiac care, cancer care, hips and knees, cataracts, MRIs, CT scans. We can't cover everything at once but we have focused on those specific areas. We think the people of Ontario are entitled to experience some real measurable progress in those areas, and I am convinced we can get there with your help.

One of the issues I have is this. We are going to make our information available. We are establishing a new Ontario health council, health quality council. It will be independent of government. It will help us make this information public on an ongoing basis. It will report to the Ontario public.

What are you going to do, Mr. Prime Minister, once we make this data available Canada-wide, so that people can compare the data? What happens if in one particular province or territory they are dramatically behind the rest of us? Are you committing to providing them with additional supports? Do you provide them with the equivalent of a turnaround team? How is that going to work?

I am sure the intention here is to make sure that we all move forward together. It is one thing to put in place the targets. It is one thing to make comparable data available to Canadians. But what support are we going to get in order ensure that we are all moving forward at relatively speaking the same pace when it comes to progress?

RT. HON. PAUL MARTIN (PMO Canada): I think that is probably a pretty good entree into the wait times funding proposal that we have put forth.

Some of you have said why would you have a fund which was time limited? The reason really is to respond to some of the issues that Premier Williams has raised and some of the issues of Premier Doer and in fact Premier McGuinty. As we discussed yesterday, we very much believe that health care funding should be long term. Overwhelmingly the bulk of our health care funding is long term. But there are going to be times when an added injection of funding is required.

To simply give you an example of this I think is the subject that we are talking about. First of all, I have been told by a number of the leading medical professionals that if what you are going to do is attack wait times, you really have to attack wait times. You have got to break the back of the problem. And once you have broken the back of the problem, then in fact it becomes much more handleable. That will require a special effort if you are going to clear those backlogs.

That is one of the reasons why we have this. You are not going to have to clear the backlogs every year. What you have to do is a concentrated effort. So that will require extra funding.

Some provinces may require extra help the way that Premier Williams has just outlined.

You, Premier McGuinty, talked about the need for data: let's get that data and let's really get right at it.

So essentially in the development of electronic registries or whatever you want to have, we recognize that there has to be an extra effort.

But I think we also understand that the federal government -- and that is where I think the work that you have been doing is so important. You have been involved in this. This is part of your ongoing program. This is being funded out of the long-term funding, and by providing you with long-term

funding we are providing you with support for what you are already engaged in. What we are talking about is funding on top of that for a period of time to provide the electronic registries, to provide the information that you require, to help coalesce that information and in fact to manage the queue in a way that will break the back of it. That is essentially what we are that looking at.

Premier Handley.

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

In my mind, the issue of wait times and the next item on our agenda, human resources, are closely related in that we can have all the electronic registries we want and all the statistics we want, but if we don't have somebody to staff that community health centre there is an awful long wait time for that person in the community who has nobody to go to.

That is our basic problem, as I mentioned yesterday. We had a 35 per cent vacancy in community health nurses at the end of June. So that is a problem.

A second one is that whatever happens on wait time in the provinces is certainly of a magnified scale in the North, but whatever happens in the provinces is certainly a big impact on us.

Some of our people are waiting. I know people who waited on the Arctic coast, for example, to be able to get into a hospital in Edmonton, and waited months; gone down and found out that something had happened and they couldn't get in; go all the way back home again; come again. Some have done it as many as three times. That is a huge expense plus a frustration for somebody who is not feeling very well.

Whatever happens in the south is certainly of value to us if we are able to shorten the wait times in those hospitals. Our biggest challenge is finding people in the North. We have increased our general practitioners by 25 per cent. We have increased our specialists. It is helping to stem the tide a bit but we are not able to do enough to be able to make a huge difference.

If there is going to be any initiative in the Northwest Territories in reducing wait time, it is going to be around looking at alternatives such as nurse practitioners who would then be able to take on some of the responsibilities and some of the load off the physicians.

Another area for us is on rehabilitation services. We have had people waiting practically a year for rehabilitation services simply because we don't have the people to be able to provide the services.

Mr. Prime Minister, this one in my mind is very related to human resources. To us in the North it comes down to having the

people to provide the services.

That goes to my comments yesterday about the need for us to train our own people in the health fields, health professions, but also to have a national priority on getting more people into the field, whether it is nurses, nurse practitioners, therapists or doctors.

Thank you.

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

I have Premiers Hamm, Charest, Fentie and now Campbell.

Premier Hamm.

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

First of all, you are probably, as I am, impressed about the amount of knowledge that non-medical people have around the table about the health care delivery system. I think that is a demonstration of how much time Premiers spend dealing with health care even though they are not themselves ministers of health.

First of all, I would like to compliment Premier Calvert in what he is doing in Saskatchewan. He is ahead of us in Nova Scotia in developing a strategy for wait times. I have listened very carefully to what he has been saying.

We are in the process of setting up our process, and we will certainly be very interested in learning from your officials some of the details that you obviously would be able to provide because of where you are in the process.

Premier Campbell I think made some very important remarks when he indicated that we cannot address wait times without addressing many of the structural areas of health care delivery. It is extremely important to all Canadians, the wait time issue, and that is why it resonated so particularly well recently right across the country. If you ask many, many Canadians what we should address, it is wait times.

But it is not perhaps as simple as some would have you believe. It has many, many aspects that go into human resources, technology, infrastructure, long-term care and acute home care issues.

That is why it I think actually opens up a number of avenues that need improvement.

The five and five initiative is a very good one, but the wait list issue is much more than a five and five kind of approach.

For example, I would like to indicate two areas of particular challenge in Nova Scotia. One is in orthopaedic surgery. Because one in seven Nova Scotians is a senior citizen, the wait list is unusually long for a province of one million people. As our senior citizen population increases, which it is destined to do over the next decade or two, the pressure on the orthopaedic system will increase. That is why I support my

colleagues in the bid not to have the wait term funding end, because the demand is increasing. I will absolutely be able to guarantee if we stop the emphasis on wait times, the wait time issue will again rear its ugly head when the funding is discontinued.

I would like to speak about another wait time issue. That is the wait time for mental health services in Nova Scotia. We have never in all of the years that I practised medicine in Nova Scotia had a satisfactory approach to dealing with mental health issues. We have developed mental health standards in Nova Scotia, and we are anticipating taking those standards and putting in place the appropriate infrastructure and the human resource component so that we can in fact meet the standards. I believe that those who are battling with mental health issues should have access to the same kind of confidence that the system will respond to their needs in an appropriate timely fashion. I think that is very, very important.

I have developed actually in excess of 15 issues that I think follow nicely into the wait time issue. I will not belabour the meeting with relating all of the issues. But it is core. If we could solve the wait time issues, I think we would in essence have solved about 80 per cent of the health care conundrum.

You very correctly identified a key issue in improving health care, and I want to compliment you on that. But I do want to add my voice to those that are encouraging you not to make it a temporary fund.

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

Monsieur Charest.

L'HON. JEAN CHAREST (QC) : Je profite de l'occasion pour dire que le problème soulevé par John Hamm pour les enjeux qui touchent la santé mentale valent pour le Québec également, et vous allez trouver si vous faites le tour du Canada qu'il y a, effectivement, beaucoup de similarités dans les enjeux. Nous, c'a été pendant trop longtemps le parent pauvre du système de santé québécois, et là, bien effectivement, on doit en faire, puis on en fait, davantage.

Vous avez fait une remarque, Monsieur le Premier Ministre, qui a attiré mon attention et je pense que ça vaut la peine de relever parce que ça va au coeur de l'organisation du système.

Je pense que ce que vous venez de dire, c'est que le financement stable prévisible, le financement de base doit être la règle. On s'entend là-dessus. Tout le monde s'entend là-dessus, il faut que ce soit la règle.

D'ailleurs, un des objectifs que nous poursuivons de la conférence, c'est qu'on puisse quitter ici avec des engagements encore plus clairs, plus fondamentaux pour un financement de base

qui est stable et qui nous permet de répondre aux besoins tout en s'entendant sur une autre réalité, c'est que, actuellement, le niveau de financement que nous avons ne répond pas aux besoins.

Vous allez mieux comprendre la réticence des gens autour de la table quand vous leur dites: « On veut aller plus loin encore faire d'autres choses » alors qu'au point de départ, nous, on vous dit, et vous reconnaissez, je crois, qu'on a un problème en partant avec ce qu'on fait aujourd'hui sans même parler de ce qui pourra et devra être fait plus tard. Alors ça, c'est la première chose.

Puisque c'est la règle, posons-nous la question suivante: Dans quel cas et dans quel scénario devons-nous faire des financements ponctuels puisqu'il faut que ce soit l'exception à la règle.

Là je vous ramène à ce qui doit être vos responsabilités puis nos responsabilités. Je me mets dans les souliers du gouvernement fédéral pour un instant. Quel rôle peut jouer le financement d'un gouvernement fédéral s'il veut faire des financements ponctuels?

Ce que je vous dis, c'est que vous devez éviter à tout prix d'entrer dans les opérations du réseau de la santé parce que ça, ça relève de nous, de nos décisions puis on est imputables de cela. Là vous allez entrer dans un domaine où vous avez aucun contrôle sur l'organisation du réseau de la santé québécois ou des autres réseaux.

Vous allez mettre les pieds, en d'autres mots, dans un champ de compétence, pour nous, c'est un champ de compétence, mais dans un domaine où vous ne contrôlez à peu près rien, vous allez fixer des objectifs, vous allez déconnecter les objectifs que vous fixez de vos responsabilités, parce que vous n'êtes pas responsables des décisions qui se prennent à ce niveau-là; et en soi, c'est une chose qu'on doit éviter à tout prix.

Est-ce que ça veut dire qu'il ne doit jamais y avoir de programmes temporaires? La réponse, c'est non. Le meilleur exemple que je pourrais vous donner, si vous voulez faire, vous, au niveau fédéral, des programmes ponctuels pour nous venir en aide, je pense à deux domaines où vous pourriez jouer un rôle très utile.

Il y a, au niveau des infrastructures physiques, des problèmes très importants à travers tout le Canada incluant le Québec. On a, par exemple, au Québec, deux projets de construction d'hôpitaux universitaires à Montréal qui sont névralgiques parce que, dans le domaine de la recherche médicale, on a une réputation d'ordre mondial, il faut aller de l'avant avec ces deux projets-là.

Vous pourriez donc, sur une base ponctuelle, temporaire, parce que ce sont des investissements qui sont ponctuels et

temporaires, offrir de l'aide à ce niveau-là.

Il y a un deuxième domaine où vous pourriez offrir de l'aide, c'est au niveau des technologies de l'information. Si vous souhaitez jouer un rôle à ce niveau-là, je pense que vous auriez une très belle occasion pour continuer sur ce que vous faites dans Infoway et nous offrir l'occasion d'obtenir un financement pour la mise en place des systèmes de technologies d'information qui vont rendre nos systèmes plus performants. Ça vous sort des opérations puis ça vous amène, je crois, au bon endroit.

Je veux parler à vos experts. Ça fait deux fois que vous les invitez à se joindre à nous autour de la table, les experts qui vous disent que des fonds ponctuels, c'est une bonne chose pour les délais d'attente, et leur dire ceci: C'est basé sur la prémisse que les demandes seraient constantes.

Quand les experts vous disent: « On va éjecter des fonds pour s'attaquer aux délais d'attente ou aux listes d'attente, la prémisse de leur raisonnement, c'est qu'il y a un problème qui est ponctuel, en injectant, on va le régler. »

Or, la réalité qu'on vous décrit autour de la table est la suivante: on l'a fait, nous autres, moi j'ai un fonds de 47 millions que monsieur Couillard nous a demandé de mettre en place, qui va être récurant; et malgré cela, on a augmenté de 10 pour cent les chirurgies et les listes d'attente ont baissé de 4 pour cent.

Or, la demande n'est pas constante, la demande va en augmentant. Je veux bien que vous experts vous donnent ce conseil, ce que l'on peut leur répondre, c'est que la réalité que nous vivons est autre.

La dernière chose que je veux, moi, c'est qu'on ait des budgets temporaires pour des programmes temporaires. La caricature, en conclusion, que je vous dis, je l'appliquerais chez nous, c'est que je ne voudrais pas expliquer à un patient, un citoyen québécois qui s'est fait opérer pour une cataracte dans l'oeil gauche, pourquoi l'oeil droit ne sera pas opéré, parce que le programme fédéral a terminé le mois dernier. Je caricature, je sais que j'exagère en vous LE disant, Monsieur le Premier Ministre.

TRÈS HON. PAUL MARTIN (CPM Canada) : Un peu.

L'HON. JEAN CHAREST (QC) : Oui, un peu. Mais des fois, pour les gens dans le réseau, ils trouvent que, eux, des situations comme ça que ces gens-là vivent, ils trouvent que ce n'est peut-être pas loin de la réalité. Alors, il faut éviter à tout prix à la fois des programmes ponctuels d'opération.

Dernière chose. La capacité du réseau de livrer, ça c'est une chose qui relève de nous, on en reparlera dans les ressources humaines, et c'est également une chose sur laquelle on a, nous,

un contrôle direct et que le fédéral ne contrôle pas.

TRÈS HON. PAUL MARTIN (CPM Canada) : Tout d'abord, j'accepte la nécessité absolue d'un financement stable. Lorsque vous regardez ce que nous sommes en train de vous proposer, c'est en grande majorité du financement stable. Que ça soit pour la santé, que ça soit pour la péréquation.

Deuxièmement, on n'a aucune intention d'avoir de l'ingérence dans la façon que vous opérez le système de santé au Québec ou dans une autre province.

Troisièmement, comme je viens de dire, les cibles pour les délais d'attente seront des cibles établies par les provinces.

Maintenant, lorsque vous nous dites: « Il y a des places où on peut avoir des fonds ponctuels, il y a des places où ça se peut que le gouvernement canadien peut nous donner un peu d'aide d'extra. Comme par exemple, dans la nécessité au tout début de ramasser l'information ou les technologies d'information. C'est exactement ça le fonds pour les délais d'attente. Ce n'est pas nous qui allons décider comment est-ce que vous allez utiliser cet argent.

Si vous dites que vous voulez utiliser cet argent pour donner un coup pour avoir plus d'information ou un meilleur système de technologie information. absolument, en plus de ce que Infoway fait, vous pouvez l'utiliser, ce fonds.

Je pense que nous sommes vraiment d'accord sur l'utilisation d'un fonds de transition pour aider de problèmes de transition.

Premier Fentie.

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

Prime Minister, there is no doubt that this is a best of investment of value in addressing wait times and taking a step towards reforming the system. I must say, for the record, that the citizens of the Yukon are predominately dependent on other provinces such as B.C. and Alberta for many of our needs, whether they be surgical, diagnostic or other services.

We are fortunate that both those provinces have been addressing this issue for quite some time, but we do have bottlenecks in the Yukon that are specific to us internally.

The troubling fact here is not so much that you are investing, the federal government is investing in this important issue. The troubling fact is, it is one time and it severely restricts us in being able to address within the Yukon territory.

We need to ensure that we can invest long term into human resource side. We need to ensure that we can invest long term into technologies and equipment and infrastructure. You simply cannot do that with one-time funding.

The point I would like to make to you, Prime Minister, is, yes, a good investment to start, but we have to come to some

reasonable equitable focus on those citizens who live in the north. They should not be penalized because they live there. They should have the same level of access and the same standard of health care that all other Canadians enjoy. One-time funding will never achieve that.

That is why I, for one, continue to try to impress upon you that the way to solve our problems is restoration of what you transfer to us.

We have contributed a great deal to the surplus over the years. Now the federal government has that surplus. I think it is time the federal government starts to reinvest some of that back long term, not in one-time funding.

With all due respect, Prime Minister, a great initiative, it is a good step, but we need to look at how we ensure that all citizens in this country can be dealt with in a fair and equitable manner.

For us in the Yukon, it means we have to go beyond one-time funding.

Thank you.

RT. HON. PAUL MARTIN (PMO Canada): I agree with you again. That is exactly why we said in our meeting that we will be increasing the territorial funding arrangement. I think your point is well taken.

Premier Campbell, followed by Premier McGuinty, followed by Premier Doer.

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

I just wanted to say that when we deal with wait times or wait lists we are in danger of being in the similar situation where you treat a fever but you forget about the underlying infection that caused it to begin with.

Let me just give you an example. I think we talked about this before, but I do think, as the Premier of Newfoundland points out, that we have this perfect storm hitting us.

Right now we have an aging population with increasing demands in a whole range of things from cataract surgeries to hip and knee replacements to cardiac surgeries, et cetera So there is a wave that we know that is here, that is coming, that is going to increase. That is important for us to understand.

The critical component, I think, of wait strategies is the human resource. The human resource is nurses and doctors. We often think about the aging population. We seldom think about the aging caregiver, the aging professional who is providing that service.

I think the average age of nurses in Canada is 47, 48 years old. We are going to have to invest substantially in bringing nurses in to the system. The same with doctors. It is four years to train a nurse; it is at least six years to train a

doctor.

So obviously short-term fixes with regard to that don't necessarily work. In fact they will not work. They will provide a -- well, hopefully they will provide some benefits in the short term, but if those benefits cut, it is much more difficult to plan long term.

Let me just give you one example. Last year in British Columbia we increased the number of hips that we replaced by 14 per cent. Fourteen per cent, Prime Minister. That wasn't the growth in population. Fourteen per cent increase in hips; 11.3 per cent increase in knee replacements. The number of people who need the procedures has actually increased.

So we have an enormous situation, a big problem here that we have to deal with. You have to deal with it systemically. You have to deal with it particularly in terms of human resource and diagnostics. I think if you deal with both of those things and you are providing medically appropriate services, you can see that it is going to take far longer than the five years that has been laid out. I think it is a long-term societal shift that we have to make which requires long-term societal funding to make it.

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

HON. DALTON McGUINTY (Ont.): I hope you are getting the point here, Mr. Prime Minister. We have a real challenge of trying to marry the notion of wait time money with one-time money.

The human resources are so important to us. These are the people who work on the front lines and who give expression through their caring work to this desire on the part of Canadians to look after one another just because you are sick, not because you have money but because you are sick.

We have done a number of surveys with respect to nurses and how do we get them back from the U.S. and how do we get those who have left the profession to do other things in Ontario? How do we get them to begin to take up an interest once again in the profession of nursing within the Province of Ontario?

The number one reason, the number one condition that they want satisfied in order to return to work full time in Ontario is permanent, full-time work. I can't use one-time money to hire nurses on a permanent, full-time basis.

The other thing is a little bit different, but just to give you an example. Inevitably, one-time money is going to lead to us having to make some tough choices. Either we are going to have to acknowledge this new upload, or we are going to have to make some cuts. Those are the only two choices we are going to have when the money runs out.

To give you an idea, we have a great new program in Ontario, a vaccination program, vaccinating kids against meningitis, pneumococcal disease and chicken pox. We are able to do that, Mr. Prime Minister, because you gave us the money. And we are grateful for that. Our families are very grateful for that.

It means that if you are a single mom and you have two kids and your take home is minimum wage when you wait on tables, and tips, you now don't have to make the terribly difficult decision about whether or not you put the money into clothes and rent or whether you put the money into a meningitis shot. This new program will save our family $600 per child. But here is the conundrum: That money runs out in three years.

So I have a choice. Do I then tell children who are born in 2007 and beyond, "Sorry, you are not the beneficiaries of the federal largesse that took place at that point in time", or do I then say, effectively, "This was an upload. I will now assume this responsibility", because in fairness and in good conscience I can't look those kids in the eye and say, "Those born before you for three years had that money, but those born subsequent to you do not."

We are going to have to make that investment, so we have made the commitment to make that long term. But that is just an indication. At the end of the day the choices that we have to make as Premiers is whether we accept this as an upload, because it will be an upload for all the reasons laid out by my colleagues, or do we say we are going to make some cuts?

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

Premier Doer.

HON. GARY DOER (MB): When I was coming into the room today, Prime Minister, a delegate, I think he is a federal delegate, who runs the cardiac -- not that there is anything wrong with that -- running the cardiac program in Manitoba said to me, very strongly, he said, "I only want to pass one thing on to you: I can't hire a cardiac surgeon on a short-term break-the-back waiting list strategy. I can't get the cardiologists. I can't attract them, I can't keep them because I am competing with American states and other jurisdictions, and you have to have a long-term sustainable strategy on that. Please pass that on to" -- he didn't say to the Prime Minister -- "to the federal bureaucracy that is providing some of the advice.

I would point out in terms of medical advice that we are getting -- recall 15 years ago when the medical advisers to all provinces and the federal government told us that we should reduce the number of doctors in medical schools by 10 per cent and we all went into the valley of death and cut the number of doctors by 10 per cent.

What is happening now with the tall foreheads who gave us that advice 15 years ago? No disrespect to tall foreheads but, you know, I would rather listen to the advice of doctors and nurses on the front line on what we have to do.

I don't disagree with your strategy on breaking the back of waiting lists on the front end. It is on the back end that we are going to die. Because the demographics, both in terms of patients and human resources, that have been discussed, are real.

I think we should listen to the people on the front lines and not people who do a lot of academic studies, because we have listened to them before. Science is good, but I think we should go with the people who know how we can deal with this.

So at the front end I think you are right. On the back end I think we are being -- it is folly to follow this kind of strategy and I don't think we should do that. I think we will not be fixing medicare for a generation without sustainable funding for a generation.

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

Thank you very much.

Premier Lord.

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

RT. HON. PAUL MARTIN (PMO Canada): May I just interrupt? I think, because we do want to go on to human resources, what I am going to do is, I will take Premier Lord and then Premier Calvert and then I will go on.

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

I think there is an interesting discussion taking place here and we really have to ask ourselves: Are we at the limit of new innovations and new thinking in health care and new interventions and new treatment? I think the answer is no.

As we try to, use your term, break the back of the wait times that exist today, we need to keep in mind by the time we have broken the back there will be new treatments, newly diagnostic equipment, new interventions that will exist in health care where there will be a wait time that we will need to address.

There are things that we do today, interventions, treatments that we provide to patients, that we did not provide 10, 15, 20 years ago. There was no wait time then because the treatment did not exist. The treatment exists today and therefore there is a wait time and we want to keep it reasonable and there will be new treatments that don't exist today that will exist 10 years from now and we will have it address those wait times.

When we talk about wait times, we need to realize there are different types of wait times. There are wait times for life

threatening diseases and there are wait times for quality of life issues. We need to address both but differently.

There is no doubt that wait times for life threatening disease, wait time has to be practically zero. That is what Canadians expect.

I do find very interesting when you say we have to break the back of this situation and therefore we need a short-term plan.

Perhaps that is what you had in mind when you tackled the deficit. You wanted to break the back of the deficit and maybe you will announce to us later today or tomorrow that the reduction in funding that took place in 1994 and 1995, that was only a short term and now you are going to put it all back in. Maybe that would be a way to address this and then we could accept a short term for the wait times.

These problems don't go away and the demand will not decrease. The demand will continue to increase. We cannot escape that reality. We would not be straight with the Canadian public if we were to tell them that we can fix wait time with a temporary fund for four years and then everything will be okay.

I wish it was true, Prime Minister. I don't think it is. That is why we are suggesting to you respectfully that the wait time fund that is included in your proposal is not sufficient. It needs to be increased and made permanent in the base for the long term.

RT. HON. PAUL MARTIN (PMO CANADA): Before going to Premier Calvert, if you don't mind, there have been a number of references to the 1995 budget and the deficit fight so I would like to make a couple of points on that.

If we had not acted in 1995, we would not be here today. If we had not acted in 1995, we would not be in a position to offer the kinds of money in terms of health care and equalization that we are offering then.

In 1995, 31 cents out of every dollar that we spent on health care was borrowed. That was an absolutely unsustainable situation. We had our back to the wall as a country. We set a national objective and the whole nation got behind it and we achieved, in a period of four years, what no other nation has been able to achieve.

What I'm saying is, if we do that in something that is as close to people like health care, and some of the other areas, if we set great national objectives and those national objectives are arrived at in partnership with ourselves and yourselves --

Ce n'est pas nous qui vont établir la façon que vous allez livrer la santé. Ce n'est pas nous qui vont vous dire comment est-ce que vous devriez le faire, mais si nous avons des objectifs en commun, des buts en commun, il n'y a absolument rien qui peut nous arrêter.

I believe that what we did in 1995 is the reason that our economy is one of the strongest in the world today. I think that you understand that and I think that you also share that view.

So let me just say that if you are looking at job creation; if you are looking at economic momentum; and if you are looking at the productivity of our economic system; if you are looking at the fact that we are no longer a net borrower; if you are looking at the fact that we have our fiscal house in order, it is due to what we all did together and what Canadians did in 1995.

I feel very, very good about that. What I am now saying is that the same kind of national effort should be translated into other areas of our endeavour.

L'HON. JEAN CHAREST (QC): Premier Ministre, est-ce que je peux --

RT. HON. PAUL MARTIN (PMO Canada): I think I have Premier Calvert and then I --

L'HON. JEAN CHAREST (QC): Oui. Je veux réagis à cela.

HON. LORNE CALVERT (SK): Prime Minister, I know we have other important issues on our agenda and I was hoping to try to perhaps summarize a little. If Premier Lord or Premier Charest wanted a quick intervention...

RT. HON. PAUL MARTIN (PMO Canada): Fine, but very briefly because we do have to go on. I think Premier Calvert made the initial presentation.

I will let Premier Charest and then Premier Lord.

L'HON. JEAN CHAREST (QC) : Je suis content que vous rameniez la question de 1995, parce qu'il faut, je pense, vider cette question-là à la satisfaction de tout le monde. Je ne veux pas vous mettre sur la défensive là-dessus, mais va présenter les choses comme elles sont.

En 1995-96, vous avez pris des mesures pour équilibrer le budget fédéral et pour amener la situation à des surplus. Moi, je ne veux pas ré-écrire l'histoire à l'envers. Je ne veux pas tourner les pages de l'histoire à l'envers non plus.

Cela a eu un effet sur l'économie canadienne, il est vrai, mais ce qu'on doit également reconnaître, c'est qu'au moment où ces décisions-là ont été prises, d'abord, elles ont été prises unilatéralement.

Cela a eu un effet dramatique sur les budgets des autres gouvernements. Il y a eu des effets positifs. Il y a eu des effets négatifs aussi. Il y a eu les deux.

On ne demande pas aujourd'hui à quiconque de refaire l'histoire, mais tout ce qu'on veut, c'est qu'on reconnaisse qu'il y a eu deux types d'effets. Certains positifs et puis certains négatifs.

Puis, dans la colonne des effets qui ont été négatifs, il y un réseau de la santé au Québec qui a été affecté par ces

diminutions de financement et qui nous a forcé à faire un certain nombre de choix.

L'histoire nous dira plus tard, dans la balance des inconvénients, la justification ou, enfin, la justesse de ces choix-là, mais reconnaissons qu'il y eu des effets d'une part.

La deuxième chose que je veux vous rappeler, c'est qu'au moment où vous avez pris ces décisions-là, vous avez livré des discours du budget où vous avez dit à la population canadienne « Je change la formule de transfert aux gouvernements provinciaux et territoriaux. Je vais créer un fonds spécial. »

Et, à ce moment-là, Monsieur le Premier Ministre, vous étiez ministre des Finances et vous avez vanté la souplesse du système fédéral comme étant une justification pour la réduction des fonds.

Au moment où vous avez réduit les fonds, vous avez dit « Je réduis les fonds que je transfère aux provinces, et cela va être en reconnaissance du fait qu'ils sont compétents dans ces domaines-là et qu'ils auront une plus grande souplesse dans la façon dont ils devront allouer ces fonds-là dans leurs domaines de compétence.

Ce qui nous arrive aujourd'hui -- avec un peu de recul -- c'est qu'on revient aujourd'hui, le gouvernement fédéral veut réinjecter des fonds qui vont nous affecter dans notre domaine de compétence et là vous imposez des conditions.

Alors, pourquoi être souple au moment où vous coupez et imposer des conditions au moment où vous remettez de l'argent sur la table ?

LE TRÈS HON. PAUL MARTIN (PCO Canada) : Absolument. Est-ce qu'il y a eu un sacrifice de la part des Canadiens et des Canadiennes en 1995 ? Un énorme sacrifice. C'est pour cela que la victoire sur le déficit et les bénéfices d'aujourd'hui, c'est la victoire des Canadiens et des Canadiennes.

Alors, j'accepte absolument. On avait des choix difficiles à faire. On a pris ces choix-là et, lorsqu'on voit aujourd'hui que c'est le Canada qui sort victorieux de tout cela. Mais je comprends très bien, et je l'ai toujours dit, que cela a été difficile pour tout le monde.

Deuxièmement, au point de vue de la souplesse, je répète, on vous donne un financement à long terme pour le système de santé que vous livrez.

Maintenant, lorsque le Premier Ministre Williams ou le Premier Ministre McGuinty parle « Qu'est-ce que vous allez faire dans le cas des provinces qui ont des difficultés ? Qu'est-ce que vous allez faire lorsqu'il y a un embouteillage ? », et puis alors, en plus, en plus, pas pour remplacer, mais en plus de ces fonds à long terme, on dit « Oui. Si vous avez besoin des fonds ciblés pour utiliser tout à coup pour les délais d'attente, on va

les fournir. »

Mais vous parlez de souplesse, on ne vous dit pas comment. On ne vous dit pas que c'est très important pour le Québec et pour les autres provinces. Les délais d'attente, c'est votre objectif. Alors, on a un objectif en commun.

Si vous nous dites « Je vais l'utiliser pour les technologies de l'information », c'est votre choix. Si vous voulez faire -- « On va les utiliser pour », je ne le sais pas moi, « la formation des infirmiers et des infirmières », c'est votre choix.

Au point de vue souplesse, la façon d'arriver, c'est entièrement à vous de choisir.

Monsieur Lord.

HON. BERNARD LORD (NB): Merci beaucoup, Monsieur le Premier Ministre.

No one here around this table is suggesting by any means that the federal government should return to a deficit position. Nobody.

The reality, though, all of us around this table are facing those choices every day, every week, every month, every year to make sure that our provinces stay out of deficit. We simply cannot escape that reality, that to have a federation that is stable and solid we need on one hand, yes, to have a federal government that is in good fiscal health. I agree.

But we can't say it is okay if the federal government is in good fiscal health and provinces are not. Ultimately, we want to make sure that Canadians are in good health. For that, we have to make choices.

I am not suggesting, no one is suggesting that you should go back to deficit. When you put your energy and your focus and your determination to break the back of the deficit, you did so for a generation. You didn't want to do it for five years.

What we are suggesting today is, if we want to tackle the issue of wait times we need the same focus, the same energy, the same determination. Let's do it for a generation, not just for five years.

RT. HON. PAUL MARTIN (PMO Canada): Let me just reply and then I am going to give it to Premier Calvert to basically sum up of the discussion.

Let me just say, Premier Lord, and really to the others, the way in which you have just put it in terms of let's do it for a generation, Premier Lord, I very much agree with. I also very, very much agree with the necessity of long-term financing.

The wait lists issue, you are not working on this -- and I have said this from the beginning. You are working on this because you want to work on this. Our long-term funding is a substantial part of our contribution to what you want to work on,

which in this particular case is in fact wait times, I think as Premier Charest has pointed out.

So it isn't that we are not providing long-term funding for wait times. It is we are providing long-term funding and the funding that we want to put in front of you in terms of the Romanow gap or in terms of equalization, that is designed to help you in those areas where you have a long-term view. And I agree with you very much in terms of wait times, the need to deal with wait times.

The purpose of a transition fund is simply because there is an immediate problem, like backlogs; or as Premier Williams has said, there is an immediate problems that some provinces have and can we help out; or as Premier McGuinty said, what are you going to say when somebody is having a bit of difficulty with this and maybe needs an extra shot to clear up backlogs or whatever it is.

Premier Lord, I have to tell you and I say this to all of the Premiers here, that there really is incredible agreement among us. Fundamentally, what is happening is that this is an analogy to medicare. Medicare was something that started in the provinces. In fact, health care started in the province of the Premier who was about to speak, and then it was taken nationally. I think that what you are seeing in terms of the discussion on wait lists is wait lists is something you have been working on and what we are now saying is: How do we do it? Are there ways we can do it together?

Forgive me for saying this, but I really don't think we differ much on this. In fact, I have got to say if we argue -- it is understandable why people think we argue and we disagree if we argue this much when we agree.

Premier Calvert.

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

I will try to summarize our discussion, if I can. I note I think six points in the discussion or thereabouts.

The first is where you just finished. There is I think a sense of a commonality among all of us to deal with the waiting list issues.

We know today, as has been identified at the discussion, that this is not an issue just for today but for the future. We have talked about the demographics and we have talked about the changing technologies that will provide new opportunities. So we know it is not simply an issue for today but for the future, and we have a common desire to work towards it.

Second, I think identified in the discussion this morning importantly was that we would all not want to set inappropriate expectations in terms of our ability. The Premier of Quebec was very helpful in describing for us the need to ensure we differentiate between wait times and wait lists and not to create

expectations that are beyond what can be met.

Third, I think there has been a real sense at the table this morning of the need for us to share best practice. When we in our own unique and individual jurisdictions find practices that work, there is real benefit in sharing those practices equally. We have identified the uniqueness of our own circumstance, the uniqueness of our need to deliver for those circumstances and you have recognized that as well.

I think an important discussion has been held here, too, about the importance both of seeking process and administrative efficiencies, the surgical registries and that sort of thing, and the real importance of the human resource factor in dealing with the waiting lists. That has been addressed by a number.

An early point that was made by Premier Binns that I think should receive even greater attention is the need to deal with the waiting list circumstance by dealing with preventive health and keeping people from the waiting list. I have often made the argument you can spend $5,000 or $15,000 on replacing or mending a broken hip or $15 on a hand rail that would have prevented the break of the hip. There is much that we I think can do to shorten the waiting list from the other end.

Then finally the discussion that is a very significant discussion, obviously. Prime Minister, you have laid before us a plan that contains substantive dollars through which you would hope that we could "break the back" of this issue. I don't think there is anyone in the room that does not seek immediate action and we appreciate that intention. We as Premiers point out that at the end of the program there will be continuing need, and we argue for the ongoing funding.

As you have concluded, Prime Minister, when we formed national medicare it began provincially and we debated it nationally, and one of the issues of the debate was the financing that was an issue of debate. No surprise that we would be debating this matter this morning.

We have some work to do. I think we have some work to do. You want the problem addressed and you want it addressed quickly. We want the problem addressed. We want it addressed both quickly, and in the long term we have some work to do around this package of resources. There is a substantial level of agreement here, and I think before the close of this conference we can do that kind of work and meet your agenda and meet what we know are the real needs of health care in the long term.

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

It is now 11:05. I would ask that we be back here by 11:15, take 10 minutes and come back.

Thank you.

--- Upon recessing at 1105 / Suspension à 1105
--- Upon resuming at 1133 / Reprise à 1133

RT. HON. PAUL MARTIN (PMO Canada): Can we call the meeting to order?

Avant de demander au premier ministre Charest, suivi par le ministre Gary Mar, de vous adresser sur la question des ressources humaines, j'aimerais simplement faire une petite intervention.

Apparently during the course of the last session, just after Premier Doer had finished making a comment, I was handed a note, which I read, and I said something inappropriate. I want to say that it had nothing to do with Premier Doer. It had totally to do with the contents of a note that was given to me by one of my staff.

But there is a second reason that I raise this and that is that as some of you may know, I have two aunts who live in Pembroke and during the break one of my aunts called me. She saw the break and she called me and essentially pointed out that I had used inappropriate language and suggested a bar of soap. I pointed out to her this is a tough meeting and that I needed all the help I could get. But I also want to apologize to anybody who might have taken offence at what I said. I most sincerely do and I apologize to my aunt.

HON. GARY DOER (MB): Prime Minister, hopefully the note from your federal official said "he's right", and that is why you were swearing. I can handle it. It is okay.

RT. HON. PAUL MARTIN (PMO Canada): That will promote another remark.

HON. GARY DOER (MB): You will notice they have changed federal officials since we came back.

RT. HON. PAUL MARTIN (PMO Canada): Well done.

I would now like to call on Premier Charest, followed by Minister Mar on health human resources.

L'HON. JEAN CHAREST (QC) : On va aller à monsieur Mar d'abord, Monsieur le Premier Ministre.

LE TRÈS HON. PAUL MARTIN : Très bien.

Minister Mar. Welcome to the meeting, Minister.

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

Prime Minister, this is my fifth year of being the Minister of Health and Wellness for the Province of Alberta, and I wish to start by reiterating the observation made by Premier Hamm earlier on in one of his interventions where he talked about the fact that there has been no time during my tenure in this portfolio that Premiers have been so well versed on the subject of health care. So I invite you to take advantage of the body of knowledge and the interventions that are being made by Premiers on these subjects today.

Premier Charest talked earlier today about 80 per cent of his health care budget being spent on health human resources. I heard a number of other Premiers, Premier Campbell, Premier Handley and others, talk about how wait lists are very much a part of many of the issues that we are going to discuss in our agenda, including the matter of health human resources.

Prime Minister, like the rest of the country, the Province of Alberta listened very carefully to your opening comments yesterday and I would like to quote something that you said. "Few would dispute the prevailing realities of our time. People

> in this country are increasingly anxious about their ability to get into see the right health care professional at the right time."

On behalf of Alberta's Premier and all jurisdictions, I offer a few other realities for your consideration regarding health professionals in Canada.

Reality: The country is losing an average of 3.5 per cent of our physicians every year due to retirement, immigration or simply leaving the practice of medicine out of frustration. By 2021, we will have 1.4 physicians per thousand Canadians, and that is almost 25 per cent fewer than the recommended minimum of 1.9 physicians per thousand.

All of this comes from the Canadian Medical Forum Task Force on Physicians, and already we see confirmation of these numbers. Statistics Canada reports that more than one in ten Canadians does not have a family physician.

Another reality: The Canadian Institute of Health Information predicts that almost 30,000 nurses, 13 per cent, will reach the age of 65 by the year 2006, but early retirement could end up claiming as many as 64,000 of those nurses.

More than a year ago the federal government promised $85 million for a national planning framework to forecast the supply and demand for health professionals and yesterday, Prime Minister, you reaffirmed that commitment. But surely those forecasts already exist. I just quoted from some of them.

Yesterday, Prime Minister, you also said there was no time to lose when it comes to training. We agree with you.

But instead of creating a high-priced national forecasting agency, we actually need to just get on with the job. Provinces and territories already are doing so.

We heard yesterday from a number of Premiers on how their jurisdictions are responding with innovative and cooperative solutions on three fronts: First, we are increasing the supply of our workers with more training spaces and increased hiring. Second, we are making better use of our workers by expanding scopes of practice, making innovative use of technology and supporting team delivery like primary care. Third, we are

working to reduce the future demand for services through the use of innovative technologies, better disease management and, of course, wellness programs.

For example, I am sure that every jurisdiction would welcome meaningful support for health career training. Yesterday many Premiers talked about increasing their training spaces, and I can tell you in the province of Alberta, we have currently 8,500 fulltime equivalent students just in medicine and nursing. That is an increase of more than 1,600 in just the last four years. In comparison, Prime Minister, you committed funds to train 1,000 primary care providers for the entire country.

Prime Minister, you confirmed your government's responsibility to our Aboriginal communities, including providing more doctors and nurses. A good place to start would be support for provincial programs that support Aboriginal health career training.

We also look beyond our borders for health professionals, and I want to acknowledge the federal government's support for the provincial nominee program, that fast tracks foreign health workers.

However, as we work to assure our future supply of health workers all jurisdictions and professional colleges are working together to make better use of the professionals that we already have today.

Yesterday a number of Premiers talked about their reliance on nurse practitioners and expanding primary care. Many talked about technology solutions like tele-health that give rural physicians and patients the specialist advice and clinical support that they require.

Many of us are expanding scopes of practice for health professionals so that they can work in new ways and to the fullest extent of their training.

Health care used to be a visit to a doctor's office. Today, there are new strategies that are redefining how our health care professionals work and how Canadians will access care from the right professional at the right time, as you said. This is vitally important, Prime Minister, because reducing wait times is intensely dependent upon an appropriate workforce. Training, changing scopes of practice, implementing new delivery methods, even hiring or importing new workers does take time. It takes many years for a new doctor to start their practice. It takes years for nurses to graduate and pharmacists, technicians, therapists. This is not something that can be done quickly.

With the money that is on the table, it cannot be done. The proposed wait list fund of $4 billion over five years is not enough to hire and train the MRI technicians, the radiologists to read the scans, or the specialized surgeons, nurses and care

providers to perform the requisite surgeries to reduce wait times.

There is nothing in the current offer to train or hire the caregivers to provide home care, and position provinces as first paired.

The reality is we only have a few years left to prepare for the loss of retirement age workers and a corresponding increased demand for health services from baby boomers for things like hips and heart surgeries.

Provinces and territories are doing what we can with the resources that we have. Taking further action requires a federal commitment that makes a real difference to our health workforce.

Prime Minister, words are cold. Deeds are hot. Provinces and territories want to help the federal government turn your words into deeds.

Thank you, Prime Minister.

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

Monsieur le Premier Ministre Charest.

L'HON. JEAN CHAREST (QC) : Merci, Monsieur le Premier Ministre.

Tout d'abord, d'entrée de jeu, je vous dirais que la question des ressources humaines, c'est l'enjeu et le problème, le défi le plus important du réseau de santé québécois. Déjà, la santé, c'est notre première priorité, et puis, à l'intérieur de cette priorité, c'est la question des ressources humaines qui est pour nous le défi le plus important.

Pourquoi ? Il y a plusieurs raisons pour cela, mais je veux, pour mettre encore une fois en contexte, rappeler, comme Gary Mar vient de le faire, que 80 pour cent de nos dépenses dans le réseau de la santé, c'est la rémunération de tous ceux qui y contribuent.

Évidemment, les infirmières, les médecins, mais aussi -- il ne faut pas oublier -- les technologues, qui jouent un rôle extrêmement important, les pharmaciens, par exemple, les administrateurs, qu'on a tendance qu'on a tendance à, dont on sous-évalue l'importance, parce que les administrateurs jouent un rôle extrêmement important dans la performance ou l'organisation de tout ce réseau de la santé, le personnel de soutien.

Enfin, tous ces gens-là qui -- profitons de l'occasion pour le dire -- qui, dans un contexte de réorganisation et de pénurie, ont tenu le système de santé littéralement à bout de bras.

S'il y a des gens à qui on doit beaucoup aujourd'hui, c'est ces hommes et ces femmes qui ont été héroïques dans certaines circonstances pour s'assurer qu'on pouvait livrer des services de soins de santé.

Et, dans toutes les recherches d'opinion publique, c'est intéressant de noter qu'il y avait des problèmes d'accès. Mais

pour tous ceux qui ont été dans le réseau de la santé -- en tous cas, je peux vous dire, chez nous, à chaque fois, à chaque fois, ils sont impressionnés par le niveau de dévouement des personnes qui travaillent à l'intérieur du réseau.

On a un enjeu qui nous affecte chez nous, mais qui nous affecte aussi sur le plan mondial -- il faut aussi le dire et puis le reconnaître parce que, si c'est vrai qu'il y a au Canada, au Québec -- et puis je reviendrai au problème à l'intérieur des juridictions que nous vivons -- s'il est vrai qu'il y a des problèmes chez nous, ne perdons pas de vue que c'est vrai en France, c'est vrai ailleurs, c'est vrai en Grande-Bretagne, dans les pays développés entre autres.

Je vais vous raconter une anecdote. J'étais en France dans la période où j'étais dans l'opposition. Je rencontrais des experts, un expert entre autres de l'Hôpital Georges Pompidou, qui me racontait que, eux, en France, tentaient de recruter des infirmières en Espagne. Je lui ai dit « Cela tombe bien, nous, on essaie de recruter des infirmières en France. » Là, on s'est posé la question tous les deux « L'Espagne recrutent où leurs infirmières, eux ?

De fil en aiguille, on voit bien qu'il y a là un enjeu qui affecte l'ensemble des pays développés en tous cas, mais qui est encore plus aigü chez nous.

D'abord parce que nous avons une pénurie, il est vrai, à travers tout le Canada, de médecins, d'infirmières et de pharmaciens chez nous, de technologues et de, par exemple, d'orthophonistes, qui sont en lien avec le réseau de la santé, de gens qui font de la formation.

Alors, cela crée un problème très aigü, mais en plus il faut se méfier des statistiques. Je vais vous donner un exemple très ponctuel, très actuel.

Dans la salle, moi, je connais quatre médecins à vue d'oeil : John Hamm, le Premier Ministre de la Nouvelle-Écosse, madame Bennett, qui est ministre dans votre gouvernement est médecin, il y a derrière moi Robert Iglesias qui est le sous-ministre à la Santé dans le gouvernement du Québec et Philippe Couillard, qui est le ministre de la Santé du Québec, qui est également neurochirurgien.

Hors, dans les statistiques de leurs ordres professionnels respectifs, je suis convaincu qu'ils sont tous inscrits. Vous êtes probablement inscrite Madame Bennett. On vous présente comme étant statistiquement une médecin active, alors que vous avez autre chose à faire.

Et on vous en remercie parce que vous savez à quel point c'est difficile recruter des gens à la politique. Quand on a l'occasion d'avoir la contribution de quelqu'un qui vient de la professions médicale, on sait que c'est un choix déchirant pour

eux parce qu'ils sont attachés à leur profession, mais ils font une contribution inestimable.

Mais les statistiques nous font dire que ces gens-là sont dans le réseau et ils ne le sont pas. Alors, petit bémol sur les statistiques. Ce qu'on sait, c'est qu'au Québec, il y a 1,9 médecin par 1 000 habitants -- moi, je vous donne des chiffres de 2003 -- tandis qu'en France, où j'ai été en visite, c'est environ trois médecins, d'où la différence.

Alors, bien au-delà des enjeux de réseau -- système public, privé, mixte et caisse par rapport au système national -- l'enjeu des ressources humaines, c'est l'enjeu le plus important.

Cela se décline à deux niveaux.

D'abord, il y a une pénurie générale, mais il y a pire que cela, et mes collègues des territoires le savent très bien, à l'intérieur de nos territoires respectifs, il y a des pénuries qui sont multipliées plusieurs fois par le phénomène de l'éloignement, et les collègues des territoires le vivent de façon probablement plus aigue que tous les autres autour de la table. Moi, je peux vous dire qu'au Québec, c'est un problème important.

On a fait quoi pour tenter de régler ce problème-là, et là, j'ouvre une parenthèse québécoise parce qu'il y a chez nous une situation unique.

Il y a eu, malheureusement, chez nous, un programme de mise à la retraite de 1 500 médecins, qui ont été payés pour arrêter de pratiquer la médecine dans un contexte d'austérité budgétaire et la mise à la retraite de plus de 4 000 infirmiers et infirmières, qui ont été payés pour arrêter de pratiquer la médecine également, leur profession, et des technologues à la retraites et pharmaciens, etc.

Cela veut donc dire que chez nous le problème a été multiplié plusieurs fois au Québec, et c'est malheureux. C'est comme cela.

On me dit qu'il y a eu des programmes plus modestes ailleurs, mais en tous cas, chez nous, cela vous donne un indice de l'ordre de grandeur du problème que nous avons.

On a agit à quatre niveaux, nous, pour tenter de régler ce problème-là, tout en sachant que l'on parle de long terme. On ne se raconte pas d'histoire. Un étudiant dans une faculté de médecine qui arrice cette année va pouvoir aider ses concitoyens dans plusieurs années d'ici malheureusement.

On a augmenté le nombre d'inscriptions dans les facultés de médecine. On a fait passer cela de 406 en 1998-99 à 716 cette année. Chez nous, en passant, on a vécu un double phénomène. On a mis à la retraite et puis, en même temps, le gouvernement de l'époque a réduit les inscriptions dans les facultés de médecine et dans les programmes de sciences infirmières.

En passant, Gary Doer a fait une remarque qui était très éclairante il y a une heure, quand il a dit « Les experts qui nous ont conseillés à l'époque, ils sont rendus où aujourd'hui ? » Les mêmes experts, il faut -- c'est pour cela que notre jugement à nous ultimement doit être éclairé par ce qui se passe sur le terrain.

Alors, pour rehausser le niveau général, nous avons posé des gestes pour inscrire un plus grand nombre de médecins et je vous parlerai de mesures spécifiques qu'on a fait pour cela aussi.

Mais on a également créé Recrutement santé Québec, qui est une instance de concertation pour tous les acteurs du réseau, dans le but d'aller chercher à l'extérieur. On travaille avec le Collège des médecins, le ministère des Relations avec les citoyens, les ordres professionnels. On a fait une chose qui est très utile chez nous.

On a fait des ateliers préparatoires pour aider les gens à l'étranger à mieux réussir leurs examens du Collège des médecins avec un taux de succès plus élevé. En cela, nous répondons aussi aux gens qui viennent de l'extérieur, qui arrivent chez nous et qui sentent que l'accueil n'est pas toujours au niveau où il devrait non plus se situer compte tenu de nos besoins.

Nous avons un problème de frais que le gouvernement fédéral peut peut-être aider parce que les permis et les frais pour obtenir des permis restrictifs et permis réguliers sont très élevés. Il y a peut-être des choses que vous pourriez faire à ce niveau-là.

L'autre niveau, c'est à l'intérieur du Québec. Alors là, on a des régions qui ont des problèmes très importants. Un exemple que j'ai cité hier, c'est la Mauricie. En Mauricie, c'est une des régions au Québec où la pénurie est la plus aigü.

Pour y répondre, nous, on a créé une faculté de médecine à l'Université du Québec à Trois-Rivières, satellite de l'Université de Montréal. Cela va nous permettre d'introduire dès le début de leur formation des jeunes hommes, des jeunes femmes, qui vont, si la vie suit son cours normal, peut-être s'installer à quelque part. Vous savez, c'est banal, mais ils rencontrent quelqu'un d'autre. On tombe en amour. On s'installe. Finalement, on essaie de créer un environnement favorable à des régions qui vont avoir besoin et qui ont besoin de médecins.

On a négocié, je dois dire, avec un certain succès -- je veux le souligner parce qu'avec les médecins spécialistes et omnipraticiens au Québec, qui ont travaillé en étroite collaboration avec monsieur Couillard -- négocié des ententes pour ce qu'on appelle des plans régionaux d'effectifs médicaux.

C'est quoi, cela ? C'est des ententes signées, conclues, avec ces organismes, les spécialistes et les omnipraticiens, pour qu'on puisse répartir un plus grand nombre de médecins dans les

régions éloignées.

RT. HON. PAUL MARTIN (PMO Canada) : Merci, Premier Ministre.

I have Premier Hamm, then Premier Doer and, then, Premier Binns.

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

There is probably no area in which we can better benefit from cooperation across the country than it is on the human resource issues. We all draw from the same pool of people. If the pool isn't big enough, then, clearly, we are all going to suffer.

We have a nursing strategy in Nova Scotia that the President of the Nova Scotia Nurses' Union likes to describe as "a strategy by nurses, for nurses" and it has been very successful.

I would like to acknowledge that the President of the NSNU is in the audience here today, Janet Hazelton, and she has been, in addition to a very effective nursing union president, a tireless worker for improvements in the health care delivery system.

Our nursing strategy, that Janet talks about, has been successful and in the last two years we have 130 more nurses registered, 136 more working. We still have deficiencies, but we have a number of support programs, which all became necessary because of the ill-conceived human resources policies on health care of the early '90s in Nova Scotia.

But our strategy is working. I believe it is working because there was so much input from the profession. We have increased training seats, supports for reentry, we have had good relocation support and we have had over 100 nurses return to Nova Scotia, nurses who felt they were being driven out because of the situation in the mid-'90s.

I think there is an issue in human resources. I will make brief reference to it because I talked with two of our nursing leaders outside the hall here on my way over here this morning, talking about workplace morale issues. It is a real issue, Prime Minister. Some of the working conditions that exist in the health care delivery system have resulted in workplace issues that I am hoping that the solution that we come here -- that we devise here in our meetings here this week will address. So, the nursing strategy by nurses is one that has worked for us.

I would like to make brief reference to the doctor strategy. A recent survey in Canada indicated that a higher percentage of Nova Scotians have access to a primary care physician than any other population in Canada. Despite that we have a problem. And I only bring that up because if we are the best, then I would sure hate to be the worst.

We have provided supports in the medical school, new seats, bursaries and so on and other incentives for physicians.

There are specific challenges within the profession, in the area of psychiatry, for example, in the area of anaesthesiology, in the areas of otolaryngology. I think we have to look at some specific programs because the deficiencies are not spread uniformly across the professions of medicine.

There is another point that is made by our approach to a training program for medical laboratory technologists. As I travelled around the province, I began to understand that a very high percentage of our technologists would be leaving the profession in well less than 10 years and we have cooperated on a training program with New Brunswick. Our demands and their demands are just barely large enough to support a single training opportunity in each province.

So we are combining our resources and there is a combined program with the New Brunswick and the Nova Scotia community colleges, along with our Department of Health, to provide specific training opportunities for 25 medical technologists.

So I think cooperation, this is an area in which we are cooperating with New Brunswick and I think we are going to have some good results.

I'm glad that the Premier of Quebec mentioned speech pathologists because that is a sore point in Nova Scotia as well. We have a two year waiting list for preschoolers who are diagnosed with speech pathology issues before they see a speech pathologist. It is one of the waiting times that I hope to address in the very near future.

So I think, bringing it up here to allow all of us to hear what is going on in the other provinces is a very, very unique opportunity.

But, Prime Minister, I think there is a strong role here for the federal government to look at the overall human resource issues because -- I almost hesitate to talk about the success we have had with our nursing strategy. I'm afraid that I'm going to have recruiters from other provinces come to Nova Scotia next week.

But, on the other hand, we have to encourage a country-wide solution for all of the human resource issues that are troubling the health care delivery system as we speak.

Thank you.

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

Premier Doer.

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

I concur with the presentation from Premier Charest and Gary Mar on the demographics and some of the comments made by Premier Hamm.

There is no question that none of us are investing on the education and training file dramatically -- it is not even in our

health care budgets, it is in our education and training budgets -- to deal with the real demographic challenges that we have on the human resource side.

I would like to thank our nurses' union for allowing us to reinstate the RN training program. The BN program we had and an LPN program. We now have a set of skills that we can utilize and it was crucial to have nurses on the front line help us reinstate that.

Yesterday, I talked about the desire to have training programs for Aboriginal nurses. We are willing to join you yesterday on a training program for that. The francophone medical services that we have with Sherbrooke and St. Boniface is another program we are willing to participate in as part of our Canadian vision. We have increased the enrolments in all these areas, like other Premiers.

We talked behind closed doors the other day at 24 Sussex about the whole issue of foreign accreditation and doctors. I just want to say that I totally agree with your sentiment about there are too many qualified people from other lands that might be driving cabs when families don't have enough doctors.

We have brought in a program -- the doctors who already have accreditation through the colleges are easy to deal with, but the ones who don't have the natural accreditation but have the knowledge, the skills, the training, are the challenges. We are now mentoring a doctor with a -- or a potential doctor, immigrant doctor with a family doctor in Manitoba.

We pay a part of their salary, resident fee for the new potential doctor, and we pay the family doctor to help mentor that person up to getting the test. After a year, they can get the test and challenge for their medical degree, but I just want to say that it is a good program. We graduate 10 immigrant doctors a year into full qualified licensed doctors, but it costs us about $100,000 per person because of the kind of work that the family doctor has to provide and the cost of allowing a person to come off their regular occupation to go and be a resident to get their doctor's degree.

So the program you have announced is a good one, and if there are any ideas from the rest of the country that you talked about sharing a national vision on this, we would support that. It is a good idea. It is a good program. It is expensive in the short term, but it really will pay off and we are willing to cooperate with your ideas on that.

RT. HON. PAUL MARTIN (PMO Canada): If I just might, picking up on that, if any of the Premiers have a view either on what is happening in Manitoba in terms of the accreditation of foreign trained doctors or if there is anything we could do nationally in fact to accelerate the process and make it possible, I think that

it would be a very, very worthwhile area for us to discuss and I would be very, very open to it. In fact, as you know, we do have a specific program but it is one we all have to work on.

Premier Binns.

HON. PATRICK G. BINNS (PE): Thank you very much, Prime Minister. I will pick up on that comment from Premier Doer and yourself.

To me, health human resources, particularly for doctors and nurses, has not just been a money issue. It is one of those where there are many other factors. I would have to say we have really never held back money to recruit doctors or nurses and yet we still have selective shortages.

We do have more doctors, nurses in our province than we ever had, but we have communities, hospitals that are short specific numbers of physicians.

You know, the question is: Why does that happen? Money is not the issue. Some of the answers have been given. It is the difficulty in recruitment, partially because we didn't have enough seats in our colleges.

It is also, I think, there is a need to try to streamline the consideration of foreign trained doctors who are already in the country. I'm not talking about stealing from other countries. These people made a decision to come to Canada. They want to live in Canada. They are somewhere in this country and, as has been said, they might be selling cars or mopping floors, but obviously they are not being put to their best use.

Now, I can understand the College of Physicians and others who will say, "But we have to make sure they were trained with the right technology so that when they get in the hospital or in a pressure situation they will do the right thing."

That is why I want to say that we have been trying to work on that to find a way so that we can evaluate whether in fact these foreign doctors who are living in this country can work in our environment. So we are working on a stepped approach where they spend time with a number of existing physicians in different hospital settings, et cetera, and over a period of months evaluate their credentials so that we can get them into the mainstream, if they in fact have those credentials, or they might have to pick up some extra skills and then we try and do that.

I want to emphasize, you know, that we around this table cannot fix that ourselves. We really do need the help of our College of Physicians and so on. They have to help us streamline this process and make it work.

I have a personal view -- and I will probably get in trouble for saying this -- I think sometimes they have been too tough on allowing people through the system.

I also want to touch briefly on the primary health care

centre direction that we have been going. I think this is a great model in many ways.

What we have done primarily, and with your cooperation, your assistance, is establish primary health care centres where the doctors are on a salary basis, not on the old fee-for-service model.

Of course, the whole idea of the primary health care centre was to lessen the load on the doctors. We would need less doctors if they are able to see the patient the first time, have the nurse pick up on the needs the next time, or it might be the social worker or the dietitian or the occupational therapist. This will have an impact on the long term.

But this needs evaluation and constant consideration as well. I know it is working great for the grad who comes out of college and doesn't want to go into a fee-for-service environment. They don't want the old model where you work 120 hours a week and never see your family and that sort of thing. So this works great. You earn a salary, you work 40 hours a week, or whatever it is.

But the problem we are experiencing, and I think we have to be aware of this as a potential problem, is that the public is expecting to see the doctor maybe more often than they are able to through this new system.

Let me explain it another way. I know of a doctor who was making over a quarter of a million dollars on a fee-for-service basis. He is now working in a primary health care centre on salary. If we determined how much money he would have made under the primary health care centre in a year, he would have made $30,000. Obviously, he was not seeing as many patients.

Question. He may well be seeing all he should be seeing, I don't know, but he is obviously spending -- if he is in the office he is spending a lot more time with each patient. Does that mean he is spinning them off to the occupational therapist or the other health care provider adequately? Perhaps, but maybe not.

I guess my point is, this is going to take a lot of evaluation, a lot of cooperation. It is going to take, I think, a concerted national approach to make these things work.

So in these two areas, on recruitment, streamlining the consideration of foreign trained doctors and looking at primary health care centres, we will have a lot of work to do.

HON. PAUL OKALIK (NU): Thank you, Prime Minister. I also want to comment on human resources for our territory.

As you are well aware, our territory's significant population doesn't speak either English or French so we have a special challenge in delivering health care. So what we have done in order to deliver basic health care for the interim is

hire agency nurses and Australian nurses to meet the basic health care needs of the territory and provide interpreters.

But what we have been trying to do since we were created in 1999 is train all nurses, Inuit nurses that can deliver basic health care to the majority of the population. We have been doing that and invested significantly and pay about a million a year to keep that training program going. We have finally graduated two Inuit nurses this year.

When we were first starting it, we asked for some federal support. Unfortunately, it wasn't forthcoming. So even though it is a federal area, we felt that -- to deliver basic health care and to train Inuit nurses, Aboriginal nurses, we felt that it was a wise investment.

We are very pleased that the federal government is finally coming through with some training money, but we still await the details of how we can access money for training for more Inuit nurses in the territory so we can train more nurses and create more stability in the communities to deliver basic health care, although like the majority of our communities are just provided with nurses to deliver basic health care, just like the NWT.

Thank you.

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

Premier Calvert.

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

Beyond what we all face, which is oftentimes shortages, and with the demographics we know there are going to be future shortages and the needs for specialists and physicians, beyond that I know that today in Saskatchewan there are 35,000, or thereabouts, men and women going to work working to provide health care services for Saskatchewan people.

While we too are looking at recruitment and training of new, I do not want us to miss the opportunity to think about those who are today providing health care, and how we retain those people in the provision of health care.

Retention is equally important in health human resources, in my view. In terms of retention, this very quickly I think should take us to a discussion about the health care workplace and building that healthy workplace for the health care provider. It could, I think, well be argued that some of our health care workplaces these days are not all that healthy for the health care worker.

When I look at our own circumstance, we have fairly significant levels of workers' compensation claims coming from health institutions. Our health care worker health plans are under stress. We have, in our system, significant levels of overtime and sick time and, as Premier Hamm has pointed out in his comments, I think in our conversations with health care

providers we are hearing the issues of morale in the workplace.

This, I believe, equally deserves our attention as we seek to recruit and train the new. I think we need to think about the workplace that exists for those who today are providing the services. Some of this of course will have to do with remuneration and salary and all of those issues, but it is my view that it is not all money either. It has to do with management style, it has to do with the health care providers' ability to be part of the decision-making. Many of our health care providers are women. Family friendly workplaces are very significant, in my view, in health particularly.

So there is a range of issues here that if there are resources that we can apply to the areas of health providers I think we need to think about some of those resources being available to make the existing workplace a healthy place, and that we should not in all of our discussion about -- and appropriate discussion about recruitment and training -- neglect the retention question of those who today provide the services to Canadians.

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

I would ask Premier Williams.

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

Again, in the interests of time, I will try to be brief. I know we are a little bit behind on the agenda and running a little bit late.

From Newfoundland and Labrador's perspective, health human resources is a huge issue. It represents 70 per cent of our health care budget. I don't know how that compares around the table, but it is a big number and a big factor.

Fortunately, we are blessed with very competent health care professionals in our province, who deliver tremendous services to our residents. I have been a beneficiary myself. I had back surgery last year and I think I have fully recovered. And, as I said yesterday, my grandson is a good example. Four members of my family are cancer survivors as a result of the quality of care they have received. So I am very proud of it and, from a personal perspective, very grateful.

There is good news. I am not here to talk about bad news. We have good news. On a statistical basis, in Newfoundland and Labrador, we are fractionally better than the national average. We have 188 physicians per 100,000, as opposed to 187, which is the national average. I am delighted to say that and that is a good news story.

We do have to deliver services over a larger geographic area. As I said yesterday, we have 700 communities along 18,000 kilometres of coastline. So that is a problem which, I guess, creates inefficiencies in economies of scale, and delivery, as

well. But despite that, we are above the national average. We do have a significant number of international physicians that come to the province, but with some of the international physicians that come, then, they move on.

Our retention rate and our churn rate is high. It is about 8.5 per cent. Which means that over the course of a decade, we basically turn over 100 per cent, technically, of our physicians. So that is certainly an issue.

We have a first-class medical school which provides us with quality graduates. A lot of Newfoundlanders and Labradorians are graduates. Fortunately, Newfoundlanders and Labradorians are homing pigeons. We stay home because we like home and we recognize that the best kept secrets in the world is we have the best place in the world to live, in my opinion -- and I am entitled to that one here today.

So as a result, we do retain a lot of our own graduates. The problem with churn, though, is, of course, that it creates some instability in the community, and that, as doctors come in and move on -- you know, people get a personal relationship and a reliance on the physician, so that creates some personal turmoil and some angst for the people that live in these communities.

Overall, we do -- we are on notice, as I said this morning, though, of an issue, an issue which is a national issue and the weather office at the NLMA has told us that we do have a perfect storm coming, that there is a problem. There is the aging workforce. There is the get-a-lifers, people who are now in the professions who want to have a reasonable lifestyle. They don't want to have to put 18 hours a day into their profession, and I applaud them for that. We have all been there. We know what it is like.

As well, the compensation issue is an issue. And that doesn't just apply to doctors, that applies to nurses and applies to a lot of health care professionals. So that is that storm that is a pending problem that we face. And as long as we realize it and as long as we work on it, then, hopefully, we can deal with it.

My challenge in my province, of course, is to compensate these very competent people appropriately, given the financial situation that I do have in my province. As you are aware, we went through a two-year wage freeze for public servants, which, of course, is -- our nurses have now put off their negotiations for some period of time, but I can tell you that during April, when we went through that negotiation, I felt the storm had arrived and I was out in a category five in my shorts outside trying to withstand it.

But Newfoundlanders and Labradorians don't evacuate when the perfect storm comes or when the perfect storm hits. We batten

down the hatches and we try to deal with it and we look for the cooperation of our health care professionals. But it is not difficult. We are in a difficult role, as premiers and leaders, in this country when we do have limited financial resources. I know, certainly, Premier Lord has been through it and other premiers around this table. It is not nice. It is not nice when we had to do that. But, you know, we thank our health care professionals for their cooperation, for their understanding and for the quality of service that they give to Newfoundlanders and Labradorians and to Canadians.

And Premier Calvert's point is not lost that we have to recognize what they provide and the circumstances and conditions in which they work, and that is all part of the whole retention issue.

So thank you. Thank you for the time, Prime Minister.

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

I have Premier Lord, Premier Charest wants to make a brief intervention, then Premier McGuinty and, then, Premier Campbell with your -- unless somebody wants to come in. Because we do want to close as close to 12:30, I will end after Premier Campbell, if that is -- Premier Fentie, okay, and then we will go.

Premier Lord.

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

It is obvious, from listening to what is being said around the table here, that health human resources are a top priority for all of us, that we cannot provide the care in the health care without having the people that provide the care. That is where the care comes from, of course.

Last week, leading up to this meeting, I brought to a public meeting all health care providers and groups and representatives to a meeting to get their point of view as to what we needed to do and where we were going and to get their advice on this meeting.

Lorsque j'ai été élu en 1999, nous avons reconnu, dès le début de notre mandat, l'importance de s'attaquer immédiatement à la question des ressources humaines dans le domaine des soins de santé. Nous avons fait un progrès énorme depuis les cinq dernières années.

Nous avons plus de médecins, plus d'infirmières que nous n'en avons jamais eu dans l'histoire de la province du Nouveau-Brunswick. Cela est venu avec des investissements précis.

Mais d'un autre côté, nous avons fait des investissements, il y a cinq ans, entre autres au niveau de la formation de médecins dont on commence maintenant à voir les résultats. Cela prend du temps de planifier ces choses-là. Nous avons commencé il

y a cinq ans et nous commençons à récolter les bénéfices.

In the last few years, we have also undertaken significant reviews of our needs. We had an independent analysis done for us that indicated, of the top 10 professional groups that we need in health care, we will have a shortage by 2007. So we have adopted some strategies to deal with that looming situation.

We are training more than before. We are paying them more than before. We are improving their working conditions compared to before. We recruit more than before in Quebec and Nova Scotia. Unfortunately, Ontario and Alberta and others come and recruit in New Brunswick, so it is a vicious circle.

We also need to not only increase but we need to better manage our human resources and make sure that we have the right professional providing the right care at the right time in the right place. We have changed the scope of practice of some. We have brought in new professionals, nurse practitioners, that did not exist before in the province of New Brunswick. These are real initiatives that we have undertaken to deal with this crisis. And we are making progress, but we know there are still some challenges ahead. All these things, unfortunately, cost money.

We would like to talk about these things and not think they cost money. I just finished negotiations with nurses a few -- well, it was last week, and at the table they were asking me for money. Yes, that is what they were looking for. We know that we needed to pay them more to be able to keep the nurses that the people of New Brunswick wanted and that they provide the care to the people.

Donc lorsque nous disons clairement que nous voulons attaquer ces questions-là, nous devons le faire ensemble. Le Nouveau-Brunswick a adopté des stratégies avec d'autres partenaires. Nos médecins francophones sont formés au Québec. Il y a des médecins francophones du Québec qui viennent faire des stages au Nouveau-Brunswick.

Our English doctors are trained in Newfoundland, Nova Scotia and some in Ontario and many of them have training done, internship, in New Brunswick. It is the type of partnership that we need. It is the strength of a federation.

Nous allons continuer à travailler avec nos collègues pour nous assurer que nous ayons des stratégies qui nous permettent de régler et d'affronter ces défis-là.

Mais il faut être réaliste, une province seule ne peut pas le faire. Même si le Nouveau-Brunswick double ou triple le nombre d'infirmières que nous allons former et de médecins, si les autres ne le font pas, c'est simple, le Québec va venir recruter chez nous, l'Ontario va venir recruter chez nous et vice-versa. On aura investi toutes ces sommes-là pour former des gens à

l'extérieur.

C'est une question que nous devons traiter ensemble. Nous devons avoir des stratégies qui font en sorte que chacun contribue pour sa part au niveau de la formation afin qu'on puisse avoir les ressources dont nous avons besoin, partout au Canada.

Le gouvernement fédéral, évidemment, peut aider avec un financement soutenu, qui est prévisible, qui nous permet de renverser la tendance qu'on avait vue il y a 10 ans, lorsque -- comme l'a mentionné le premier ministre Doer ce matin -- les provinces avaient coupé le nombre de médecins qu'on formait et d'infirmières qu'on formait. On a réduit l'offre. En conséquence, on fait face à la pénurie d'aujourd'hui.

Malgré les défis, je crois qu'il y a toujours place à l'optimisme. C'est l'optimisme qui va gagner la journée, si on est prêts à s'attaquer au problème. Les solutions existent. Nous les mettons en place au Nouveau-Brunswick et nous allons continuer à le faire avec nos partenaires autour de la table.

TRÈS HON. PAUL MARTIN (CPM Canada) : Merci beaucoup monsieur le premier ministre Lord. J'ai maintenant Monsieur Charest.

L'HON. JEAN CHAREST (QC) : Quelques remarques additionnelles. D'abord, une chose à retenir c'est que la pratique de la médecine a beaucoup changé dans les dernières années, entre autres pour les infirmières, chez nous, au Québec, depuis le virage ambulatoire. L'objectif était de faire en sorte que les gens passent moins de temps dans les soins primaires, dans les hôpitaux, qu'on puisse leur faire des interventions plus rapides et leur permettre de retourner dans leur milieu de vie. La conséquence de tout cela chez nous, comme cela a été souvent le cas ailleurs, c'est que les gens qui sont maintenant hospitalisés sont, en général, des cas plus lourds.

Donc, le travail a beaucoup changé et le niveau de difficulté a augmenté à un point tel où Bernard évoque les questions de recrutement chez l'un et chez l'autre.

Il y a deux facteurs à retenir quand il y a du recrutement. On le vit, ici, dans l'Outaouais, en particulier, l'Outaouais, la région de la capitale fédérale, où les infirmières sont beaucoup intéressées de ce qui se passe du côté ontarien, pour les Québécoises. Ce n'est pas seulement pour une question de rémunération ou d'impôt, mais également par les conditions de travail. C'est devenu un facteur extrêmement important dans le choix qu'ils font, plus important que la rémunération; ce sont les conditions de travail. C'est une chose dont on doit tenir compte.

Dans le cas de la pratique de la médecine, un facteur qui a un impact très important chez nous, c'est qu'il y a un plus grand

nombre de femmes qui pratiquent la médecine et qui sont moins intéressées à certaines pratiques - en orthopédie par exemple - et pour qui le mode de vie est différent de celui d'un homme qui pratique la médecine. Cela a changé, en quelque sorte, le type de pratique de médecine que nous avons. C'est un facteur dont on doit tenir compte.

Il y a un lien que je veux faire, Monsieur le premier ministre, qui est extrêmement important par rapport au résultat de la réunion d'aujourd'hui. Vous avez entendu tous les collègues parler de formation. Tout cela doit se payer.

Chez nous, au Québec, l'inscription d'un plus grand nombre d'étudiants en médecine, une fois qu'on sera rendu à terme dans la cohorte, va nous coûter par année, 50 millions de dollars de plus, de façon récurrente. Je vous donne cette information pour ceux qui s'interrogeaient pour quelles raisons les premiers ministres et le Conseil de Fédération ont insisté pour faire un lien entre le financement de la santé et la péréquation. Il est là le lien.

L'argent qui va servir à former les nouveaux médecins, les infirmières, les technologues, les pharmaciens, sera payé à même le budget des ministères de l'Éducation de nos gouvernements respectifs. Il y a un lien direct entre les deux.

Nous, on ne peut pas séparer l'un de l'autre. Ils sont là. On vient de dire au monde entier, incluant nos citoyens - on vient de leur dire ce qu'ils savent déjà --, que l'enjeu le plus important pour nous, à l'intérieur de ce qui est déjà la priorité numéro un, c'est les ressources humaines.

Alors j'en profite pour le dire parce que c'est la raison qui nous amène à vous présenter, comme enjeu de cette conférence, le financement pour la santé, et également la péréquation comme étant un enjeu extrêmement important.

TRÈS HON. PAUL MARTIN (CPM Canada) : Merci Monsieur Charest. Monsieur McGuinty.

HON. DALTON McGUINTY (Ont.): Well, Mr. Prime Minister, just by way of an opening unsolicited gratuitous remark, it is possible that we work ourselves into such a morose funk in the face of all the challenges before us that we lose sight of the wonderful foundation on which we can build.

We are taking the time today to elaborate in some detail the nature of those challenges and how we will have to work closer together in order to overcome them. But I think it is important for us not to lose sight that we have one hell of a good base here on which to build which so many have worked so hard to hand down to us.

With respect to human resources, we have our own share of challenges of course in the province of Ontario. We have about 140 communities now, some major cities, which are designated as

underserviced. We could use 694 family doctors right now. One of the ways of course to meet that challenge is through primary care reform, and I will have an opportunity to speak about our family health teams later this afternoon.

We are building a brand new medical school up north, which is a wonderful development. It is something that has not happened, a new medical school, in I think some 30, 35 years in our province, expanding existing medical school spaces.

Nursing is another challenge for us in terms of attracting nurses, and I have spoken a couple of times now about the importance to them of having fulltime permanent employment. But the working conditions are also very important to them.

We have today some 2,000 nurses who are on disability. The workplace -- and this is really rather perverse. One of the most dangerous places for nurses to find themselves in Ontario is to be working in a hospital: stress related, back injuries. So we have some new best practices guidelines in place where we provided funding for 12,000 now new bed lifts.

One of the things -- it is a bit of an intangible but it is important nonetheless. If you ask people why they go into nursing, they will tell you it is because they want to make a difference in the lives of the patients that they care for.

I think Jean was making reference to this a moment ago. It is not entirely the money. It is a sense of satisfaction so that when you go home at night and the house is quiet and your head is on the pillow and you are alone with your thoughts, you get to say "I made a difference today. I made a difference in the lives of the people that I cared for".

One of the problems that too many nurses face today is they don't get that sense of satisfaction, that sense of reward, because of the working conditions that prevail.

One of the ways to address those is through bed lifts; make sure there are more there working on a fulltime basis. About 50 per cent of our nurses are working on a casual or part-time basis. And that is not out of choice. Hospitals are saying this is cheaper for me to hire you. I don't have to give you benefits. Get you in here on a part-time or casual basis.

We are training more nurse practitioners. We are providing mentorship opportunities now. We are finding opportunities for some of our older nurses who may have suffered some injuries and give them an opportunity to avail us of their skills and expertise in other perhaps non-traditional ways.

That is kind of a broader picture of some of the challenges connected with nursing in particular. The working conditions are so important if we are going to convince them to come and stay in the practice.

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

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

Let me just say a couple of things quickly.

We often talk about the health care system. We often talk about a number of things but we should all remember this: without the people in the system, there is no system. When we talk about investing 70 per cent in people or 80 per cent in people, that is the way it should be. That is what care is. It is people giving care to people.

Having said that -- I think it has been mentioned before -- I want to say this. There was an eight-and-a-half by eleven piece of paper solution that was made in the early 1990s that said let's cut back on docs, let's cut back on nurses, let's cut back on medical technologists. What we know now, without casting aspersions on the people who said they thought that was a good idea, is the result was in fact abysmal. They had the result they wanted. We don't have enough doctors. We don't have enough nurses. We don't have enough medical technologists. We know all that. We are living with that and now we have to change it.

I think people do what people need to do when it comes to health care. They won't fall into whatever line we want them to go to and just be predictable. I think we know what they want.

Let me start by saying I do think we have to expand training for doctors and education for doctors. I think we have to expand it beyond our traditional basis, as was mentioned yesterday. We have already gone and expanded so we have our first northern medical school, our first entry class coming this year.

And there is a very interesting thing about training people in northern communities or more remote communities and that is they tend to stay in those communities and practise in those communities. We found that with our nurses, as we have expanded nursing spaces in colleges and universities across the province. We found that 93 per cent of the nurses that we had stayed in the northern region that they were trained, which was very critical in terms of rural and remote medicine.

We can get here in Ottawa and think about urban areas but there is a huge rural, remote part of Canada that there is a gap. There is a delivery gap in health care. So we have to train doctors for rural and remote. We have to train nurses and give them the support they need for rural and remote.

We were in Northwest Territories and it was pointed out that we need more nurse practitioners in those communities. That is part of the training package that we have to provide and all of those are long term.

One of the things, Prime Minister, that I think is important is that when we talk about health human resources we are not just talking about medical human resources. I think the medical practitioners will tell us, the nurses and doctors will tell us

they have a huge support team behind them or underneath them that is holding them up and allowing them to deliver those services. So I do want to remember that.

I also think it is critical for us to remember, as Premier Calvert and others have referred to, what is taking place in the workplace. What we have to do is provide people with support within the workplace.

I should say that in British Columbia we have had our good days and our bad days as we have tried to go through health reform. But I want to say that our physicians and nurses have done something that is pretty exceptional. They have accepted 0 and 0 per cent increases in their wages over the next couple of years because they are going to contribute that to improving the quality of life in the workplace, to improving the quality of life for patients.

We are joined here today by Debra McPherson, one of the nurses from British Columbia who has been a leader there. I want to say that I am pleased she has been able to come. More importantly I am pleased with the constructive attitude that our nurses and our doctors have brought to the table as we have done this, and opening up this discussion for them is important.

It is also important to remember we need nutritionists, medical technologists, physiotherapists, massage therapists, chiropractors. We need those folks who are a critical part of the health system as well.

Let me just close with this. When we train a doctor or we train a nurse there is a practical period of time, particularly doctors, where they need residency programs. We do have an international medical graduate program. We have tripled the number of international medical graduates in British Columbia. But let me be more explicit about that. We have gone from two to six. That doesn't really solve a problem.

One of the challenges we have as we increase that is you need the residency programs in the system to do it, and as we expand the number of doctors that we are training we have to expand the number of residents that are available to help do that.

To put it in context for you, it was about $134 million to build the structure, the new medical school opportunities for doctors. It is about $27 million just to get the facilities we need to train those doctors in the practical workforce, in the residency workforce. Equally importantly we should remember this: the doctors that train the doctors are taking time out of actually providing health care to patients on the front line. It is clearly an -- it is not a distraction, but it is a different level of service that we get.

Finally, Prime Minister, let me say this: One of the things

that we have an opportunity to do, if we invest well and in the long term, is not just maintain what we have but improve the quality of what we have, improve the quality of care we will have, which is I think something we have to remember. For that we are going to have to provide support for family physicians that are such a critical part of our health care service. That family physician support is going to be something that we all have to get our collective minds around as we move through the decade ahead because they do provide the kind of time necessary for people to get the top quality care that they need. We are after quality here, not just numbers.

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

Before I close, among the Premiers the last word goes to Premier Fentie.

HON. DENNIS FENTIE (YT): I will be very brief, Prime Minister.

We need not repeat a lot of the common issues that we face in this area. However, I must put on record that in the Yukon and indeed the North this is a very difficult challenge, the human resource issue for us. We lag behind in this area.

I think the main problem is obviously our ability to compete when it comes to recruitment and retention. Often professional caregivers must work long hours in small communities. It is difficult to convince people that it is good for them to spend a significant amount of their time in 40 below plus weather for long periods.

I just quickly want to say to you that we have discussed a number of times in the past and recently the northern vision approach, in collaboration with the federal government. We have a large population that is Aboriginal in the North. They do not leave, and I think we should open up discussions on training our Aboriginal people in the North to enter into these fields. I think we can advance our problem and catch up much more quickly if we can find an initiative here that will do exactly that.

I thought I would put that on record. It is something that we can do in collaboration with the federal government.

Thank you.

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

Let me just say that when I first started in public life and I would go around the country, very many times in a smaller town you would run into people who would talk about a shortage of doctors and nurses. That is 15 years ago. Over the course of the last couple of years when I was wandering around the country in search of a job, I spent quite a lot of time in hospitals and in much larger cities and it was amazing, both the points that you have made, the incredible dedication of the people who work in hospitals and no matter how large the city a shortage of

medical professionals, which did not exist 15 years ago.

So I think the points that you have all made are well taken.

Le gouvernement canadien, comme vous le savez, on fait un financement spécifique en termes des minorités linguistiques, les Autochtones, l'accréditation à l'étrangère, et je suis entièrement d'accord avec le premier ministre Charest que la péréquation est très importante dans ce domaine.

As Premier Lord said, and a number of you said, this goes beyond one province. We need a national strategy. We have set up this body to do this kind of thing. It is very interesting, as you all have gone around, I think it does prove the importance of measurement performance, identifying the problems, setting the priorities and dealing with this as much as possible collaboratively. As far as I am concerned, I think one of the things that should come out of this meeting is asking our officials if in fact there is some way that we can take this much further, whether it is spaces in medical schools or I think the point that was made by Premiers Doer and Binns on foreign accreditation, I think we should ask our officials, if you would all agree: Is there more that we could be doing in that area?

Again, this seems to be happening a little bit more this morning. I do agree with everything you have said. And Premier McGuinty, on behalf of all the Premiers, as the chairman at the present time, if you think it would be a good idea for your officials and our officials to sit down and really see if we can develop a broader strategy, we would be very much in favour of that.

HON. DALTON McGUINTY (Ont.): We are quite prepared to do that.

RT. HON. PAUL MARTIN (PMO Canada): Okay. We will now break. We reconvene at 2 o'clock with Premiers McGuinty and Williams on family and community care. We will try to speed this up through the rest of it. I think it has been a good morning.

I am now going to call my aunts for a lesson in linguistics. I want to thank all of you very, very much.

--- Upon recessing at 1243 / Suspension à 1243