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Chair

Mr. James Rajotte

Standing Committee on Finance

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● (1530)

[*English*]

The Chair (Mr. James Rajotte (Edmonton—Leduc, CPC)): I call this meeting to order. This is meeting number 46 of the Standing Committee on Finance. According to our orders of the day, pursuant to Standing Order 83.1, we are continuing our pre-budget consultations for 2014.

Colleagues, we have two panels this afternoon and early evening. I want to welcome our guests for the first panel. We have with us this afternoon from the Canadian Doctors for Medicare, Dr. Richard Klasa. From the Canadian Foundation for Healthcare Improvement we have the president, Maureen O'Neil. From the Heart and Stroke Foundation of Canada we have the CEO, Mr. David Sculthorpe. From Hope Air we have the executive director, Mr. Douglas Keller-Hobson. From Sunnybrook Health Sciences Centre we have the president and CEO, Dr. Barry McLellan.

Welcome to all of you. You will each have five minutes maximum for your opening statement.

We'll begin with Mr. Klasa, please.

Dr. Richard Klasa (Board Member, Canadian Doctors for Medicare): I'd like to thank the House of Commons Standing Committee on Finance for this opportunity to present on behalf of Canadian Doctors for Medicare.

My name is Dr. Richard Klasa. I'm a medical oncologist at the BC Cancer Agency in Vancouver and a clinical research scientist at the research institute associated with that, and a professor of medicine at the University of British Columbia.

Canadian Doctors for Medicare has an abiding interest in the evolution of the federal role in health care. As medical professionals, we are firmly committed to evidence-based health care policy reform. We advocate for innovations in treatment and prevention services to improve the quality, sustainability, and equity of our health system. We believe our health care system can and should be improved, and we hope today's hearing will play an important role in providing more equitable high-quality and sustainable health care from coast to coast to coast.

As practising physicians, CDM members see first-hand the disparity in care experienced by Canada's marginalized and multi-barriered residents. CDM believes that improving the care experience of our most vulnerable communities is both necessary and achievable.

We advocate for action in three specific areas: first, in upholding the Canada Health Act; second, in developing a new health accord; and third, in improving access to prescription drugs through a national pharmacare program. These have all been outlined in the five-page brief that was circulated beforehand.

Each of these reforms begins with strong, accountable federal leadership to enforce standards across the country and to improve the care of our most vulnerable population.

As part of its commitment to the Canada Health Act, the federal government must recognize that new forms of privatization, including user fees and extra billing, have emerged since the act was passed in 1984. Some of these take advantage of legislative loopholes while clearly violating the spirit of the act. These loopholes must be closed, and violations must be penalized. An accountability framework that requires provinces to proactively regulate or investigate clinics for compliance with these laws is clearly needed to ensure the CHA is upheld.

Another area in which the federal government must demonstrate leadership is in establishing a new health accord. The absence of such a guiding document exacerbates current provincial disparities in health care, again with the greatest impacts experienced by vulnerable populations. Improving equity in care requires establishing a new 2015 health accord with improved measures for accountability and especially standardization of care across the country.

We also must take some starting steps towards a national pharmacare program. Canada currently pays at least 30% more than the OECD average for prescription drugs. By offering first-dollar coverage, a universal pharmacare program would generate savings of between 10% and 41% on various prescription drugs, representing total savings of up to $11.4 billion per year in Canada. Moreover, a national pharmacare strategy would improve the health and quality of life of our most vulnerable residents.

While one in ten Canadians can't afford their prescriptions, among those without any supplementary health insurance that number increases to one in four. Inability to access medically necessary prescriptions results in decreased quality of life for patients while increasing demand on our hospital resources as their untreated conditions eventually lead to hospitalizations.

At the provincial and territorial health ministers' meeting recently in Banff, the ministers agreed to work together to reduce the cost of some 53 commonly prescribed drugs. This decision will result in over $260 million in combined savings annually.

● (1535)

The Chair: You have one minute remaining.

Dr. Richard Klasa: Okay.

However, the capacity of provinces to implement pharmacare-like strategies is limited in the absence of a national formulary. C.D. Howe pharmacare expert Steve Morgan cautions that any attempt to institute a national pharmacare strategy requires active leadership from the federal government.

Canadian Doctors for Medicare is pleased to have the opportunity to contribute to this hearing. In conclusion, we recommend that the federal government close loopholes that allow for-profit clinics to violate the Canada Health Act, demonstrate leadership and vision by reopening the Health Accord negotiations with provinces and territories, and support the provincial and territorial health ministers' initiative to develop and implement a national pharmacare strategy.

Thank you.

The Chair: Thank you very much for your presentation.

Ms. O'Neil, I understand you're beginning with a video presentation. Is that correct?

Ms. Maureen O'Neil (President, Canadian Foundation for Healthcare Improvement): No.

The Chair: That's the second panel. I'm sorry, I was mistaken.

Ms. Maureen O'Neil: Thank you, Mr. Chairman, and good afternoon.

I'm Maureen O'Neil, president of the Canadian Foundation for Healthcare Improvement, CFHI.

[*Translation*]

Thank you for this invitation to appear before the committee.

[*English*]

CFHI is a federally funded not-for-profit organization dedicated to accelerating health care improvement. We play a unique pan-Canadian role in supporting health care innovation on the front line, bringing together teams from different jurisdictions to improve continuity of care, focus on patients and families, and increase value for money. We work with leading organizations, such as Sunnybrook down the table here. These teams include patients and family members, health care providers, and executives.

[*Translation*]

Our work is in keeping with to the committee's priority, that is to say contribute to the health of Canadian men and women, a large number of whom are members of vulnerable groups.

[*English*]

My message today is that we are helping to save health care dollars while improving patient care and health outcomes right now, but for our work to continue we need funding in budget 2015.

[*Translation*]

We work in every province and territory, and we currently have more than one hundred projects ongoing in the field. More than half of these projects are innovative ones that have been tried and tested and are becoming more widespread. We benefit from considerable participation from Quebec organizations.

[*English*]

This year we are spreading innovative ways of working, with better care for people with dementia living in long-term care, and better support for patients with advanced chronic obstructive pulmonary disease, or COPD. One in three long-term residents receives strong antipsychotic medication without a diagnosis of psychosis. We helped the Winnipeg health region use data and proven approaches to take one-quarter of their residents off antipsychotics without any negative consequences. Now we're supporting 52 long-term care homes across the country to replicate Winnipeg's success: small investment, big savings, better care for patients and families.

The second collaboration focuses on a huge driver of hospital costs: COPD. When people with COPD have trouble breathing, they and their caregivers rush to the emergency room. In Halifax, home visits, teaching self-management, and advanced care planning have reduced hospital use by 60%. That's a good idea worth spreading.

[*Translation*]

Currently, we help teams in 10 provinces to adapt and implement their programs. These exchanges among regions and provinces are opportunities for mutual stimulation and learning.

[*English*]

We secured $600,000 from the private sector to leverage federal dollars in this program. This will improve care for more than 11,000 COPD patients. The potential cost savings are huge: once again, small investment, big savings, better care for patients and families.

We're also working with first nations, veterans, and the Canadian Forces. In our brief you can learn more about these initiatives, including pioneering work involving patients and families in the design and evaluation of health care. An independent analysis by RiskAnalytica has determined that just five of the innovations we have supported over the past 15 years could generate well over $1 billion in annual savings through fewer ER and specialist visits and hospitalizations. KPMG recently confirmed this finding in an independent evaluation: small investment, big savings, better care for patients and families.

● (1540)

[*Translation*]

In Budget 2015, we are asking for $10 million annually over five years. We will see to it that that modest investment bears fruit, as we will find ways of reducing health care costs and improving care and the health of Canadians.

[*English*]

We have had great support from parliamentarians, many around this table. Thank you very much for your time.

The Chair: Thank you very much for your presentation.

We'll now hear from Mr. Sculthorpe, please.

Mr. David Sculthorpe (Chief Executive Officer, Heart and Stroke Foundation of Canada): Thank you, Mr. Chair and honourable members.

The Heart and Stroke Foundation is a national volunteer-based charity led and supported by more than 140,000 volunteers and close to two million donors. The aim of the foundation is to create healthy lives free of heart disease and stroke. We do this through the advancement of research and the promotion of healthy living.

We've come a long way since my grandfather suffered a heart attack many years ago. At that time he was put on enforced bedrest and only allowed to sit upright in a chair after a month. Only 15 years ago when someone had a stroke they were transported to the local hospital in an ambulance with no lights or siren on, and were told there was nothing that could be done.

Today a stroke is treated as a medical emergency. The ambulance quickly transports the person to the right hospital set up to handle strokes. Following an immediate CT scan or MRI, if a clot is present the person is given TPA and is often able to leave the hospital within days with no significant disabilities. It is the $1.4 billion in research funded by the Heart and Stroke Foundation and the leadership of the foundation and our partners that have made these changes possible.

Despite an impressive 75% reduction in the death rate from heart disease and stroke over the last 60 years, every seven minutes someone in Canada still dies from heart disease or stroke. That's unacceptable. It amounts to more than 66,000 deaths a year. That's unacceptable.

Heart disease and stroke are the leading cause of hospitalizations and the second leading cause of death in Canada. We clearly have much more to do.

Despite the shocking statistics, further investment in cardiovascular research has stalled. I'm before you today to seek a partnership with the federal government and our partner organizations to: one, sustain Canada's leadership in heart disease and stroke research to improve health, reduce death, lower health care costs, and improve Canada's overall productivity; two, launch programs to reduce vascular dementia; and three, improve the health of indigenous people.

With regard to cardiovascular research, we're looking for an investment of $30 million annually from the federal government to match funds that we have committed. This federal investment would be managed in partnership with the Canadian Institutes of Health Research. What's the opportunity here? In addition to saving lives and improving Canadians' quality of life, this investment would create high-value jobs. Some 70% of the funds would go toward job creation. It would also help to attract and retain young researchers in the field.

We're also working with the YMCA, the Alzheimer Society of Canada, and the Canadian Diabetes Association to have the federal government help address the prevention of dementia. The connection between cardiovascular disease and dementia is undisputed. In older adults, vascular disease is implicated in 80% of people with cognitive dementia, cognitive impairment. An investment here would reduce the risk factors that impact vascular dementia and many other conditions. Delaying the onset of dementia by five years could decrease the prevalence of the disease by as much as 44%, reducing health care costs, increasing productivity, and improving quality of life.

For this initiative we're seeking an investment of $20 million annually. Partnering with the foundation would also be consistent with the government's focus on healthy living, its recently released national research and prevention plan for dementia, and the announcement made by Minister of Health Rona Ambrose last Wednesday.

Dementia-related diseases currently cost the economy an estimated $33 billion a year. This figure is expected to soar to $293 billion by 2040. Our initiative will combat this prediction.

As a third initiative, the foundation is also working with the Canadian Diabetes Association and the YMCA on a plan to improve indigenous people's cardiovascular health. Indigenous people are twice as likely to develop cardiovascular disease and have a higher proportion of CVD risk factors. This simply can't continue, and we have programs that can help.

We have been in discussions with indigenous groups, and they're very enthusiastic about our commitment to work with them. We believe that an investment of $50 million annually will be needed to support locally based programs that build capacity and improve health.

● (1545)

Mr. Chair, thank you. I look forward to the questions and discussion with the honourable members.

The Chair: Thank you very much for your presentation.

We'll now go to Mr. Keller-Hobson, please.

Mr. Douglas Keller-Hobson (Executive Director, Hope Air): Good afternoon. My name is Doug Keller-Hobson and I am the executive director of Hope Air.

I appreciate this opportunity to appear before the finance committee during the budget 2015 consultations and share with you our proposal for a very specific legislative change that would improve access to necessary health care services for low-income Canadians regardless of where they live across Canada.

Hope Air is a registered charity whose mission is to provide free flights for those who are in financial need and must travel long distances to reach specialist medical care. The only Canadian charity dedicated to providing this service from coast to coast, Hope Air helps low-income Canadians of all ages who are suffering from a wide range of illnesses.

Hope Air is not an airline. Rather, we are a lifeline for many fellow Canadians who need to access the advanced medical technology and specialists that are typically available only in larger urban centres across our country. Since its founding in 1986, Hope Air has arranged over 87,000 free flights for low-income Canadians, including over 7,000 flights last year. There are over 8,000 projected in 2014.

Hope Air's submission to this committee is focused and specific and can be enacted at little cost to the treasury. Our budget proposal seeks an exemption from the air travellers security charge for all flights being provided free of charge by a registered charity to low-income Canadians travelling to required medical appointments.

The air travellers security charge is a flat rate fee currently set at $7.12 plus HST for a one-way flight to cover security costs in place at the 89 airports across Canada. This proposed change would cost the treasury approximately $57,000 for 2014 and can be made by either revising or adding a clause to section 11 of the Air Travellers Security Charge Act.

More to the point, for today's mandate of exploring ways to support and help vulnerable Canadian families, this change would enable Hope Air to provide an additional 230 flights per year for fellow Canadians in need.

There is a precedent for enacting a change such as this. Although the act contained an exemption for air ambulance flights when it was passed in 2002, the ATSC still applied to other non-emergency medical flights. Recognizing the importance of excluding necessary medical travel from the ATSC, the government passed an amendment in 2007 making flights donated by air carriers to registered charities exempt from the ATSC.

Since that time, Hope Air's business model has adapted to changing circumstances to include more private donations and funding partnerships. This enables us to directly purchase many more flights for our clients, but also makes us still subject to the ATSC levy. The continuing impact of the current ATSC legislation is to restrict the number of clients we can serve.

Almost half of Hope Air's flights are provided for children and their parent or guardian, most of whom live in a household where the average income is close to their community's low-income line. This means that the vast majority of the families that Hope Air helps devote a larger share of their income to food, shelter, and clothing than the average Canadian family does.

Canadians who live in communities far from larger urban centres face many challenges in accessing the health care they need. They frequently face long-distance travel to get to their medical appointments at their own expense, and in winter they risk dangerous long drives. This puts low-income Canadians at risk, as they often decide to cancel or delay treatment due to the travel costs. It also takes people away from work, school, family, and community for much longer than is necessary.

Making the legislative change will benefit many Canadians by supporting families and vulnerable Canadians at a critical time when they are focused on improving their personal health.

● (1550)

I appreciate your consideration of this issue for inclusion in the 2015 federal budget, and look forward to your questions.

The Chair: Thank you very much for your presentation.

We'll now hear from Mr. McLellan.

Dr. Barry McLellan (President and Chief Executive Officer, Sunnybrook Health Sciences Centre): Good afternoon, and thank you for the opportunity to appear before you today.

The growing global significance of diseases of the brain and mind, including dementia, stroke, and depression, is not a secret. The World Health Organization reports that depression is now the leading cause of disability worldwide, and that in people over the age of 65, stroke and dementia are the medical conditions with the greatest burden to society. With respect to dementia, over half a million Canadians suffer from this disabling condition, and the prevalence is set to double in the next 20 years.

When the health ministers met at the G-8 dementia summit in December 2013 to discuss how to shape an effective international response to the growing challenges of dementia, they committed to: a call for greater innovation to improve the quality of life for people with dementia and their caregivers, while reducing emotional and financial burdens; the ambition to identify a cure or disease-modifying therapy for dementia by 2025; and increase collectively and significantly the amount of funding for dementia research.

The vision of the brain sciences centre at Sunnybrook is to approach dementia, stroke, and depression, across the lifespan through a model of convergence, research embedded in care, a model tested and proven with remarkable success at Sunnybrook in the Odette Cancer Centre and the Schulich heart research program. At Sunnybrook we already provide local, regional, and national leadership for these three major neuro-psychiatric illnesses of our society. The brain sciences centre at Sunnybrook will enhance our proposed transformative role.

We are, of course, aware that the federal government does not directly fund the delivery of health care. This proposal is not about funding the delivery of health care. It is about creating an infrastructure that will enhance innovation and new discoveries that are relevant and beneficial to all Canadians, innovation that will have national and global impact. Bringing our model of convergence to fruition through the creation of a brain sciences centre will bring researchers together with specialists in neurology, psychiatry, neurosurgery, and neuro-radiology, to grow innovation. The centre will promote accelerated discovery and application of new cures and disease-modifying treatments, including unique diagnostic imaging capacity, genome analyses and drug development, and image-guided interventions, including novel models of drug delivery.

It will enhance networking. The centre will be part of a national network of brain sciences and brain health centres across Canada, including the brain health centre in Vancouver, enabling economies of scope and scale and accelerating national capacity. It will advance the development of commercial partnerships, create jobs, and help develop brain health-related companies. It will enhance care across the country and the globe by developing and evaluating new models of care. In so doing, it will protect vulnerable Canadians and their families. It will train and educate the next generation of brain science researchers and health care professionals. It will provide international recognition to the Government of Canada for not only taking a lead role in recognizing the burdens of these debilitating ailments, but for taking demonstrable action to create a better future.

The request of the federal government is to invest in the future for Canadians by contributing as close to $30 million as possible towards the estimated $60-million cost for this research embedded in care brain sciences centre. The Sunnybrook Foundation has committed to raising the balance.

This private-public partnership presents an unprecedented opportunity to mitigate the profound impact of the major illnesses of our time now and over the decades to come.

Thank you for your attention.

● (1555)

The Chair: Thank you very much for your presentation.

Colleagues, we should have enough time for seven-minute rounds, so we'll start with seven-minute rounds and see how long we get with them.

We will begin with Ms. Davies, for seven minutes.

Ms. Libby Davies (Vancouver East, NDP): Thank you to the witnesses for coming today.

I'm the health care critic for the NDP and usually I'm at the health committee and not at the finance committee. I have to say though that often at the health committee when we raise questions about health care related to finance, they say, “Oh, you should be at the finance committee”, so I'm glad to be here today to ask some of those questions.

I'll start off by saying that I think the debate around health care in Canada is always a very topical issue. It's something that people care about deeply and think about. But it's about more than health care. It's very much about a very cherished Canadian value in that the public health care system we have should be accessible to everybody. It's a foundation of our Canadian society, so I'm very glad that you're here today.

Having listened to the issues you've raised and having read the briefs, I'd say that whether we're talking about the health accords or affordable drug coverage or prescription plans or brain science or dementia or research dollars, I think all of those coalesce around the question of what the federal role is. Again, the federal role is not just to sort of shovel money out the door, and there are certainly problems with doing that, because we do have a lot of independent assessment that says in the long run the provinces will probably be shortchanged by about $36 billion.

It seems to me that the central point is to recognize that the delivery of health care is a provincial matter although there is a role for the federal government. Since the health accords ended in March 2014 and they have not been replaced, what do you see as the federal role? We can talk about individual issues such as dementia or drug coverage, but how will any of that happen unless there is a clear federal responsibility at the table and there is sort of a proactiveness to what goes on?

Maybe, Dr. Klasa, you could begin by letting us know what you foresee needs to be done with regard to a new set of negotiations. The health accords we had previously were far from perfect. In fact, many of the things were never followed through on, so certainly accountability is very important. If you were at the table saying what a new agreement would look like, whether it's for a drug plan or for funding, what would that look like to you with regard to the role for the federal government?

Dr. Richard Klasa: As stated in our brief, we feel that for any plan—and we focused particularly on a pharmacare plan—to be successful, strong federal leadership would be required to engage the provinces and set the standards. We wish that all the provisions of the Canada Health Act and the Medical Care Act would be continued, which would mean there would be portability, accessibility, and basically equitable access to resources across the country.

It's very difficult if you're dealing with individual provinces to actually ensure that occurs; so, from our perspective, again, strong federal leadership to set the rules of the game and to set the stage for how programs would move ahead will be required. I do realize these will be enacted by the provinces, but given the kind of country we have and our federalist system, I think it is the role of the federal government to take the lead on this.

Ms. Libby Davies: Thank you very much.

To follow up, Mr. Sculthorpe, one of your recommendations deals with government investment for indigenous people. That's clearly a federal responsibility. You talk about partnerships with the Heart and Stroke Foundation, the Canadian Diabetes Association, and the YMCA, and it seems to me that this is a very critical issue that has really sort of fallen off....

Again, in terms of the federal role, do you foresee that as needing some kind of overall agreement with provinces, territories, and first nations? What is the federal role in actually guiding that? It's not just about the money. It's about actually delivering the health outcomes and having very clearly established goals. How do you foresee that happening?

● (1600)

Mr. David Sculthorpe: I'm going to speak specifically to this initiative, which is important for the first nations and for all those groups.

We want to work with the federal government. They have invested significant dollars there. We think that in partnership we can help engage the communities that are interested in the programs that we, ourselves, have to offer, with the Canadian Diabetes Association's programs, and with the reach of the YMCA.

We have programs that we have been activating, if you would say that, with first nation communities in many provinces across the country, with very, very substantial success and returns. We have picked those best in class from our initiatives that really get tremendous engagement with different bands and different communities. They range from very cheap, inexpensive greenhouses, where they can grow fresh vegetables very affordably, to hypertension initiatives, where we can actually show where we've reduced blood pressure, to education in schools.

We think that this partnership is very important because it takes a significant amount of money—it's a big investment—and it goes to areas where people are genuinely committed and willing to try to partner with us. It's not a cookie-cutter approach. We go to each band and work with them, and they figure out how to tailor the programs where we have the science and the arms and legs to make it work.

The Chair: Thank you very much, Ms. Davies.

We'll go to Mr. Saxton, please.

Mr. Andrew Saxton (North Vancouver, CPC): Thanks to our witnesses for being here today.

Each one of you in your opening remarks highlighted some important issues facing Canadians' health and also facing the health care system. One of the common themes for at least two of you is the looming problem with dementia and the potential crisis as the Canadian population ages.

My first question will be to the Heart and Stroke Foundation. Could you elaborate on the scenario that you highlighted in your submission to the committee?

Mr. David Sculthorpe: Thank you, I would love to.

The linkage between dementia and vascular disease is undisputed. In fact, 80% of dementia is vascular related.

The Heart and Stroke Foundation has been working in the vascular area ever since we started with cholesterol, hypertension. What we're doing is we're taking our prevention programs that we know prevent vascular disease—80% of vascular disease is preventable—and educating Canadians that, similarly, this can prevent dementia. Fifty-four per cent of Alzheimer's is preventable and 80% of the vascular dementia, because it's vascular, is preventable. People don't think in terms of dementia being caused by lifestyle or diet, and that's where we're trying to go. Working with the Alzheimer Society, the Canadian Diabetes Association, and the YMCA, we can get this message out.

The Alzheimer Society is doing great work. They are focusing primarily on research for a cure, and then what happens if you have dementia, as well as prevention. If you think about what Heart and Stroke has been doing for 60 years, we have been focusing a significant amount of our effort, whether it's research dollars or advocacy or health promotion, on preventing vascular disease. We have a very big footprint across the country, with all of our volunteers and health promotion specialists and major relationships with leading research institutions at hospitals and universities, where we can get this message out and do our program, which in our submission, the Alzheimer Society as well as Canadian Diabetes have completely supported, to prevent dementia.

● (1605)

Mr. Andrew Saxton: Your ask that is specific to dementia is $20 million, if I'm not mistaken. A number of different organizations have asked for funding specifically for dementia. How can you assure us that there is going to be an avoidance of duplication? How are you going to be coordinating with the other groups that are also looking into a cure for and treatment of dementia?

Mr. David Sculthorpe: I have two answers for that.

First, we're partnering with the Alzheimer Society on this prevention initiative, which is significant. They're the biggest and they're focused on Alzheimer's. We're focused on vascular dementia. Those two universes cover most of it, so you're going with the two biggies in that instance. Then we can go the route to market with the YMCA, our outreach, the CDA, and also the Alzheimer Society.

Second, there is a tremendous need out here. I think that if you look at our program, which has $2 million for awareness, $12 million for reducing hypertension, $2 million to get Canadians walking through active transportation, and $2 million to educate around nutrition, you see that when you parcel those down, these are significant dollars in the area of vascular dementia, getting the message out, and changing behaviour. But if there are other organizations doing it, that's good too.

Mr. Andrew Saxton: Thank you.

This question is for Sunnybrook.

How would what you're proposing for dementia complement what the Heart and Stroke Foundation is proposing?

Dr. Barry McLellan: First of all, I want to build on something that Mr. Sculthorpe has already covered, which is that there's a close relationship between disorders like depression, stroke, and dementia. It's not well recognized, but if a person experiences depression, their risk of stroke and dementia increases. If someone has dementia, the risk of stroke and depression increases. These are closely related, so there does need to be a very coordinated approach to dealing with diseases of the brain and mind.

With respect to working together, we cannot in this environment afford redundancy. We cannot afford to have a situation in a country like Canada where we don't know what's happening in Vancouver and where work at Sunnybrook is not being shared nationally to make sure we get the best future bang for our buck. Our proposal in fact is building on networks that already exist. I highlighted the excellent centre that's in Vancouver right now. There are strengths in Calgary. There are strengths in other centres in Toronto.

Going specifically to your question, being successful in treating dementia is dependent on our being coordinated, on having a network of researchers and ensuring there is a strategy that's known by all.

Mr. Andrew Saxton: Thank you very much.

I'd like to turn to Hope Air.

Very quickly, what are the main challenges you're facing right now? Will the increase in fees for carry-on bags, checked bags, and that sort of thing also affect what you're trying to do?

Mr. Douglas Keller-Hobson: Increased fees always do; hence, we're asking for this specific legislative change here, which would actually reduce fees. We partner with all the airlines. There are very close relationships. Just as we're advocating today for assistance here to help vulnerable families, I'm doing exactly the same with our airline partners as to whether we can get them to waive certain fees. Again, sometimes our donors pick up additional costs if the families themselves cannot.

Today's request here, though, is very direct and will certainly add more flights.

● (1610)

The Chair: Thank you, Mr. Saxton.

Mr. Brison, please, for your round.

Hon. Scott Brison (Kings—Hants, Lib.): Mr. McLellan, you've spoken of the potential of this brain sciences centre in terms of breaking down barriers and creating a more collaborative platform for research. I would add to your list as well the work being done at the Dalhousie Medical Research Foundation and the Irene MacDonald Sobey chair for Alzheimer's research, with Dr. Sultan Darvesh, and also some of the work done by Dr. Kenneth Rockwood.

Are there other barriers to collaboration in terms of this kind of research and perhaps even issues around commercialization, ownership, and IP? In addition to direct funding of your initiative, are there other areas we should be looking at to break down the barriers that may be impeding collaborative results?

Dr. Barry McLellan: First of all, I will acknowledge that there is significant strength in eastern Canada as well, and specifically Dalhousie. Our researchers right now are working with teams there collaboratively. I don't want there to be a message left today that there is not existing collaboration in our country.

With respect to barriers, one approach that's used at Sunnybrook, which we believe is a model that others should emulate, is treating those with disorders of the brain and mind together. Helping to destigmatize mental illness is a major undertaking right now in our country. By having individuals who have depression in the same clinic area as those who may have dementia, or stroke, or other diseases of the brain, is a major step forward. We believe that cooperative model within organizations is important.

I have already mentioned the importance of networking to make sure we have collaborative research taking place not only across the country but across the world.

With respect to commercialization initiatives, we're starting to make progress in certain clusters across the country. We very much favour the cluster environment, where we can bring together those with public and private sector expertise and interest. We believe that by having a strategy around disorders of the brain and mind, we'll be better positioned to capitalize on commercialization opportunities, as I mentioned, growing jobs and companies.

Hon. Scott Brison: Thank you very much.

Maureen O'Neil, welcome back to the committee.

Your funding is running out. According to your submission, six of your projects reduced health care spending in the provinces by more than your total budget between 2006 and 2013.

Is there another organization in Canada doing what you're doing today, in terms of developing this research and sharing it with the provinces?

Ms. Maureen O'Neil: No. In fact, what we're doing is actually not research but really working with people on the front lines and helping to bring evidence of what does make a difference to them, but more importantly, bridging the divides across provinces.

Canada has both a great strength and a great weakness in that the primary responsibility for health care is with the provinces, but we have very few vehicles for innovations at the provincial level in delivery of care to be shared across the country. What we are able to do is provide support to teams who are juried in, who want to share in particular areas, to get the kind of assistance that is required, and also the opportunities to share one with the other.

Hon. Scott Brison: This would be disproportionately important for smaller provinces that don't have the bandwidth to garner this sort of best practice model.

Ms. Maureen O'Neil: Exactly, it's very important.

For example, in the Atlantic all four provinces agreed that they would work together to look at ways of improving the care for people with chronic conditions, COPD, diabetes, mental health, etc. Ten regional health authorities are working together. I think this is a first that the four Atlantic provinces agreed they would combine to look at doing things differently to find better ways of actually delivering health care now.

This is delivering health care in the here and now. It's not as adventurous as what we're hearing about from further down the table on looking ahead, but it is dealing with problems that people have right now, and helping to put into place solutions that we know about right now.

● (1615)

Hon. Scott Brison: Thank you very much.

Mr. Sculthorpe, for the Heart and Stroke Foundation funding, you're seeking to support indigenous peoples health initiatives. Given that the federal government is responsible for overall investments in aboriginal and first nations health care, and we can pay now or pay later, have you done some analysis of what kinds of savings to the federal government this $50 million per year would render in the future?

Mr. David Sculthorpe: On this program, no, because the suite of initiatives we would be bringing to the communities to pick and to massage, to make it work for their needs and their desires would be slightly different for everyone.

I can tell you that when you get into the programs we have today, such as the hypertension program, where we drop the blood pressure by a significant and statistical amount, they do reduce the health care costs and the death rate over the short, medium, and long terms going forward, and we have all those numbers. We also know that coming out of the B.C. program with the greenhouses, the quantity of fresh vegetables that are grown and available goes up significantly. So on a program-by-program basis, we know.

The Chair: Thank you, Mr. Brison.

We'll go to Mr. Keddy, please.

Mr. Gerald Keddy (South Shore—St. Margaret's, CPC): Welcome to our witnesses. We're having a very good discussion today, with lots of questions being raised.

My question is for Mr. Keller-Hobson from Hope Air.

You're the only registered nationwide charity that provides free flights for people who cannot afford the cost. I think you stated there have been somewhere around 85,000 free flights since 1986. Congratulations on that.

I think most of us around the table are sympathetic to your ask, but I'm not certain how we can drill down to find a way to do it. You're looking to really get around the air travellers security charge of $7.12 a flight. It's impressive that this would give you a lot of extra flights across the country; an additional 230 flights I think was the number you used.

It would be a legislative change. How can government do that and treat one charity differently from another?

You need to help us.

Mr. Douglas Keller-Hobson: Yes.

When the legislation was implemented, it was clearly established at that time that vital medical flights were to be exempted. That was always the spirit of the legislation. It caught up in 2007 with the next amendment, when it was really discovered and then advocated that Hope Air was not an air ambulance service but still was vital for medical appointments.

Now we're looking at it again, more than seven years out. I take the view that the intent and spirit of the legislation is very clear. It applies to all Canadians in that scenario, through charities. It's time for us to continue to look at our legislation and keep up with changes in society. Here Hope Air has changed its business model. It considerably grows more, and we put a considerable amount of money back into the airline industry through our purchases. A simple act like this would, I think, deliver good results.

Mr. Gerald Keddy: Thank you.

This question is for the Heart and Stroke Foundation.

You've put some numbers forward. The health care costs of heart and stroke, dementia, and other similarly related diseases are somewhere around $35 billion per year, rising to somewhere around $200 billion by 2040, which is a frightening number.

You have a great reputation and a good record—a 75% decrease in heart and stroke deaths—and I think a fairly reasonable ask. How do we meet that ask, and how do we seek out partnerships from business and the provinces, as well? Have you done that, or is that a possibility?

● (1620)

Mr. David Sculthorpe: We're a not-for-profit.

Mr. Gerald Keddy: I understand.

Mr. David Sculthorpe: We raise all of our money through door-to-door donations, Jump Rope for Heart, corporate partnerships, major gifts, and direct mail. We work very hard on building corporate relationships. In 2011 we unified into one foundation across the country to enable better partnerships with national corporations, because our relationships were all provincial, and to become much more efficient and effective and to have more mission impact. We're seeing tremendous results from that.

We do believe our corporate support will grow, but it's a very small amount relative to what every Canadian gives to us. As I said in my opening address, almost two million Canadians donate $40 or $50 to us, and a few give us a lot more money, but that's a small part of our fundraising.

Mr. Gerald Keddy: I guess it's the immediate costs versus the costs coming in the future if we do nothing.

Mr. David Sculthorpe: When we get into the prevention business, that's always the debate we're faced with: whether we spend a dollar now to save it over the long term. We believe in the prevention area for dementia. When we see those numbers, we can do nothing but make the choice to try to prevent the disease today, because those numbers will swamp us in the future, and we know the issue and the concern.

My father had Alzheimer's for almost 10 years and passed away. We know how much strain and stress that puts on a family and on society.

Mr. Gerald Keddy: Very quickly, Ms. O'Neil, you're looking for $10 million over five years. You're seeking ways to improve health care, and I think that's a noble idea, and there's room to do it.

One of the frustrations I have as a member of Parliament is the lack of coordination. You mentioned that the four Atlantic provinces are starting to work together. Good for them. It was a long time coming. But there's a lack of coordination among the provinces on things as rudimentary as one simple pharmaceutical buy for all provinces and all territories.

What holds that up? Why can't we do that in Canada?

The Chair: Could we have just a brief response, please.

Ms. Maureen O'Neil: I don't have the answer to that question on pharmaceuticals. I think Dr. Klasa is working hard on lobbying to have that happen.

The Chair: Do you want Dr. Klasa to respond briefly?

Mr. Gerald Keddy: Absolutely.

The Chair: Make it very brief, please.

Dr. Richard Klasa: Very briefly, I think the problem has been that a lot of these activities have been siloed in different health care jurisdictions. There is no real reason that it can't happen.

The Chair: Thank you, Mr. Keddy.

[*Translation*]

Mr. Caron, you have the floor. You have five minutes.

Mr. Guy Caron (Rimouski-Neigette—Témiscouata—Les Basques, NDP): Thank you very much, Mr. Chair.

Mr. Klasa, in your presentation you mentioned that at this time there are several gaps in the Canada Health Act that are not being addressed by the federal or provincial governments. Could you give us an example of one of those gaps?

[*English*]

Dr. Richard Klasa: There are two different parts to that question.

The gaps in the Canada health accord have to do with the different provincial jurisdictions and the ways in which the funding comes to them currently. At the present time, I'm not an expert but my understanding is that in the current system the funding is based on a head count. Basically provinces with growing populations tend to get more money than do those without that growth.

A simple calculation tells us that in those provinces that perhaps don't have as much growth, where, one might suspect, there may be more vulnerable populations, which is what we're discussing today, the amount of relative funding will be less.

My understanding is that in the previous set of accords, more thought was given to how that money was apportioned.

That's one example of that sort of thing.

● (1625)

[*Translation*]

Mr. Guy Caron: I want to come back to the issue of federal leadership in health care, which my colleague talked about at some length.

We are agreed that health is a matter of provincial jurisdiction. Last week I put the same question to the president of the Canadian Medical Association. How can the federal government play a leadership role in this area, when health is a matter of provincial jurisdiction? How does this work in practice?

I have a second question to ask, which is a corollary to the first.

The provinces do not seem to have adopted many coordination measures. In your brief your refer to one of these measures, that is to say the Pan-Canadian Purchasing Alliance, for the purchase of medication, but there is very little cooperation in that regard.

Should the federal government play a role in helping the provinces share their best practices, and in developing a broader vision when it comes to the administration and delivery of health care?

[*English*]

Dr. Richard Klasa: Undoubtedly, the federal government should have a major role in doing this and providing leadership in many initiatives.

The issue again is that provinces are somewhat siloed and separated in terms of how they have traditionally dealt with their health care issues. What one would hope from a federal government in our system is leadership that maintains the actual provisions of both medicare and the Canada Health Act. That does provide, and did solidify to some extent, this idea that access to care would be equivalent across the country and that there would be portability from one province to another. It seems to me that without federal leadership we can't even begin to discuss that, because then we have each province arguing one-on-one with each other about how to proceed.

I don't see that there is any lack of a need for federal leadership in this debate whatsoever. What is necessary is a strong unifying voice that can help the provinces to each see the strengths that may be present in different jurisdictions—and there are strengths, many strengths, that are present in one jurisdiction that are not in another. The federal government could help; the federal policy-makers could help to point that out and to allow the provinces to come together and actually agree upon standards.

[*Translation*]

Mr. Guy Caron: Thank you very much.

That federal leadership could be expressed in certain strategies.

I' m going to put my questions to Mr. Sculthorpe and Mr. McLellan. I will come bact to you, Mr. Klasa, if time permits.

Mr. Sculthorpe and Mr. McLellan, you are in fact the fourth and fifth witnesses to tell us over the past two weeks that it is important for the federal government to take concrete action in developing a strategy to counter dementia. In fact, our colleague Claude Gravelle tabled a private members' bill on that very issue.

What form can federal leadership take to develop a concerted strategy to deal with dementia, do research and implement solutions against dementia, while the provinces are in fact responsible for the implementation of those solutions?

How can the federal government and the provinces work together in a productive way to come up with concrete results in that regard?

[*English*]

Mr. David Sculthorpe: I think that if they put together an action plan done collaboratively with the provinces, it would go a long way and set the vision for the future.

Dr. Barry McLellan: If I could add, an investment in infrastructure, which would help to guide the strategy, which would be a national strategy, bringing together hubs from across the country, would go a long way to building the innovation and the changes we need in order to actually implement the innovation. Innovation is one part. If we don't implement and make the changes, we're not going to see better care for Canadians in the future, whether it's dementia, stroke or depression. I do see that an investment in infrastructure would in fact help us to get to that point.

● (1630)

[*Translation*]

Mr. Guy Caron: Mr. Klasa, could you suggest some concrete action that the federal government could take, as a federal entity working in an area of provincial jurisdiction? What strategy could the government adopt to counter dementia or help our seniors?

[*English*]

Dr. Richard Klasa: I don't know that I can address the issue of dementia, but there are many experts here on dementia.

Certainly in terms of care for the elderly in general, one of the major issues of our time, and perhaps it's coming into its time now, is that we have to shift from a medicare system designed 40 or 50 years ago to deal with acute illnesses and hospital-based care, when the average age to which people lived was in the sixties, to one now where people born today are, on average, going to live to be 85. Many of the acute diseases are being well taken care of, but we are making out of acute diseases chronic conditions, and those demand care of a different sort. That care is now moving out of hospitals and into communities. One role the federal government could have and should have would be to embrace this and to give funding and to encourage ideas that actually move the model towards one of more in the way of community-based and home-based care.

I don't think that's a surprise to anybody around the table.

The Chair: Thank you.

Merci, monsieur Caron.

We'll go to Mr. Allen, please.

Mr. Mike Allen (Tobique—Mactaquac, CPC): Thank you to our witnesses for being here.

Ms. O'Neil, I'd like to start with you.

I'm not familiar with your organization, but I read your brief. What is the size of your organization? How do you work? Do you work virtually? Could you briefly tell me how that happens?

Ms. Maureen O'Neil: Yes, certainly. It's a small organization of 40 professional staff and a board of nine people that includes a couple of deputy ministers, one from Alberta and one from the Northwest Territories, the associate deputy from British Columbia, and the former head of the Ontario Hospital Association—that kind of person, like the person in Nova Scotia who is charged with the incredibly politically delicate task of reorganizing a number of regions there into one. There's a board that is heavily endowed with people who have direct front-line experience in the provinces in managing health care and there are staff who are professionally competent.

We work often through the use of ICT. We run webinars. Our collaborations combine online learning with face-to-face meetings. We back it up. We have a very strong capacity to assist the groups with whom we work to develop indicators and measure their performance so they are able to evaluate whether the interventions they are making are actually making a difference.

The benefit of bringing groups together from across the country, usually those working at a sub-provincial level with health regions and hospitals, is that they have an opportunity to learn what is going on in other jurisdictions, because policy frameworks in each province are slightly different.

I must say that our organization is one of the few that works across the country and that has always had very strong participation from institutions in Quebec, going back 15 years. For some organizations that are participating in programming, this might be the first and maybe the only time that they actually sit down with colleagues from Quebec.

Mr. Mike Allen: Extending on that, you said in your brief that a "recent analysis...demonstrated that if just five of the innovations CFHI supported were implemented across 50% of the healthcare system in Canada, they could generate more than $1 billion in annual savings".

When I look at that, I'm very intrigued, because even though you said you're not as adventurous as the others, to me getting the best bounce for a buck in health care means the basic blocking and tackling. With that in mind, are some of the five, in those eight that you listed as the most effective, CFHI-supported innovations?

● (1635)

Ms. Maureen O'Neil: Yes, exactly, and you would be surprised at how simple some of these things are. We were chatting before the meeting about how simple changes can make a big difference. The challenge is that they are shared and that they are taken up.

For example, I talked about the approaches to COPD, which will move care outside of the hospital into the community with proper supports. That alone is a big saving. That keeps people from going to emergency, because by keeping people out of emergency, you are providing care that is good for people but is less costly. There are other things. Doctors' offices using open access and being available for longer hours keeps people out of emergency rooms. It's a whole bundle of things.

Canada has been very slow to organize its emergency differently. We have also been very slow in providing appropriate funding—I'm talking about the provincial level—outside of hospitals. It's really a bit of a mishmash out there at the community level, and that's where we have to go.

It is true, and we've documented it very well, how small interventions can make a surprising difference in expenditures. This money never goes back to anybody. It's shipped somewhere else in the health care system, but hopefully it's shipped to somewhere more appropriate.

Mr. Mike Allen: Is this because of the silos, I guess, the barriers to implement making it difficult to work together, so you have this spread initiative...? I'd just like to understand those barriers to implementing. It just seems like a no-brainer. It's a billion dollars. Why don't we go after it? If that's the case, does your organization receive any funding from the provinces? They're a major benefactor of this, too, because our provincial tax dollars are going into this. Are they a partner in the funding of your organization?

Ms. Maureen O'Neil: Yes, they are a partner inasmuch as it is teams within their provinces who are working on these innovations and working to share them; hence it's the labour of the people in these institutions who are making the changes. In that way the provinces are indeed assisting greatly. Where I don't feel we are where we ought to be is in ensuring an understanding of how you move from, say, across the country 52 long-term care homes doing this and then the work that we have to do as a kind of intermediary, which is really to do the convincing work to put that information before provincial people to say, “Look how this has spread”.

That happened in Manitoba. After the first personal care home used a different approach to dealing with long-term care residents with dementia who had been over-prescribed antipsychotics, the province, looking at that, said, “Okay, now we're going to spread it all across Winnipeg, and now we're going to work on spreading it across the province”. Similarly in B.C., in another very interesting project that reduced the time for a patient between seeing a GP and seeing a specialist, they are now working on spreading that across the province.

Provinces are key in taking up the innovations in health care delivery. Our challenge in what we do, in working with people across the country, is then also working with them in their provinces and moving things along. Why doesn't it happen? People get used to doing things a certain way, and they continue doing them a certain way. The economists call it path dependency, and that's what we see operating all the time.

The Chair: Thank you, Mr. Allen.

We'll go to Mr. Rankin, please.

Mr. Murray Rankin (Victoria, NDP): Thank you to all the witnesses for coming today.

I'd like to start with Dr. Klasa of Canadian Doctors for Medicare.

First of all, I'd like to thank your organization for its passionate support of publicly funded health care in Canada.

You had three points, I think, in your very short presentation. The first was the desire that we uphold the Canada Health Act. The second was that we renew the health accord that has expired. Third, you talked about a national pharmacare program. I'd like to talk about each of them.

You mentioned in your remarks what you called “legislative loopholes” that violate the spirit of the act. Then you talked about new fears of privatization. I can't help thinking that you may be referring to the federal government's apparently lacklustre support of the medicare program in the Cambie Street clinic case, Dr. Day's clinic in Vancouver. Is that what you had in mind? Is the federal government there aggressively supporting our medicare system?

● (1640)

Dr. Richard Klasa: The case that's before the B.C. Supreme Court now involves a suit and then a countersuit that basically involves the provincial health care authority. The main protagonists here are Cambie Surgeries Corporation, the provincial government PHSA in terms of the Ministry of Health, and then there are intervenors, such as Canadian Doctors for Medicare and the BC Health Coalition, which have that status to inform the discussion.

The federal presence in that particular argument has been less than obviously all the other players. It is, at this point, as far as I can tell, a provincial jurisdictional matter. The crux of the matter is there needs to be some sort of enforcement of the Canada Health Act if indeed we have a Canada Health Act. The issue has been there are providers of private for-profit care across the country that have, it would appear, or it is alleged, abused the system and inappropriately billed. That is in the public record. There was an audit done of the Cambie Surgeries clinic.

The question is, what is the power, and what is the power that will be used by the federal government in response to this? Supposedly the Canada Health Act says that if a jurisdiction is improperly using the resource, then those tax dollars that were spent...let's say in overbilling or double billing or extra billing. If any of that came out of billing on top of what the province was paying, of which a proportion was coming from the federal government, then we have a right to reclaim that money. There has been no attempt made federally or provincially to actually enforce those provisions.

Mr. Murray Rankin: It's a lack of enforcement by the federal government that has led your organization to appear as an intervenor in that lawsuit, to defend the medicare system.

Dr. Richard Klasa: It certainly is one of the things. We are there because we believe that the medicare system deserves to be protected, but also deserves to be changed and reformed as is required by the times. It's not as though we're for a static medicare system of all things going on as before, forever—that's not true. What we do want here is to not throw the baby out with the bathwater.

The majority of what the Canadian health care system can deliver, it delivers very well. There are other things that need to be dealt with, but a solution is not to have more in the way of private care, and the brief details why.

To cut to the chase, you withdraw much more in the way of resources from the public system when you set up a private system parallel—

Mr. Murray Rankin: —and develop a two-tier system by stealth.

Dr. Richard Klasa: Yes. It seems counterintuitive, the idea being, for those who propose it, that you can take people waiting in line who have resources, move them into the private sector, get them off the rolls, and that will make both systems function well and the public system will be more efficient. But it's not true.

We cite a number of documented situations where that's happened in other jurisdictions: Australia, New Zealand, and Europe. What happens is that you move a whole lot of resources, such as physicians, nurses, and physiotherapists, out of the public system into private, for-profit care. The result is that those who can afford to pay—and our vulnerable population certainly can't—will get care sooner. For everybody left in line in the public system, the wait becomes longer.

Mr. Murray Rankin: Thank you, and thank you again for your organization's intervention in that case.

The third thing you talk about is pharmacare. I understand that one in ten Canadians today can't afford the medications that have been prescribed to them by physicians. I understand that Canada is the second worst in terms of drug costs in the OECD.

You called for federal leadership and you said that it needs a national formulary for your pharmacare reform to take effect. Could you elaborate on what a national formulary would mean and how you see the pharmacare strategy unfolding?

Dr. Richard Klasa: In essence, what we've looked at, and what a number of other organizations, including the CMA, have now looked at and agreed with us is we are overpaying drastically in terms of our drug costs. Part of that has to do with where we're located on the planet, but the other part of it has to do with simply not having a large bargaining unit to be able to cut a better deal.

There are ways to do that, if provinces can get together. We do that at the cancer agency where I work. We essentially have pharmacare for all drugs that treat cancer. We negotiate for the whole province for those drugs. We would be much more efficient and we could cut a better deal if we were all negotiating for the entire country.

Similarly, it is a saving of scale. If we can come to the point of being able to negotiate for all of the pharmaceuticals that are necessary to treat a population base of 35 million, we simply would have more power to be able to deliver more for less.

● (1645)

Mr. Murray Rankin: In a footnote in your submission you referred to the work of Dr. Marc-André Gagnon of Carleton, who shows the tens of billions of dollars Canadians would save if we had such a pharmacare program.

Dr. Richard Klasa: It is a huge amount. If you look at the figures, it is quite shocking how much more expensive certain drugs are here than in other jurisdictions. That's detailed in the brief.

Mr. Murray Rankin: Thank you, again, Dr. Klasa.

The Vice-Chair (Hon. Scott Brison): Thank you, Mr. Rankin.

Now we'll hear from Mr. Van Kesteren.

Mr. Dave Van Kesteren (Chatham-Kent—Essex, CPC): Thank you all for coming. It's a great discussion.

Dr. Klasa, I'm going to keep going with you. It's great to hear somebody who is in the medical profession who has first-hand knowledge and a bird's-eye view of what's going on. It must be frustrating at times to see how....

I think in essence we all agree that the health care system that we have has to be preserved. This government has provided more funding than any government. I believe it's a 60% increase, $20 billion since we formed government, and it will be at $32 billion this year.

How does that help? Can you perhaps talk about your ability as an organization to do its critical work and how that helps you?

Dr. Richard Klasa: How specifically the funding helps?

Mr. Dave Van Kesteren: Yes.

Dr. Richard Klasa: Again, funding is necessary to deliver the services that we deliver across the country. There is no question that our population demographics are shifting somewhat. This requires perhaps a modicum of more spending, but that really isn't the big issue. To me the big issue is the distribution of that spending and how we're using those dollars.

Innovations are never cheap. New drugs in cancer tend to be very expensive, and fortunately, they actually do prolong people's lives these days. The question we have as a society is how we are going to distribute the money and how we are going to spend for the best outcomes.

If your question is whether the extra funding that's being put in, the funding being put in by the federal government, is something that is obviously a good thing and used well, the answer is yes.

Mr. Dave Van Kesteren: I want to go a little further. The issue isn't so much funding, because there seems to be.... I don't want to pick on anybody here, because I think everybody does great work. I think most members of Parliament can testify to this, especially those who are on the finance committee, that as we are visited by the different organizations, there seems to be a lack of coordination. It has been brought up in a number of other questions that possibly we need to coordinate a little better.

If you were king of the medical world, how would you coordinate heart and stroke, mental health, all the others? Are we doing that right? I'm going to give them a chance to defend themselves. I'm not here to criticize them either, but there seems to be that lack of coordination. Do you want to comment on that?

Dr. Richard Klasa: Well, one can set up coordinations, I guess, in different ways.

I'll let my colleagues speak to their areas of expertise. In mine, if I could do it all my way, then I would say, if we had a national cancer program as opposed to just provincial cancer programs, we could be more efficient, take the best innovations that are present in each province and spread them across the whole country, and deliver uniform care that Canadians deserve at the very highest level, in that way.

● (1650)

Mr. Dave Van Kesteren: Would you close cancer research centres possibly in one province, but not another if they did better work or if they're more advanced or had better equipment?

Dr. Richard Klasa: I don't think that would be the approach. I think the approach would be to bring people up to speed. In all provinces there are pockets of expertise; there are areas of expertise. Some provinces have a little more than others, but there is expertise in every part of Canada. Here the idea would be to build upon that expertise and to really exploit what is being done much better in one province, and that then could be translated to another.

We've done some of that even in our own work, where we've talked to other provinces and said, “Here are all our protocols. We put everything up on the web. This is how we treat every patient with this cancer in this province at five cancer centres and 75 smaller outlets.”

Mr. Dave Van Kesteren: I'm going to put you on the spot with this one.

Dr. Richard Klasa: I'd better make sure I hear this one right.

Voices: Oh, oh!

Mr. Dave Van Kesteren: If, for instance, Mr. McLellan had a research centre to work with mental disorders, would you possibly suggest that Heart and Stroke would fund him and raise the money for that? Is that a better approach? Or should we keep on doing what we keep doing, which is let all these other different organizations do, basically...? I know it's not the same work, but it's trying to achieve the same thing.

Dr. Richard Klasa: I think it's important to have different approaches to the same problem, because unfortunately we actually don't know.... We are involved in research, and the reason we're doing research is that we don't know the answer. Preconceived notions of how to go ahead sometimes turn out to be wrong. I think that different approaches from different jurisdictions and from different groups with expertise that spans a much larger spectrum is what I would do.

Mr. Dave Van Kesteren: Okay.

I'll go to Mr. Sculthorpe.

As an organization you have identified a number of things to stop. You have slowed down heart disease and stroke. Now you want to expand that to first nations.

If we know what causes it, what exactly do you want to do within the first nations groups to implement what you already know causes the exacerbated problem?

Mr. David Sculthorpe: It's a great question.

On your last question, I mentioned before that we have unified, so we are now all one. We are looking at best practices that go on in each province and sharing them across the country. We're getting rid of our duplication. We have formed alliances with the top 20 leading research hospitals and universities across the country, and we're committing $30 million to them. Sunnybrook is one of them. It's one of the best in the country.

We would do the same thing we have done in B.C., Manitoba, and Ontario, taking the best practices from programs that are already very impactful, and we would offer them to first nations and all the different communities, including Inuit and Métis, on reserve and in urban communities, with our partners at the CDA and the YMCA.

The Chair: Thank you very much, Mr. Van Kesteren.

Mr. Adler, go ahead, please, for the final round.

Mr. Mark Adler (York Centre, CPC): Thank you all for being here today, and thank you for all the great work you do across the country.

I do want to focus my line of questioning on Mr. McLellan.

At the end of this process, what we are doing here is prioritizing and assessing. There are so many worthy causes, but of course we can't fund everything, as much as we would like to do that.

You spoke about creating a centre whereby disorders of the brain and mind would work hand in glove with each other. Could you please explain in layman's terms what exactly that means? Is that being done now at Sunnybrook? Can you give a concrete example that stands out in your mind of that process taking place?

● (1655)

Dr. Barry McLellan: I'll start with the third part of your question. It is happening right now. I believe the context for your question and the last few that have been put to other witnesses really comes down to return on investment. What is the best use of dollars in order to get the greatest impact? In support of what others have said, I believe the investment should be selective. That doesn't mean only one centre in the country, but it means the investment is made strategically, that it's made in centres where there is expertise and where there's an opportunity to grow, and then the end result will be maximized by having networking and coordination.

With respect to what it means to actually have disorders of the brain and mind treated together, our brain sciences program at Sunnybrook is unique. We bring psychiatrists together with neurologists and neurosurgeons and those who specialize in imaging as well as the non-medical professionals, and we look at the total patient.

It is unique in that in most organizations there is still a separation between disorders of the mind, which is the domain of psychiatry, and disorders of the brain, which usually fall to neurologists and neurosurgeons. We believe there are many benefits to this, including the destigmatization of mental health. I mentioned earlier the fact that there's an intersection between many of these disorders. There's a relationship between depression and stroke and dementia, and only by taking all of these together will we get the best result, so we're doing it right now.

I'm now going to go to the innovation piece, Mr. Adler. We have actually built a significant program around focused ultrasound for treating disorders of the brain. This is a way of actually doing surgery without a scalpel, of treating disorders inside the brain without actually cutting through the skull.

We focused initially on disorders related to the brain diseases, and we focused on tremor and tumour, but we are now expanding this to disorders of the mind. We're going to be looking at opportunities to treat obsessive-compulsive disorders. We believe that through another application of ultrasound, we can break down the blood-brain barrier and get medications across and into the brain to treat depression and other disorders.

From our perspective, actually focusing on the total patient and bringing disorders of the brain and mind together will truly have impact, and as I hope I have emphasized, it's happening today.

Mr. Mark Adler: You've mentioned that you are doing it now, so if you're doing it now, why are you here? What are you asking for? Why the $30 million? What do you plan to do with that $30 million?

Dr. Barry McLellan: We are doing it now, but we have treated fewer than 10 patients with benign essential tremor. What we have identified is what we call a preclinical model for breaking down the blood-brain barrier, which means that we're not yet doing this in humans. We have the opportunity, by investing in infrastructure, to bring those individuals together in the same environment and get the synergy that we believe will actually help to change the future of disorders like dementia and depression for those patients across the entire country.

The infrastructure, the environment of bringing everyone together in one centre, is different from what exists in Vancouver. In Vancouver, it's more around research. This is research embedded in care, and we believe this is the model that's going to result in the best return on investment.

Mr. Mark Adler: That is unique, right? That's not happening anywhere right now.

Dr. Barry McLellan: That's right. What I have described to you, the totality of the program, the focus we have in research, is not happening elsewhere.

Mr. Mark Adler: Our government has been funding $100 million for brain research, I'm thinking, between 2011 and 2017. That is not what you're talking about, is it?

Dr. Barry McLellan: It is not. This is around an investment in infrastructure to bring all of those various individuals together, the researchers, those who are treating clinically, and then building the networking across the entire country to have that dementia strategy, that strategy for treating disorders of the brain and mind that doesn't exist right now.

● (1700)

Mr. Mark Adler: You mentioned $30 million. In your presentation, you mentioned private sector funding, so you're not here with your hand out simply asking for the government to fund a centre for $30 million. You have matching private sector funding. Can you talk about that?

Dr. Barry McLellan: We are building on that right now. I anticipate that by the end of this month we'll be in a position to announce a lead gift of $20 million against the $60 million. We have other donors who are incredibly interested in disorders of the brain and mind. We see that as a great trend for the future at Sunnybrook and beyond. Our commitment is to continue to work with our donors in order to raise at least 50% of the $60 million total.

Mr. Mark Adler: Thank you very much.

The Chair: Thank you, Mr. Adler.

On behalf of the committee, I want to thank all of our witnesses for partaking in the pre-budget consultations. We appreciate your input very much.

Colleagues, we'll suspend for a couple of minutes and bring forward our second panel.

● _____ (Pause) _____

●

● (1705)

The Chair: I call this meeting back to order. This is meeting number 46 of the Standing Committee on Finance.

We are starting with our second panel for today.

We're very pleased to have our guests with us. Thank you so much for being with us.

First of all, we have with us the Assembly of First Nations, with National Chief Ghislain Picard.

Bienvenue.

We also have with us Jessica McCormick, from the Canadian Federation of Students; Ms. Kathryn Hayashi, chief financial officer, the Centre for Drug Research and Development; and Bill Rogers, adviser, with the National Initiative for Eating Disorders.

Welcome.

Also, we have a former colleague back with us. From Partners for Mental Health, we have with us the Honourable Michael Kirby, former senator and founding chairman.

Welcome back, and welcome to the House of Commons finance committee.

It's a pleasure to have all of you with us. You will each have five minutes maximum for your opening statements, and then we'll have questions from members.

[*Translation*]

We will begin with Mr. Picard, who has five minutes for his presentation.

Chief Ghislain Picard (National Chief, Assembly of First Nations): Thank you very much, Mr. Chair.

[*English*]

I would like to thank the committee for inviting us to appear today.

My name is Ghislain Picard. I'm the national chief of the Assembly of First Nations. The Assembly of First Nations is the national political advocacy organization for first nation governments in Canada.

I am joined today by my colleague, Manitoba Regional Chief Bill Traverse, who is also the national portfolio holder on the AFN executive for housing and infrastructure.

The need for investment in first nations will not be a surprise to this committee. For over a decade the AFN has been raising chronic issues of underfunding directly to this committee as part of the pre-budget process.

Additionally, first nations and other organizations have been bringing your attention to these urgent needs. This year alone, there were 67 submissions that had direct recommendations regarding first nations. Chronic underinvestment in first nation communities creates widespread and long-term impacts on all aspects of the economy.

We have moved beyond having to prove that a disparity exists. The deep inadequacies in federal funding to first nations in all areas —core operations, education, child welfare, infrastructure, and health—are known and accepted. However, what we lack is the clear political commitment to address these. Within this context, the AFN once again is put in the position where we are forced to advocate for continuing already inadequate funding, because even losing that would be untenable.

When we look at the budget cycle for this year, we see a number of programs that support first nations where funding is not currently identified beyond this fiscal year. This includes the aboriginal skills and employment strategy, a critical support for training first nation citizens and creating linkages with employers. Also, numerous programs that support the health of first nation citizens need to be continued in the next budget, including the health services integration fund, the aboriginal health human resources initiative, the aboriginal diabetes initiative, maternal and child health, the children's oral health initiative, and the national aboriginal youth suicide prevention strategy.

The specific investments required in the 2015 budget are outlined in the AFN pre-budget submission, but we all know that we cannot continue with piecemeal, inadequate, and discretionary project-based funding. A fundamental transformation of the relationship between first nations and Canada is required in order to achieve significant change for first nations. New funding mechanisms are needed that move away from arbitrary and coercive contribution agreements to a fiscal mechanism that recognizes first nation titles and rights.

I would like to specifically refer to funding commitments made last year by the Prime Minister for first nations education. Our children cannot continue to face inequities in education across Canada. The AFN has been directed to ensure these funds are provided to our communities immediately and to engage with Canada on a new financial framework on education that supports predictable and sustainable transfer payments to first nation schools.

I will turn to my colleague now, who will make brief remarks specific to infrastructure.

We welcome the questions you may have. Thank you.

● (1710)

Chief William Traverse (Manitoba Regional Chief, Assembly of First Nations): Thank you. *Meegwetch*. Good evening.

[*Witness speaks in Ojibwa*]

I am here tonight to speak to you about the dire situation in first nations communities related to housing and infrastructure.

In Manitoba we have 64 first nations, and 31 of them are remote or isolated. They rely on winter roads for access, for supplies, but with climate change these are lasting for less time. They are often unreliable and unpredictable.

There are substandard and deplorable housing conditions in first nations communities. Recent environmental disasters affecting first nations communities, such as flooding, especially the flood of 2011, and forest fires, have just made this worse in Manitoba. Two first nations have been forced out of their communities due to floods, and are facing great hardships in temporary housing or hotels in Winnipeg and other urban centres. They have been there for over four years now. Many of them are passing on, are dying.

We are facing a housing crisis in our communities. The government knows this. A recent report identified that between 2010 and 2034, there will be a housing shortfall of 130,197 homes, that an additional 11,855 homes will be required to replace existing ones that are inadequate, and that at least 10,000 will need major repairs.

● (1715)

The Chair: Chief Traverse, I'm sorry, but we are out of time. Could I get you to conclude your opening remarks, please.

Chief William Traverse: Just like with education, we need to move forward on a framework that respects and fulfills our treaty and inherent rights and that responds to the real needs of our people.

Meegwetch. Thank you.

The Chair: Thank you very much for your opening statements.

We'll move now to Ms. McCormick, please.

Ms. Jessica McCormick (National Chairperson, Canadian Federation of Students): Good evening. My name is Jessica McCormick. I'm the national chairperson of the Canadian Federation of Students.

The Canadian Federation of Students is Canada's largest and oldest student organization, representing more than 600,000 students across the country. Our association advocates for an accessible, affordable, high-quality public post-secondary education system.

My presentation to the committee today comes at a time when students are facing significant hardships. Students are struggling to cover the increasing costs of a post-secondary education, an education that has become a prerequisite to participating in the workforce, and are graduating into a precarious labour market.

More than ever, students are looking to the federal government to build on its long history of involvement in funding post-secondary education in Canada. For more than 60 years, Canadians have benefited from federal education funding, either through direct or indirect transfers to the provinces, or from student loans and grants. It's this kind of national leadership that is critically needed to advance Canada's economy and reduce socio-economic inequality.

Our budget recommendations focus on making post-secondary education more affordable for students and ensuring graduates have access to good jobs. Throughout our lives, students have been told that we need some form of higher education in order to get a good job and participate in the workforce. However, rising tuition fees have made getting that education increasingly difficult. Across the country, educational choices are limited based on the region you live in or your socio-economic background.

Growing up in Cape Breton, Nova Scotia, I knew I had to get an education in order to get a good job, but my options were limited. I could stay at home and live with my parents and go to school in Cape Breton, or I could move to St. John's, Newfoundland and Labrador, and attend Memorial University. Other public post-secondary institutions in Canada were completely out of reach for me. After we compared costs, my parents and I soon realized that it would actually be more affordable for me to leave home and go to school in Newfoundland and Labrador, where tuition fees are about half of what they are in Nova Scotia.

Ensuring that all students, regardless of which province they're living in, are able to pursue a higher education and get the training and skills they need to succeed must be part of any long-term economic strategy. While the federal government makes significant investments in education each year through the Canada social transfer to the provinces, there's no mechanism for accountability of these transfers. A dedicated transfer payment for post-secondary education would not only increase accountability but also help establish long-term post-secondary education objectives that target quality and affordability. In return for upholding these principles, provincial governments would receive increased and predictable funding from the federal government.

In 2008 the federal government answered our call for a national system of grants. However, high tuition fees erode this historic investment by forcing many students to borrow in order to finance their education. Each year more than 450,000 students borrow through the Canada student loans program. On top of that, an increasing number of students are enrolling in the repayment assistance program because they're unable to make the minimum monthly payments on their loans upon graduation.

The long-term impacts of carrying student debt include delayed participation in the economy, the inability to invest or save for retirement, choosing to move out of the country to find work, starting a family later in life, and an aversion to taking financial risks. Increasing the value and number of non-repayable grants available to students could significantly reduce student debt in Canada. In Newfoundland and Labrador, the provincial government recently announced that they had completely replaced the provincial loans program with grants. The expansion of the grants program in that province has greatly reduced student debt and is an example for the rest of the country.

Young workers and recent graduates enter a labour force riddled with high youth unemployment, a characteristic that experts agree harms our economy. Young Canadians are highly educated; however, many have difficulty getting a foot in the door in today's workforce. While investing in education is one of the primary vehicles for reducing youth unemployment, there are other areas that need attention. The precarious labour market means that many new graduates take on unpaid internships in order to gain relevant work experience. Although Canada does not track the numbers, it's estimated that there could be as many as 300 unpaid positions per year. More robust protections are required to safeguard interns, and increased enforcement is required to ensure employers who break these laws face consequences.

While Canada is not the only country facing high youth unemployment challenges, there are lessons that could be learned from peer nations that could be successful here. One such model is the German dual system of vocational education. The system combines classroom-based academic learning at public colleges and universities with practical on-the-job vocational training. This model has a proven track record, and contributes to Germany's low youth unemployment rate and one of the strongest labour markets in the world. Additionally, Germany's private sector plays a vital role in the system. Unlike many employers in Canada who have reduced on-the-job training over the years, employers in Germany are providing training that gives students applicable skills that help them advance within their jobs and are portable to other work.

● (1720)

I would be remiss if I didn't note that less than a decade after they were introduced, Germany recently eliminated tuition fees.

Five minutes is never enough time to do justice to the recommendations we've put forward for this year's budget, but more details and background research on our recommendations are provided in our written submission.

I'd be happy to take any of your questions.

Thank you.

The Chair: Thank you very much for your presentation.

We'll now to go Ms. Hayashi, please.

Ms. Kathryn Hayashi (Chief Financial Officer, Centre for Drug Research and Development): Good afternoon, ladies and gentlemen. On behalf of the Centre for Drug Research and Development, CDRD, and our commercialization vehicle, CDRD Ventures, I'd like to sincerely thank you for this opportunity to speak with you today.

First, I will introduce our organization. Headquartered in Vancouver, CDRD is Canada's national drug development and commercialization centre, the only one of its kind, providing the expertise and infrastructure to transform basic health research into commercialized therapeutics, improving human health, while at the same time growing our national health sciences industry into a fully optimized generator of economic prosperity.

CDRD represents an effective means to advance innovative technologies forward along the innovation continuum, adding value throughout that process. These value-added technologies can then form the foundation of a critical mass of new health sciences companies, thus creating long-lasting high-paying jobs for Canadian families, and supporting continuing Canadian brain gain by providing biomedical researchers with attractive opportunities in Canada.

At the same time, training opportunities that generate new, industry-ready, highly qualified personnel to lead the industry into the future is also a key cornerstone for CDRD's success.

CDRD-developed technologies also represent an opportunity to improve patient care while reducing health care costs through more effective treatments and front-line care for Canadian families, for example, better management of chronic diseases and subsequent reduced hospitalization.

In terms of supporting families and helping vulnerable Canadians specifically, CDRD represents a new way to bring innovative therapeutics to patients, a national model that fosters collaboration, sharing of resources, leveraging of investments, and mitigation of risk. It also offers the opportunity to improve patient care while reducing health care costs through more effective treatments and front-line care.

To further illustrate the potential impact on patients, I refer to our partnership with the Multiple Sclerosis Society of Canada announced earlier this year. This partnership has been created with one goal in mind: to speed up the development of new treatments and find a cure for people living with MS.

I'd like to cite a related passage by MS Canada's vice-president of research, Dr. Karen Lee. She said:

> When I look back over the years I can recall a lot of great research that has been done to better understand, diagnose and manage MS. Studies funded by the MS Society, in addition to what has been conducted around the world, have changed the landscape of MS research in monumental ways. But one thing that always seems to come up in my conversations with people with MS is that advancements in research still take a very long time, and they fear that they will not see the true benefits or impacts of the research in their lifetime.
>
> This led to the establishment of a very important collaboration with an organization that not only has the tools and resources to speed up treatment delivery for MS, but is located right here in...[Canada], CDRD.

Next week we will in fact be announcing our very first drug development collaboration under this partnership, one which is very reflective of the strength of our model as it brings together a lead researcher from Memorial University in Newfoundland, CDRD's drug development and commercialization experts in Vancouver, clinical collaborators at the Montreal Neurological Institute, and global industry funding partners.

To ensure Canadian families are provided with the best treatments and to further support this type of critical collaboration and CDRD's ongoing sustainability as a large-scale national endeavour, CDRD is therefore requesting a unique federal investment to support its next five years. This will provide the foundational support CDRD requires to ultimately reach the point of self-sustainability.

The federal government has a tremendous opportunity to build on CDRD's success and further optimize what it has already helped to seed. We have established an international competitive advantage for Canada and now have the opportunity to leverage this advantage to realize the full potential of Canada's health sciences industry and improve the health of Canadian families while creating good jobs. In doing so Canada will not only be the generator of world-class health research that it is today, but also be the generator of world-class innovation from the translation of that research.

● (1725)

The Chair: Thank you very much for your presentation.

We'll now hear from Mr. Rogers, please.

Mr. Bill Rogers (Advisor, National Initiative for Eating Disorders): Thank you very much for letting us present today.

I am a volunteer for the NIED organization. I'm here with my associate, Lauren Jawno, who is a founding member of NIED and a recovered eating disorder patient. She also works with people with eating disorders.

Who is NIED? NIED is a for-purpose, not-for-profit coalition of parents and children challenged by eating disorders, sufferers, health care professionals, and counsellors. NIED's aim is to increase the awareness and education of eating disorders to promote change in the understanding, treatment, and funding of the disease in Canada.

What does eating disorders mean? First of all, it's a disease that has one of the highest mortality rates of mental illness in the world, but it can be prevented and cured, which makes it unique. It is prevalent in young girls and women, but is expanding its presence to citizens from all walks of life—recently a seven-year-old boy who was admitted to Sick Children's hospital in Toronto with eating disorders, all the way up to an 86-year-old woman who'd had bulimia for over 30 years.

As to the cause, the blunt reality is that we don't know. There is lots of research but there is no true cause. What we do know, and it's more important than anything else, is that it can be prevented if it's treated at an early stage.

The number of eating disorder cases in this country continues to increase. There are very few data points on eating disorders. One of the more recent ones, and this was done in 2006, may be representative. Researchers in Edmonton studied 700 children in grades 5 to 7. Of these children, 15% were purging or over-exercising, 16% were binge eating, and 19% restricted themselves to one meal or less per day—very disturbing facts.

How is it currently being treated? The only thing I can say is not well. The number of family doctors trained in treating eating disorders in Canada is almost nil. The community health care agencies lack both the time and the funding for training in eating disorders, and are generally overwhelmed by mental health referrals. There's also a huge shortage of psychiatrists who specialize in this. Currently there are 4,100 psychiatrists in Canada, of which 12 specialize in eating disorders. Of these 12, only a handful specialize in treating children and adolescents, where it's most prevalent. However, there are evidence-based programs that have been developed by researchers and doctors over the years that work. They've been proven in test studies to work; however, there have been no funds and no initiatives to develop them among our health care system.

What do we need? In order to really beat this disease, and many doctors and researchers we talk to believe it can be done, we have to develop an infrastructure that can build the capacity for the delivery of timely, age appropriate, evidence-based treatment and support services. These services have to span prevention, specialized outpatient treatment, intensive treatment, and residential services. We have to educate and train. We need to train family doctors to screen for eating disorders, to have the language to talk to our children about nutrition, body image, and eating disorder thoughts, urges, and symptoms. We need to send more trained mental health nurses and health care counsellors into our high schools to help young people who are struggling with these issues.

How do we get there? We know that this disease is pervasive in Canada. There's no data that tells us how many people have it. However, the NIED phones ring off the hook. We're all volunteers. We fund it with our own money. People and families are looking for help. They're looking for help for their children, their loved ones, because so many of them end up dying as a result of this disease.

● (1730)

Provincial health care systems typically need hard data to be able to allocate their scarce resources to this disease. Provincial health care systems inadvertently have developed their charting systems to hide the data on ED. That's not on purpose; it's just the way it has developed. For example, there's no charting category for eating disorders in any of the doctors' charts, which ultimately are being used for the data on many of the health care decisions that hospitals and health care administrations have to deal with.

The Chair: Mr. Rogers, could I have you conclude, please.

Mr. Bill Rogers: In conclusion, we believe it's an insidious disease that can be prevented and cured, but today it continues to kill people. We welcome and would love your support to help us make the first step to get there.

The Chair: Thank you for your presentation.

We'll now go to Senator Kirby, please.

Hon. Michael Kirby (Founding Chairman, Partners for Mental Health): Thank you very much, Mr. Chairman.

The clerk and I believe we have a way of showing you a short video, with 30 seconds in English and 30 seconds in French, and I'm going to take the first minute of my time to do this. Since I didn't bring my grandchildren to make sure it was going to work—

Voices: Oh, oh!

Hon. Michael Kirby: —I'm relying on the clerk to try it.

Go ahead, please.

It's on your iPads, as I understand it.

[*Video Presentation*]

Hon. Michael Kirby: Thank you for that. I thought it would set the scene for the rationale for my proposal.

As an aside, that particular public service announcement was played at no cost to Partners for Mental Health. Indeed, we got the actual making of the 30-second piece contributed. Last year we got a million dollars' worth of free publicity, according to the networks. The next PSA, in terms of frequency of play, got $100,000. That piece obviously touched a lot of people in the media and a lot of people who watched it.

Let me give you a couple of very simple facts about the issue of children and youth suicide.

First of all, it's the second leading cause of death of people between the ages of 15 and 24, second only to car crashes. Among first nations youth, it's four times—four times—the Canadian average. Canada has the third worst youth suicide percentage among all the industrialized nations of the world.

More importantly in many ways, three times more youth die by suicide than by all forms of cancer combined. To put it in perhaps a very graphic way, over 750 young people kill themselves each year, which is the size of a mid-sized high school. Visually, if you think of a mid-sized high school being totally wiped out, it gives you some indication of the size of the problem.

What I did was convene a team of experts from across the country under the chairmanship of Dr. Ian Manion, who is the executive director of the Ontario Centre of Excellence for Child and Youth Mental Health. We developed a research proposal. In the document, I've given you the summary of the methodology and so on. The fundamental thing to understand is that the methodology is to choose 25 communities cross the country, communities that will be geographically dispersed but also very culturally dispersed and different. Some will be first nations; some will be Inuit; some will be multicultural; some will be rural.

We need to understand what the characteristics of a community are in order to develop the best community-based way of dealing with the problem, because the one thing we absolutely know is that you cannot simply have a laying on of hands from the national level or provincial level and have a meaningful impact at the community level. It has to be community-based and it has to be essentially whole-community-based, in that it has to involve people from education, health, justice, child welfare, and families, and indeed, youth themselves.

What I anticipate as an outcome is not dissimilar to the kinds of outcomes I got from a similar cross-country study I did when I was running the Mental Health Commission, our study on the mentally ill homeless, where we determined what the most important characteristics of delivering mental health services to the homeless are, because we know that approximately 80% of homeless people have some element of a mental problem. We intend to have exactly the same kind of outcome, geared to a particular makeup of a community.

● (1735)

The final point is that we intend to do this with matching funds. I'm not interested in just getting federal money. We will get matching funds from provinces, from philanthropic organizations, from some private sector organizations, and so on. I've had enough conversations across the country now to say quite comfortably that we can raise that money, simply because everybody believes it's a paramount problem and we have to have an evidence-based approach to solving the problem.

Mr. Chairman, I'd like to add one thing. Several senior members of the government have asked me to add on a component that will also look at the issue of military suicide. I'm in the process of doing that. The communities will be military units or bases. In a sense, we will expand from 25 communities to 30, with the other five being related to the military.

Mr. Chairman, my bottom line is that this government has been exceedingly kind to me. They asked me to put together the Mental Health Commission, and we ran that. They asked me to run the program on the homeless mentally ill. I'm now asking them to give me a chance to do one last very important thing, which is address the issue of youth suicide.

The Chair: Thank you very much for that presentation.

Colleagues, for the first round, the first four questioners will do seven-minute rounds. Then we'll move to five-minute rounds, because we do have at least one vote this evening.

Ms. Davies, for seven minutes, please.

Ms. Libby Davies: Welcome to our witnesses.

I'm not usually on this committee. I'm the health critic for the NDP. I'm subbing in because there are a lot of health issues that are coming up today, and I want to focus on them.

In particular, I'd like to follow up with Grand Chief Picard. You raised a lot of issues, but I will focus on the issues having to do with health and wellness. Finally, after many years of advocacy and lobbying, there is now a joint study of the non-insured health benefits, which is a federal responsibility. It just started recently, after the AFN called for it for years. Could you give us an update as to how that's going or what you hope the outcomes will be?

Also, I'm very concerned to see the list of programs due to sunset in 2015. They're all critical programs. I can't imagine the anxiety it causes the organizations, worrying about whether they're going to be able to continue. Could you tell us a little more about the impact, should there not be any continued funding? I could name a couple. A major one is the aboriginal diabetes initiative, for example, which we heard about earlier.

I'd also like to ask Mr. Kirby a question, if there's a couple of minutes left.

Grand Chief, could you talk about the non-insured health benefits partnership?

● (1740)

Chief Ghislain Picard: On this issue we can follow up with the committee in terms of providing the information that you are requesting.

I want to take a few seconds to respond to the second part of your question. This is key in terms of our role before this committee and our numerous attempts over the last 10 years to adequately represent exactly what you're speaking about. If the cost of health care is rising in aboriginal communities it's because the costs of other programs stay the same—housing, education. All of that has an impact on the health sector.

We often find ourselves in this vicious cycle that is reflected in the last part of your question, which is what happens beyond 2015? That creates a lot of uncertainty in our own institutions and in our own first nations governments, not counting the tremendous turnaround in personnel. That also causes instability in many of the programs, which we don't need.

As I said earlier, we come and we respect. I don't want to be out of order but I need to say this: we respect the institutions of Parliament, but at the same time some of our people might not agree with this. We come to these committees and express what we feel about these totally disappointing programs in terms of their impact on our communities. We provide suggestions for change, but with little result. To me, this is what we take back to our leadership.

Ms. Libby Davies: Thank you. I understand and respect where you're coming from because it is about action and follow-up rather than empty promises. The NDP is going to be pushing this and making sure that those commitments are made.

I'll turn now to Mr. Kirby.

Suicide prevention is a huge issue in this country and it's good that there has been a fair amount of discussion in Parliament about this issue. We've had private members' bills and we've had sessions at the health committee.

I want to ask about the organization you head up, Partners for Mental Health. What is your record—not what you want to do, but what you've actually done—in terms of collaboration with other key partners?

I'm a bit surprised that you're here. I presume you're asking for federal funds. There are major players already doing this work, whether it's the Mental Health Commission of Canada, the Canadian Alliance on Mental Illness and Mental Health, Canadian Psychiatric Association, or the Canadian Psychological Association. It's not clear to me what your record of collaboration is.

I think it's very important that there not be duplication. The Mental Health Commission of Canada, which you were involved with, has a very significant ask in terms of continuing its work right across the country. I know that suicide prevention is very much a part of its agenda. What is your collaboration there?

● (1745)

The Chair: A brief response, please.

Hon. Michael Kirby: Partners for Mental Health has been going for about a year and a half. Our intent was, and still is, to build the kind of social movement that exists with breast cancer. We've already recruited 70,000 members and that number is growing.

None of the organizations you mentioned are doing anything on the ground to figure out how to make changes at the community level. They're doing lots of what I would call paper work—

Ms. Libby Davies: I'm very surprised to hear that. I've met with them and I don't agree with you.

Hon. Michael Kirby: They are not doing the kind of empirical work on the ground that is required to ultimately make a difference. I've always been—

Ms. Libby Davies: What's your level of collaboration with them? What have you actually done to collaborate with those organizations?

Hon. Michael Kirby: At this point we haven't had anything to collaborate on with them because I've been out building a social movement. None of them are into the business of building a social movement. We're the only people doing aggressive social marketing, so there hasn't been anything.

Ms. Libby Davies: What are you actually asking of the federal government in terms of financial support?

Hon. Michael Kirby: I'm asking the federal government to do as it did with the homeless mentally ill. They contributed $100 million over five years to run projects in 25 different communities targeted specifically at finding out what really works, not theoretically, but in fact in practice.

Ms. Libby Davies: Thank you.

The Chair: Thank you, Ms. Davies.

We'll go to Mr. Saxton, please.

Mr. Andrew Saxton: Thank you, Mr. Chair, and thanks to our witnesses for being here today.

My first questions will be for the Centre for Drug Research and Development.

Ms. Hayashi, as you know, I recently had the opportunity to visit your very impressive facilities at the University of British Columbia and to see first-hand the work that you're doing there. Perhaps you could share with the committee some of the successes that CDRD has had to date, and how CDRD is going to help Canada become a world leader in drug research.

Ms. Kathryn Hayashi: We've had quite a good record so far. We are a relatively new organization. We were initially funded in 2007 by the Province of B.C. and spent the first couple of years building labs and building up our team. Since then, we have a couple of spin-out companies. One is called Sitka Biopharma. They are working on a platform technology, but their initial application is for bladder cancer. There has not been a new treatment for bladder cancer in 30 years. It's the most expensive cancer to treat per patient over a lifetime because it's a recurring cancer that comes back and comes back. This could be a new treatment paradigm for bladder cancer, with one treatment resolving the disease enough that it wouldn't recur. That's one of the things. The platform also has other applications. It could also be used in prostate, or other sorts of vesicle-type cancers.

We also have a company called Kairos Therapeutics, which is an antibody-drug conjugate platform. It's a very exciting technology, very high interest from the investor community, spearheaded by a man called John Babcook, who left a very good job at a very large company to lead the initiatives of starting a company that he wants to see as the next Genentech in Canada. He wants it to be a successful company that runs, is not acquired, and creates jobs and prosperity for Canada.

He's had a high level of interest from angel investors and venture capital investors, so we'll see how that progresses. It's a cutting-edge platform of biologics that was initially funded through a grant from Western Economic Diversification Canada to bring him aboard with a few staff and some start-up equipment. We're at a point now where we have a very exciting new company on board.

Mr. Andrew Saxton: In addition to research and development, you're also focused on incubation as well as commercialization of [*Inaudible—Editor*]. Is that correct?

Ms. Kathryn Hayashi: That's correct.

We've kind of figured this out over the past several years of operating. We have a search team of very experienced scientists with industry focus who go to our partner institutions across Canada. All of the health research institutions are part of our network in Canada. They travel to Memorial University, Dalhousie, and all across the country. They look at projects, speak to investigators, and try to figure out whether there's a commercially promising piece of research that they're working on, and develop a project plan. Once we have a project plan, we pull in, and they all take a look at the plans and figure out which projects they wish to fund.

Right from the very beginning, we have external validation in terms of independent review of the science, and also some indication that there's some market pull, that there's some real interest in this technology as an investable and developable drug.

● (1750)

Mr. Andrew Saxton: You've asked for $153 million over seven years, roughly $22 million a year. How do you intend to invest that money?

Ms. Kathryn Hayashi: Actually, it's only $140 million.

It's really to leverage what we've already started, but really to establish CDRD firmly as a national organization with an expanded search team that we can really have people on the ground all across the country, and also to really invest in some of the projects.

Drug development is a very time-consuming and complicated process. You have to expect a lot of attrition. It's science and sometimes the experiments don't work out. You need a lot of shots on goal to find the successes that will provide not only the economic success at the time but the self-sustaining aspect, which we built into our model right from the beginning. We realized that, at the start-up period, if we can invest in technologies, then hopefully there will be a couple of home runs in there that will fund our continued operations after a start-up period.

Mr. Andrew Saxton: Thank you very much.

My next question is for the National Initiative for Eating Disorders.

In your submission you propose a ministerial advisory committee. What role would a ministerial advisory committee potentially play in drafting and implementing a national strategy on eating disorders?

Mr. Bill Rogers: That's a good question.

As a small organization, or relatively new one, we recognize that any funding for this research should fall under some sort of federal organization to oversee it. In going out into the marketplace, we believe we have two things that have to be done. First of all, we have to look at all the data that has been collected—there's been a bunch of little studies here and there—and determine how to get at that data. A national organization undertaking this will have much easier access in terms of obtaining that data and will be able to manage the funds.

We don't propose to do this ourselves. We're not set up do it. It's not what we want to do. What we see is that we need one of these organizations to take this on so that the data becomes available nationally, to the provincial governments and the federal government, and we can start building an action plan to move this forward.

Mr. Andrew Saxton: Thank you very much.

I will now turn to Michael Kirby with the Partners for Mental Health.

First of all, that was a very powerful ad you showed us, so I think you have a very good team making those.

Very quickly, what strategies can be used to lower youth suicides in Canada?

Hon. Michael Kirby: The evidence from elsewhere in the world —it hasn't been done in Canada—is that you have to do, as I said, a whole community approach, which means all of government services but a number of private sector services and volunteer services. You essentially have to get them all coordinated and working together. If you don't do essentially a full-service group working together, it won't work.

The second thing you need to do is have a significant role for youth in designing the actual program. The evidence elsewhere shows very clearly that coming in with a laying on of hands by some group of adults, whether they're local or not local, doesn't work. The kids don't buy it.

The best examples in the world, one in Germany and a couple elsewhere in Australia, have been cases not where the youth were running it but where they were a very major player and all of the various public, i.e., government, social services and the private sector typically not-for-profit social services got together.

The Chair: Thank you very much, Mr. Saxton.

Mr. Brison.

Hon. Scott Brison: I'll start with Chief Picard.

What would be the aboriginal versus non-aboriginal school funding gap today? We hear from various witnesses that there's a significant funding gap, but what would be the funding gap today in terms of the percentage of non-aboriginal school funding?

Chief Ghislain Picard: The rough figure that comes to mind is that an aboriginal student costs maybe half as much as a non-aboriginal student. I think this also speaks to the issue of what happens in other programs as well. I could easily tell you that in Canada tomorrow morning we need 60,000 new units in housing in order to meet the current Canadian rate of occupancy. I could easily tell you that there needs to be a look at the escalators, the annual escalators, when it comes to provinces, versus that of first nation communities, which have been capped at 2% for the last almost 20 years now.

The same principle applies in education. It hasn't been reviewed, and we fall into this cycle of coming to these committees and making our points.

● (1755)

Hon. Scott Brison: On a per-student basis, schools in aboriginal first nations communities receive 50% of the funding of non-aboriginal.

Chief Ghislain Picard: Well, it all depends—

Hon. Scott Brison: As a specific question, though, in your written submission you call for money that was set aside in budget 2014 for first nations education to be released immediately. Why has the government delayed this funding?

Chief Ghislain Picard: To us, it's obviously tied to our position with regard to Bill C-33, first nations control of first nations education. That's been really what I would call the dialogue of the deaf since the spring, in the sense that there has been no communication whatsoever except our expressing our interest to engage government based on terms that we could also define as first nations.

Hon. Scott Brison: Senator Kirby, thank you for your work on mental health. That's your latest initiative.

Given that we have the youngest and fastest growing population in Canada, which is aboriginal and first nations youth, and given that you were saying that there is four times the rate of suicide in these communities, would that not be in some ways the lowest hanging fruit to focus on, the one area where the federal government has a greater level of responsibility in terms of those communities to focus on fixing that incredibly severe social crisis?

Hon. Michael Kirby: I absolutely agree with your evaluation. It's scandalous. I actually thought about doing that, but the more I thought about it, the more I realized that if you were going to get broad support for it, you really had to go beyond first nations, and I include Inuit—

Hon. Scott Brison: Both.

Hon. Michael Kirby: —because it's not as bad as first nations, but it's not good.

But you'd have to go beyond first nations and Inuit. As I said, a primary focus will be first nations and Inuit, but you have to include the rest of the population as well. I guess I would describe that as a pragmatic conclusion to try to make progress on the issue.

Hon. Scott Brison: In some ways, working in non-aboriginal and non-first nations communities in terms of the initiative helps build a broader coalition of support from the public for the initiative.

Hon. Michael Kirby: Extremely, and we know it does that.

Hon. Scott Brison: Regarding the whole issue of the stigma around mental health issues, I know that organizations like CAMH, the Centre for Addiction and Mental Health, have done a good job in breaking down some of that stigma.

How important is that part of your work in terms of reaching out and changing people's minds, particularly young Canadians, about the stigma around mental health?

Hon. Michael Kirby: Addressing the stigma issue, which a lot of people are now doing, sort of began when the Senate report came out, and it as escalated over the 10 years since then, but just attacking awareness or stigma is not going to solve the problem with the individual children and youth who have a problem.

Take the Bell Let's Talk campaign, for example. The beauty of that campaign is that it has increased public awareness, but in the end what you have to do is take that increased sense of public awareness and ask what we are going to about the problem, because awareness doesn't solve the problem.

I've always been on the let's-solve-the-problem end of the business, which is a logical step to go. It would be much harder to do this if the public weren't nearly as aware of mental health as they are now.

Hon. Scott Brison: Thank you very much for your work on this.

Ms. McCormick, from the CFS, you've spoken of the challenges in terms of affordability of post-secondary education, of the youth job situation, and the unpaid internships.

Stats Canada currently does not track unpaid internships. We know from anecdotes that it's an issue that's growing. Would that be the best starting point, that Stats Canada actually commence the tracking of unpaid internships in Canada?

● (1800)

Ms. Jessica McCormick: Yes. We appeared before the committee on a study about youth unemployment and we spoke about the need to track those statistics just to get a good idea of what it is we're dealing with, because we only have estimates that there are as many as 300,000. That would be a good place to start.

We're lobbying provincial governments to enforce provincial legislation around the issue as well.

The Chair: Be very brief.

Hon. Scott Brison: Mr. Rogers, on some of the work of Senator Kirby, I think there may be some opportunities, particularly around eating disorders in young people, for some collaboration. You may have some thoughts on that in terms of collaboration.

The Chair: We're right up against the end of Mr. Brison's time.

Do you want to make a brief comment, Mr. Rogers?

Mr. Bill Rogers: Sure.

Absolutely, we brought Michael and his organization into where we are. It's just another cause of suicide among children, as well as death.

Hon. Michael Kirby: We've talked about that explicitly.

The Chair: Thank you, Mr. Brison.

We'll go to Mr. Keddy, please.

Mr. Gerald Keddy: Welcome to our witnesses.

To Grand Chief Picard, regarding the ongoing investment in first nations education, you're asking for an immediate release in your budget ask of the $1.9 billion for first nations education, and at the same time your organization was involved in the drafting of this. I'm not quite certain what has happened. There seems to be toing and froing over the dollars. It's budget 2014.

We have to find a way to make sure that money goes out to first nations. I don't think there is any argument on any side of the table that it happen. How do we do that and how do we make sure there is an equal level of expertise, and that all the first nations are involved in first nations education? How do we distribute those dollars in partnership? The one thing you've heard at this table was partnership, collaboration, and best practices. That's the one thing I've not heard from you, so you need to enlighten me.

Chief Ghislain Picard: What you're raising is exactly what we're hoping to achieve.

We're seeking an arrangement, or a framework, if you will, with the government in terms of how to best expend the moneys that are needed. Obviously, we might have as many interpretations as we have people around this table in terms of what happened over the last six months, but this doesn't change the fact that this money is needed for many reasons, including the fact that first nation citizens across the country experience demographics that no other Canadian citizen or society experiences. That's a good point right there. The point made earlier about the discrepancies between what is available to first nations communities versus what is available elsewhere is another argument that I think needs to be considered. The fact that the funding formulas have not been revised for the last 20 years is also a good point to make.

Let's discuss that. Let's find an arrangement on this. Let's look at a much broader fiscal framework where first nations leadership would find some benefits.

Mr. Gerald Keddy: Thank you.

Recently a group called Indspire appeared at committee. They're doing some great work with aboriginal students. They're achieving some great high standards at post-secondary institutions, at both the community college and university levels. They've been able to leverage fairly modest—compared to what we're talking about—federal funding into more scholarships, and they've been able to work with the private sector as well.

I have two questions. I assume you're familiar with the group. Can we find that same ability—and again, I want to use the words “collaboration”, “partnerships”, and “best practices”—to access those funds and move forward?

● (1805)

Chief Ghislain Picard: I think no one will dispute what Indspire has been able to achieve across the country. At the same time—and we totally agree with the argument that they defend as well—if you're caught in a situation where you have to negotiate year after year what you plan for the next 10 years, it's never a comfortable situation. We certainly support that principle. This is where most first nation communities find themselves, as was raised earlier: that you can plan only for the next 12 months, instead of the next 12 years. It's the situation that many of our communities find themselves in.

Mr. Gerald Keddy: Thank you.

Ms. McCormick, you talked a bit in your presentation about the German model. Around this table we've had some great discussion about the German model, the success that it's had, quite frankly, and the buy-in from everybody, from the educational institutions to private sector to society. It truly is a remarkable model. Whether the German model or the Swiss model is first and second in the world, both of them are great.

In your submission you asked that the federal government create a post-secondary education act in cooperation with the provinces, with a dedicated cash transfer modelled after the Canada health transfer. That's a big ask. How much do you foresee that transfer being? How many students would that affect? Again, would it be all federal dollars, or would there be some private sector partnerships?

Ms. Jessica McCormick: Right, it's a big question.

We talked about the dedicated transfer payment in the recommendations. One of the main reasons we bring it up is it allows for a level of accountability for investments that are being made in the provinces. Whatever arrangement is made, and this is very similar to the German model where there's a lot of cooperation between the federal government and the states, it needs to be something that's developed in cooperation with the provinces, because similarly, here provinces have jurisdiction over post-secondary education.

On the specifics of the number of students that would benefit, I don't have that number. We can come back to the committee to provide it in more detail. But I think whatever the arrangement is, similar to in Germany, it needs cooperation between provincial governments and a level of accountability for the investments that are being made by the federal government.

Mr. Gerald Keddy: If you could get those numbers back to the committee, that would be appreciated.

Ms. Jessica McCormick: Absolutely. Sure.

Mr. Gerald Keddy: Finally, because I just have to ask this question of the National Initiative for Eating Disorders, one of the highest mortality rates of mental illness—

The Vice-Chair (Hon. Scott Brison): I'm sorry, your seven minutes are up.

Mr. Gerald Keddy: —in the world is an outstanding statistic. I don't know how you deal with that. And I'm out of time.

The Vice-Chair (Hon. Scott Brison): If I could have helped my neighbour from Nova Scotia, I would have.

[*Translation*]

Mr. Caron, you have the floor. You have five minutes at your disposal.

Mr. Guy Caron: Thank you very much, Mr. Chair.

Thank you to all of you for your presentations.

I'd like to be able to put questions to each and every one of you, but I only have five minutes. I will speak to Chief Picard. I also want to welcome Chief Traverse to the committee.

One thing really surprised me. I knew that the transfer increase ceiling was 2%, but I just realized that that is the way it has been for 18 years. In your brief, you did specify that during the same period, the average transfer increase from Ottawa to the provinces and the territories was 6%. You also estimated that since 1996 the shortfall caused by that ceiling was of $3 billion. Did you calculate that $3 billion using the cost of living increase, or does it also reflect population growth in aboriginal communities?

● (1810)

Chief Ghislain Picard: Indeed, those two arguments at least support the figures that we have put forward. Demographic growth among first nations is unequalled anywhere else in the country. So it is very important to also consider those realities.

By the same token, we must also realize that if we do not invest in housing, that is going to have impacts on education and health care costs. Those costs may potentially double if not triple.

Mr. Guy Caron: Chief Traverse talked about infrastructure in Manitoba, particularly in the north of the province. I think there is an infrastructure problem throughout the whole country. Take Attawapiskat, in 2011, and the crisis that took place there. I'm also aware of the situation in northern Quebec, especially in the Innu and Inuit communities. To get back to Attawapiskat, in 2011 there was a crisis and it became known that there were crises as well in several other communities. How would you assess the progress made on infrastructure since 2011, that is since the whole issue of infrastructure came back to the fore in the news?

Chief Ghislain Picard: Once again, you are raising the issue of infrastructure. That matter is intimately linked to what I was saying earlier, which is the issue of what is given to the provinces and what is made available to our communities. I was pointing to the fact that there has been a ceiling in place now for close to 20 years, where infrastructure is concerned in particular.

In addition, since the budget is already so tight—and has been for close to 20 years—from one year to the next there may be budgetary reallocations. I am referring to funds that were normally designated or reserved for infrastructure and were reallocated to other programs or other sectors such as health care and social assistance. The impact of that can be that our needs will be multiplied by a factor of five or ten in some sectors.

Mr. Guy Caron: You say that currently, the communication between the government and the Assembly of First Nations or other representatives has essentially been interrupted, or has broken down. In the past, however, you did have discussions with the federal government. How did it justify the decision to limit transfer increases to 2%—transfers to aboriginal communities—whereas transfers to provinces and territories were larger? What argument did the government use to defend that decision?

Chief Ghislain Picard: We sure would like to have an answer to that question.

I think that beyond that, that can be a basis to try to better define the framework that has to be created for the First Nations, the governments we represent and the federal government. In my opinion, and with all due respect for the different organizations that come before the committee, I think that the framework needed for the First Nations is on a whole other plane and requires a much broader intervention.

Mr. Guy Caron: Thank you.

I only have a minute left, but I have a last question for you.

In your brief, you also raised the issue of the aboriginal women who have disappeared and been murdered. The debate is ongoing at this time and our position is that there should be an inquiry into this. The government's reply is that it has a $25-million action plan, over five years. Is that sufficient? What is your interpretation of the priorities in that action plan?

Chief Ghislain Picard: On the face of it, we think that that is not enough. However, such an inquiry might shed light on the causes of that situation throughout the country, some if which have not been identified, allowing us then to perhaps better gauge the needs of the communities.

The Chair: Very well. Thank you.

Thank you, Mr. Caron.

[*English*]

We're going to Mr. Adler next, for a five-minute round.

Mr. Mark Adler: Thanks to all of you for being here this afternoon.

I want to pursue my line of questioning with Mr. Rogers.

Portia de Rossi, Lindsay Lohan, and Snooki: celebrity after celebrity, high-profile people, have suffered from eating disorders. Everybody knows somebody with an eating disorder, yet why is there so much ignorance about eating disorders? Why do people who don't understand just say that all you have to do is eat more and you'll be fine, or just eat a big meal and you'll be fine? Why do only 12 of 4,100 psychiatrists specialize in eating disorders? Why are there so few resources committed to the treatment of eating disorders in Canada?

● (1815)

Mr. Bill Rogers: It's an excellent question and one that I've asked myself many times. We've looked at it and looked at it. Everyone has an experience, but what we don't have.... I talked earlier about things like the charting that goes on in hospitals.

I'll give you another example. When a child or an adolescent goes into the hospital with a severe eating disorder issue and they need to be hospitalized, they have to be put under a different category in order to allow the hospital to admit them to the hospital for the number of days it's going to take. Eating disorders have been hidden under other mental categories for so many years that there is just no data.

When you talk to administrators and provincial regulators around this, they know the problem is there. Everyone knows it's there, but it's very difficult for people with scarce budgets and limited time to allocate on the basis of what they think they know. It's our view that if we can get this data out into the public and in front of the regulators, both federally and provincially, it will compel them to start investing the time and the money in these programs to save the poor patients who suffer with this disease.

Mr. Mark Adler: This is a widespread issue. This is not just in the health community. The police get involved, so there's criminal justice. This is widespread, so it's not just about educating people to identify eating disorders. It's much more than that. Can you talk about that?

Mr. Bill Rogers: Sure. I'm happy to do that.

It's twofold. They're a big burden on the health care system, there's no question about it, because it's continual. If we can prevent it and cure it, we can keep them out of hospital.

The second thing that happens, particularly with youth, is that you'll find them being picked up for stealing, for all kinds of criminal activities. That leads to it, because they're hungry. Parents don't want them to eat, so they go out and steal. We have that burden. We also have the burden of the families, which is a huge economic problem. We see families all the time. These are parents who lose their jobs, who are afraid to leave because their kids are so sick and there's no place to take them. There are no programs to help them, so they have to stay home. They're worried about suicide and issues like that. It's a huge economic burden.

We don't know what the data is, but I can tell you that phones ring off the hook at NIED with people looking for help, because there just is none in this country. We believe that if we can get the data together and get that out there, we can make a huge difference in this disease and actually do something that's preventable, and we can cure it.

Mr. Mark Adler: It's pretty fundamental. NIED needs to get funding in order to compile this data, because when people die of an eating disorder, it's not registered that they died of an eating disorder. It's heart failure, or liver failure, or whatever, so we don't know how many people.... We know it's a lot of people, but we don't know how many people actually have eating disorders, do we?

Mr. Bill Rogers: That's correct. We do not.

Mr. Mark Adler: Which is an abomination, I think.

Mr. Bill Rogers: It is, absolutely, and it has fallen under the radar of our health care systems for too many years.

Mr. Mark Adler: In terms of the treatment of eating disorders....

Let me step back for a second. You're not here asking for money for yourself or a need to conduct a study, are you?

Mr. Bill Rogers: No, we're not. We're asking for the money to be put into what could be a number of agencies, but something like the Public Health Agency of Canada could conduct this service. We want the data. We don't have to do it. We're not prepared to do it, but we need the data and we need the allocation of funds to do it.

Mr. Mark Adler: Then step two is—

The Chair: Thank you very much, Mr. Adler.

We'll go to Mr. Rankin, please, for five minutes.

Mr. Murray Rankin: Thank you to all witnesses.

I'd like to start with Jessica McCormick of the Canadian Federation of Students.

I was taken with your excellent brief. There are a few recommendations I'd like to have you elaborate on, but the one I'm thinking of is the one where you talk about implementing a federal post-secondary education act in cooperation with the provinces modelled after the Canada Health Act.

I wonder if you think that would do the trick. Given that the federal government has not exactly been aggressive in enforcing the Canada Health Act, why would you have any more confidence that they would do so if there were a post-secondary act like that?

● (1820)

Ms. Jessica McCormick: Canada is one of the only OECD countries that doesn't have a national ministry of education.

The situation right now in Canada is that there is a significant disparity in the tuition fees that are charged from province to province. It's a situation whereby students in Newfoundland and Labrador pay about $2,600 per year in tuition fees, whereas students in Ontario pay more than $7,000 per year.

The goal behind implementing a post-secondary education act is to provide some sort of consistency across the country and a level standard of access to post-secondary education, and to provide some accountability for transfer payments made to the provinces to ensure they're being invested as they were intended to be invested rather than the situation we have now where money is going to the provinces through the Canada social transfer, but it's often unclear whether or not that money is being spent as it was intended.

Mr. Murray Rankin: I think you mentioned in your presentation just now that in Newfoundland and Labrador the government has replaced the loan program entirely with a grants program. You're advocating that be done on a national basis, or that other provinces use the transfer to do the same thing.

Ms. Jessica McCormick: In both cases.... It's something we're advocating that provincial governments do with provincial student loans, but we're also advocating for an expansion of the national grants program that was introduced in 2008. In Newfoundland and Labrador it has been progressively expanded over the years and it was announced just this year that they would fully expand the grants program to replace the provincial student loans.

Mr. Murray Rankin: Do you have any information as to what that might cost?

Ms. Jessica McCormick: The information we have in our submission is to reallocate some of the money currently invested in registered education savings plans and tax credits into Canada student grants, because we currently invest about $2.5 billion per year in those programs.

Mr. Murray Rankin: You noted in your brief first nations and Inuit students and their post-secondary student support program, and you are asking for the cap on the increase that was implemented in the 1990s to be removed. Is that essentially it?

Ms. Jessica McCormick: Yes, in 1996 a 2% cap was placed on increases to the post-secondary student support program. As we've already discussed at the committee, the population growth of first nations and Inuit students far exceeds other demographics, so there are more students who want to access funding through that program but because of the cap are unable to access the funding.

Mr. Murray Rankin: Your statistic was shocking. You say that between 2006 and 2011, over 18,500 people were denied funding, roughly half of those who were qualified, because of that problem.

Ms. Jessica McCormick: That's correct.

Mr. Murray Rankin: Okay.

Chief Picard, in your brief you mentioned skills training and the need for new investment. I think you suggested half a billion annually over five years is needed to support that program.

Then you suggest that the government implement the recommendations made in the May report of the Standing Committee on Human Resources and Skills Development that there be a renewal of the aboriginal skills and employment training strategy for an additional five years.

Are you suggesting that the new investments of $500 million over five years be done under the umbrella of that strategy?

Chief Ghislain Picard: Yes. I think what is important here is to create some level of certainty in terms of what we should be planning for the next five years. I was part of the original program back in 1995. The negotiations we held at the time provided us with a program that went far beyond the three-year period. We had a five-year program. That certainly makes for easier planning than what we have today, where we're just unsure as to what will happen next year and the following year.

Mr. Murray Rankin: It's particularly poignant given the demographics of first nation communities and the number of children that are coming along and who will need education and training in the future.

Chief Ghislain Picard: Well, I think that proof needs not to be made anymore. It's evident right across the country.

Mr. Murray Rankin: Agreed.

Thank you, sir.

The Chair: Thank you, Mr. Rankin.

Colleagues, we have two members' rounds left of five minutes each. If we do that, we will go five minutes into the bell. It's a 15-minute bell. Do I have your consent to do that?

Some hon. members: Agreed.

The Chair: Thank you.

We'll go to Mr. Allen first, please.

● (1825)

Mr. Mike Allen: Mr. Chair, does that mean I'm going to get a full five-minute round or not? I was going to share—

The Chair: Well, apparently you're sharing with Mr. Van Kesteren.

Mr. Mike Allen: I'm going to share it with Mr. Van Kesteren.

I have a quick question to ask Mr. Rogers.

I had a chance to meet with a couple of people, Allyson Giberson and Kelly Beveridge, in my riding in western New Brunswick, who are actually intervening in an eating disorder program. It was an interesting and very informative meeting that we had. I didn't personally realize some of the challenges. As you said, a lot of young women and girls tend to be the most impacted by this.

One of the things they talked about, and they're starting to get some numbers, are repeats, where young girls and women have to go back to the hospital—repeat visits, repeat visits, repeat visits. With their intervention, they're actually starting to cut that down.

When I was talking with Maureen O'Neil of the Canadian Foundation for Healthcare Improvement, I talked to her about how we can save money in our health care system, as opposed to necessarily just spending more money.

Has there been any work on this and do you have some of these cost-saving numbers that we could actually use to justify an investment in this?

Mr. Bill Rogers: There's limited data, to the best of my knowledge. I can ask some of the consultants and physicians who have been active in this if there are any. To the best of my knowledge there are not. However, there are places, like the London Health Sciences Centre in London, Ontario. It has a very large eating disorder program. Ontario has a $30-million program in various hospitals. When I've talked to the physicians there, mostly they're outreach programs, but they work. It gets people back onside. For example, my colleague here, Lauren, recovered. She had it when she was 18 and she recovered. It never leaves you, but now she knows how to deal with it. That's what the programs come down to: they allow you to go through your life without having to be an anorexic or a binge eater, or whatever.

I wish I had more data, but we will check and get back to the committee.

Mr. Mike Allen: I would appreciate that.

The Chair: Mr. Van Kesteren.

Mr. Dave Van Kesteren: How many minutes do I have, Chair?

The Chair: There are about six and a half minutes for you and me, so....

Voices: Oh, oh!

Mr. Dave Van Kesteren: All right. It really puts the pressure on.

I want to go to you, Grand Chief. I appreciate your coming down here, and I thank you for your words.

My colleague mentioned Indspire. Would you agree—and we're talking about the testimony of Mr. Kirby, too—that so many of the problems that you experience...? Your young people need jobs. There are some great opportunities for them. Wouldn't you agree that that is probably the greatest need that your young people have at this point?

Chief Ghislain Picard: Well, they also need to be prepared to take on jobs. To me, that's where education falls into place.

Mr. Dave Van Kesteren: Ultimately so they can enter the workforce....

Maybe you can tell this committee if there's a way that you could help us. The testimony by Indspire...it was a great success story, but the problem is that most of the young people who are trained and graduate don't go into the private sector.

Could you help this committee and maybe just give some advice where the government might be able to enact something so that we can see more young people going into the private sector? We know there are so many opportunities for your people, especially up north in the mining areas.

Chief Ghislain Picard: I would say the reality is that if we were provided with more opportunities, that certainly would happen more in our communities. But the other reality is that we are also facing a situation where we have a lot of catching up to do.

Mr. Dave Van Kesteren: I realize that.

Chief Ghislain Picard: It certainly doesn't happen overnight. To us, being given the opportunity to provide quality education as it exists anywhere else in the country would be very key.

Mr. Dave Van Kesteren: Maybe I'm not making myself clear. What I mean is that many of your young people who are graduating.... As a matter of fact, I heard that up to 85% are working in the community, which is a great thing. We're not discouraging working in the community. But there are so many opportunities, and great opportunities, that would help first nations people if they would go into the private sector, in those jobs. How can we encourage them to move into that sector as opposed to the other sector?

● (1830)

Chief Ghislain Picard: Our young people have that choice now. At the same time, it certainly would fall, I would say, under the objectives of this government to reinforce the governance in our communities as well. To me it also speaks to that objective for our first nations governments to reinforce their own governance structures.

The Chair: Thank you, Mr. Van Kesteren.

I have a number of questions. I'll try to get through some of them.

Ms. Hayashi, I want to start with you.

I enjoyed your presentation very much. In your submission, you talk about the support for the Networks of Centres of Excellence and the centres of excellence for commercialization and research. You talk about CIHR. Then you state:

> There remains however, a key gap in our ability to translate this world-class research into its commercial potential, and realize the full extent of resulting economic and societal benefits.

I think that was probably a consensus around the time of this government's science and technology strategy back in 2007. You do hear from people, researchers and others, who say that somehow we've focused too much on commercialization of research at the expense of funding for basic research. I just wanted you to address this concern that some researchers are raising.

Ms. Kathryn Hayashi: There clearly always has to be a balance. There can be no later-stage projects if there is no early-stage research. Absolutely, there is an ecosystem of innovation in the health care system where you must have basic research, but hopefully, the best, most commercializable aspects of that basic research can be found, focused upon, and developed quickly, cost-effectively, through organizations like CDRD.

The Chair: In our first panel, Mr. Saxton asked some questions about ensuring that we focus health research dollars in a way so as to try to not create so many different pots of funds but ensure these groups collaborate. One of the concerns some people may raise is we fund a lot through the Canadian Institutes of Health Research, and the government should focus on funnelling money there.

In terms of funding commercialization, though, that's perhaps not the best vehicle. That's why we have things like the Networks of Centres of Excellence. It does lead to the question of ensuring that we're not just funding a thousand different pots and not actually getting commercialization or value for dollar, or the researchers who are working are not accessing enough funds to commercialize their research.

Is the Networks of Centres of Excellence the model for doing that? What's the best way for the government to—

Ms. Kathryn Hayashi: We've had a lot of success. It has been an excellent program for us to start with. We were one of the original cohorts of centres of excellence for commercialization and research. We were successfully renewed in that program, but we have outgrown those types of programs.

In the previous session there was a lot of discussion about how government, how we as Canada, can do this better. An organization such as CDRD, that has a national focus and is about bringing together the right people in the right regional centre.... For example, we don't want to build everything at CDRD. We need to leverage what has already been built and what has already been built successfully.

At Dalhousie we have our zebrafish node. The CDRD zebrafish node is a very interesting cutting-edge, global-leading centre. Basically, zebrafish are little transparent fish. You can see their insides. You can see, without killing the fish, how a drug is working, or you can just see them swimming around. You can do tests on them.

There is a researcher at Dalhousie who has a world-class zebrafish node. We have a relationship with him. We can use their resources, their expertise, so that researchers all across the country can benefit from that.

The Chair: From a policy point of view, is it better for the government, then, to fund a number of initiatives like yours across the country and pick them directly, or is it better to fund a program that's not the Networks of Centres of Excellence, but something in addition to that? Is it better to fund a program that funds organizations like yours, or is it better to directly fund right from the government?

Ms. Kathryn Hayashi: We think we've reached such a level that we are the national centre for drug development and commercialization. We have, over the past seven years, worked very hard to develop a national network. We feel that we have outgrown federal programs, and we really are now seeking a foundational funding that would allow us to operate through our next period to sort of build up to the critical mass of being able to deliver as a national resource.

● (1835)

The Chair: You'd almost have, then, the government establishing those criteria which an organization such as yours would have to meet, and then it would move beyond the Networks of Centres of Excellence and then be funded directly.

Ms. Kathryn Hayashi: Yes.

The Chair: Okay.

I'm sorry, but my time is up here, and I imposed a limit on others, so I'll impose it on myself.

[*Translation*]

I thank all of you very much for your presentations.

[*English*]

If you have anything further, please submit it to the clerk and we'll ensure that all members get it.

Thank you so much.

The meeting is adjourned