

Party leaders debate the health of the nation

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Health care. It's *the* big issue of the federal election campaign, according to public opinion polls and party platforms. From home care to pharmacare, from \$9-billion pledges to the Ontario Liberal's premium-bombshell, the candidates are flogging their promises on the hustings. In a quest for more specific details about their policies, the *CMAJ* asked the leaders of the 4 major parties to participate in an interview that sought their views on 9 questions.

NDP Leader Jack Layton was first to respond, in a lengthy interview expanding on a New Democratic government's health care vision. Conservative Leader Stephen Harper also responded in person, providing more succinct responses to the questions. Bloc Québécois Leader Gilles Duceppe and Liberal Leader Paul Martin chose to respond in writing, via an email sent from staff as they stumped. An abridged version of their responses will appear in the June 22, 2004, issue of *CMAJ*; the following is a longer version.

1. Does the Canada Health Act need to be modified? If so, how?

NDP Leader Jack Layton: We would like to see the Canada Health Act principles protected, either in court, or through modernization, to prevent the privatization of health care that is going on. We are focusing particularly on for-profit, private health care. ... These private clinics are ... diverting dollars essentially away from care and into return-on-investment, which eventually will make their way into the big stock-market traded companies. We don't want to see the Enrons of the world running our health care system.

The question of whether or not ... what's happening piecemeal is the gradual privatization of our health care ... is something we feel should have been challenged by the government in court. If the court interpreted the Act as [saying] that privatization seemed to be permitted, ... then that Act should be changed, because it certainly was never intended that we would be dealing with for-profit operations in health care. It was never the plan in

the Canada Health Act.

If the NDP were to form the government we would either challenge the practices in court, or amend the legislation — or both. Our party has proposed such an amendment to the Canada Health Act in the past in the House of Commons.

Conservative Leader Stephen Harper: The position of the Conservative Party is that we support universal health insurance [so] that no one is ever denied health service because of inability to pay. We support the national health accord signed between the provincial and federal governments [in February 2003]. It doesn't contemplate any changes to the Canada Health Act so we wouldn't either. We're prepared to operate within the national health accord.

Bloc Québécois leader Gilles Duceppe: Bien que le Bloc Québécois soit en accord avec les principes de cette loi, nous ne croyons pas que la *Loi canadienne sur la santé* nécessite une modification puisque celle-ci représente l'exemple le plus flagrant d'empiètement du fédéral dans le domaine de la

santé. Cette loi, «impose des conditions et des critères relatifs aux services de santé assurés et aux services de santé élargis que les provinces et les territoires doivent respecter pour recevoir la contribution financière complète au titre du Transfert canadien en matière de santé et de programmes sociaux (TCSPS) »¹. Pourtant, le domaine de la santé et des services sociaux relève clairement des responsabilités du Québec et des provinces.

Le gouvernement fédéral prétend s'octroyer un rôle essentiel qui ne lui revient pas en santé. Il s'érige comme protecteur des 5 principes de la *Loi canadienne sur la santé* et comme coordonnateur de l'ensemble des décisions concernant les normes communes et les orientations qui guideront les transformations des systèmes de santé des provinces et du Québec.

Tout en étant en accord avec les principes de la *Loi canadienne sur la santé*, le Québec refuse que le fédéral impose des normes pancanadiennes alors que le domaine de la santé relève exclusivement du Québec et des provinces. Le Bloc Québécois s'oppose donc à un système pancanadien de santé dirigé par le gouvernement fédéral qui, d'ailleurs, n'a ni l'expertise, ni les compétences nécessaires pour assumer un tel rôle.

Liberal Leader Paul Martin: My government stands by the Canada Health Act, which requires that the health care insurance plans of the provinces be administered and operated on a non-profit basis by a public authority, responsible to provincial governments and subject to audits of its accounts and financial transactions.

2. What is the federal role in Canadian health care? Is it limited to setting standards and defining what are medically necessary services?

NDP Leader Jack Layton: The first role is to properly fund it, as recommended by [Roy] Romanow's [Commission on the Future of Health Care in Canada]. The second is to assist and work collaboratively with the provinces to accomplish our Canada-wide objective, which is to assure the highest level of health care for every Canadian, irrespective of who they are. That means staying on top of the evolving trends ... For instance, new ideas to help us deal with the aging population, such as a home care program right across the country, should be promoted by the federal government.

The big new area that's not all that new — Tommy Douglas himself spoke about it — is the cost increases of pharmaceuticals. Having initiatives that we are able to be put in place and encouraging the provinces around pharmaceuticals is extremely important. We're now at the point — and I know this must distress many doctors — that [as many as] 1 in 10 prescriptions written by physicians are not filled because people can't afford it. I agonize about what it must be like for families who aren't in a medical plan or don't have coverage of any kind and whose kids need to be on these very expensive inhaler systems. ... We've got to move in this area. I also believe we should be taking on these pharmaceuticals in a much smarter way. For example in Saskatchewan, they do bulk buying of some of the key most prescribed medications, and the result is significantly lower costs than you see in other provinces. Or take a look at what Australia does with bulk buying for the whole country. This sort of strategy can still make a buck for pharmaceuticals — which are doing rather well, by the way — and it is an increasingly important part of the health care pack-

age and its costs need to be recognized.

I believe that significantly more of our resources should be devoted to avoiding disease in the first place. Health promotion and disease prevention would be a major priority for us.

Conservative Leader Stephen Harper: The irony is that it's not really clear to me that that has been the federal role. The Canada Health Act has set some very, very broad standards and it says that necessary medical services have to be covered. But the federal government has not provided much of a guide as to what is a medically necessary service. To implement all the various aspects of the health accord requires the federal government to play some role — obviously a funding role, which I am prepared to discuss with the provinces. I think the most critical thing is to develop performance standards whereby we can measure the performance and accountability of the funds given, but developed in consultation with the provinces. Broadly speaking, the day-to-day running of the health care system is up to the provinces.

Bloc Québécois leader Gilles Duceppe: L'intervention du fédéral en matière de santé devrait se limiter à ses champs de responsabilités, des autochtones à l'évaluation des produits toxiques en passant par l'approbation des nouveaux médicaments. Québec, pour sa part, est le seul maître d'œuvre quant aux orientations et à la gestion des services de santé et des services sociaux offerts à la population sur son territoire.

Le fédéral prétend que sa mission en santé consiste à aider les Canadiens à maintenir et à améliorer leur santé. En réalité, ses responsabilités se résument principalement à :

- aider au financement de la santé, par l'entremise de paiements de transferts aux provinces et au Québec ;
- offrir des services à certains groupes : les communautés

autochtones, les anciens combattants, le personnel militaire, les détenus des pénitenciers fédéraux et la GRC;

- assurer le contrôle des nouveaux médicaments.

Le Québec et les provinces sont donc les seuls ayant l'autorité d'évaluer les besoins en service de santé. Malgré cette évidence, le gouvernement fédéral provoque des dédoublements et empiète dans les champs de compétence du Québec et des provinces. Pourtant, Ottawa n'a clairement pas de leçons à donner. Le peu d'hôpitaux qu'il gère, qui s'adressent à une clientèle particulière dont les autochtones, les militaires et les anciens combattants, sont souvent en décrépitude. Le fédéral veut se montrer vertueux en imposant des normes alors qu'il n'est même pas en mesure de gérer adéquatement le peu d'hôpitaux qu'il possède.

Le Bloc Québécois, à l'instar du consensus des premiers ministres provinciaux, exige que le financement fédéral en santé et en éducation atteigne 25% d'ici 2009-10, sans imposer aucune condition. L'augmentation des transferts fédéraux en santé et services sociaux donnerait au gouvernement du Québec une meilleure marge de manœuvre lui permettant d'investir davantage pour résoudre les problèmes actuels.

Liberal Leader Paul Martin: Medicare is more than just another government program. It is a statement of our values as a nation. In fact, the Liberal government has, and will continue to remain, firmly committed to the 5 fundamental principles of the Canada Health Act: universality, accessibility, comprehensiveness, portability and public administration.

The Liberal Party's platform on health care makes a commitment for further investments in Canada's health care system. In Budget 2004, we committed an additional \$2 billion in funding for health care. This investment brings the federal contribution to public health spending in Canada

to \$36.8 billion. I also intend to meet with the premiers this summer to agree on a long term plan for a health care system that is properly funded, clearly sustainable and significantly reformed.

The federal government's efforts will be guided by the work of Romanow and many others who have studied the health system exhaustively, and will fully involve health care professionals, who are on the front line. We will concentrate on reducing wait times in hospitals and doctor's offices, making doctors, nurses and other health care professionals available when and where they are needed, ensuring timely access to quality services that improve health outcomes and ensuring diagnostic tests, surgeries and treatments are governed by need. We are also looking forward to forging a cohesive relationship with the provinces and territories, opening up medical spaces in universities, establishing appropriate home care and community services, and creating a new pharmaceuticals strategy.

3. Health care expenditures are continuing to escalate above the rate of inflation. Is this sustainable?

NDP Leader Jack Layton: Absolutely it's sustainable. Let's face it, people are going to be cared for one way or the other anyway. Either they'll end up in emergency wards with very expensive care because we didn't nip things in the bud, or their families will have to absorb those costs either in terms of money or in terms of their time. They'll have to quit their jobs to look after people. That's why a national home care initiative, which ... would actually save money ... would be the way to go.

You have got excellent analyses out there about how new ideas could actually save us money when it comes to health. It is possible to create a sustainable approach here. It does require the federal government to come to the table. As long as the costs are left to this extent in the

hands of the provinces, then what happens is they have to cut education, they have to cut prevention programs, they have to stop building transit, which then creates more disease. This is penny-wise and pound foolish.

Conservative Leader Stephen Harper:

I think health care could be sustained above the rate of inflation; it can't be sustained above the rate of economic growth. That's probably the really critical measure, and that has been happening. So, no. That's why I say, as willing as we are to sit down with the provinces to discuss the needs for more funding, it is essential that we develop the performance measures that are promised in the health accords and ensure that the money is spent getting results, because simply spending more money is not a long term viable solution.

The biggest change that has been made in recent years is the development of alternative delivery systems. Alternative delivery goes all the way from core health services to peripheral services like janitorial and support services. This is one set of ways — it's not for me to comment on whether it's effective or not — the provinces have tried to sustain the costs to the system. One of the reasons we do support the national health accord is it did not prohibit those kinds of developments.

Bloc Québécois leader Gilles Duceppe:

Il est vrai que les coûts des systèmes de santé augmentent à un rythme supérieur à l'inflation. Mais les revenus des gouvernements (particulièrement ceux du gouvernement fédéral, du fait que ce dernier occupe près de 60 % du champ de l'impôt sur le revenu des particuliers, champ fiscal qui présente la croissance la plus élevée) augmentent aussi à un rythme supérieur à celui de l'inflation.

Le principal problème est le déséquilibre fiscal qui sévit au Canada. Le déséquilibre fiscal, c'est « lorsqu'un ordre de gouvernement dispose de revenus

excédant ce qui est nécessaire au financement de ses propres compétences, alors qu'à l'inverse, l'autre ordre de gouvernement a des revenus insuffisants compte tenu des dépenses résultant de ses compétences constitutionnelles »². Cette situation prive le Québec et les provinces des revenus nécessaires pour remplir leurs responsabilités, dont la santé.

Ainsi, le Québec et les provinces sont dépendants d'Ottawa et de ses transferts pour la santé et les services sociaux. Or, depuis l'arrivée de Paul Martin, d'abord ministre des Finances et ensuite premier ministre, les paiements de transferts en santé et en éducation versés par le gouvernement fédéral pour le Québec sont passés de 20 % à 15,4 % par rapport aux dépenses totales en santé et en éducation assumées par le Québec.

Dans ce contexte, le Bloc Québécois s'engage à poursuivre la bataille pour le rétablissement de l'équilibre fiscal, afin que le gouvernement du Québec ait les moyens d'assumer pleinement ses responsabilités, particulièrement en santé.

Liberal Leader Paul Martin:

Since the First Ministers' Health Accord of 2003, the federal government has added the following additional spending and planned spending to 2005–06:

- \$6 billion: health reform transfer
- \$1.5 billion: diagnostic equipment fund
- \$2.5 billion: federal funding supplement 2003–04
- \$2 billion: federal funding supplement 2004–05
- \$12 billion: total of existing committed spending
- \$3 billion: provided for in the Liberal platform
- \$15 billion: "Romanow Gap" to 2005–06

The "Romanow Gap" refers to this short-term funding, over 3 years, to provide catchup funding to the provinces.

In the Romanow report, Mr. Romanow identified that the base for federal cash transfers should be \$15.3 billion by

2005–06 using his allocation of the federal share for health. A new Liberal government will commit an additional \$1 billion in 2004–05, and a further \$2 billion in 2005–06.

The federal transfer for health, using calculations in line with Mr. Romanow's, will be \$16.3 billion in 2005–06. Using the formula by which the federal government calculates its contribution, as reflected in Budget 2004, the transfer will be \$20.3 billion in 2005–06.

4. What would your government do to reduce waiting times for elective and non-elective surgery and to solve over-crowding in emergency departments?

NDP Leader Jack Layton: There is a series of things that should be done, and I would turn to many of the recommendations in the Romanow report, a very extensive study of these kinds of issues. Some involve trying to ensure that people can get care for things that don't require the intense facility and 24/7 capabilities of an emergency room. ... [This involves ensuring] the availability of more family physicians. The number of Canadians not covered by family physicians right now is quite shocking. We [also] favour clinics ... that allow for multidisciplinary teams to work together [so] physicians can use their specialties while well-trained partners like nurse practitioners take care of those things that they are very, very capable of doing. It is cost-effective and it allows us to reduce certain kinds of waiting times without cost implications. It's really about being smarter in the way we do things. There are best-practice examples from around the country that can be drawn upon and we should be sharing these.

I'm quite concerned about the waiting lists for diagnostics, for example. By artificially starving our system of diagnostic capabilities, both in terms of equipment and staffing, we're opening the door — almost en-

couraging, by default — the private diagnostic sector.

Conservative Leader Stephen Harper: There's little the federal government can do directly, other than provide funding and insist upon the development of accountability and performance measures on that funding. The provinces themselves, because they ultimately run the core of the health care system and the hospital systems, are going to have to make sure that the money translates into better results. We're prepared to support them in that role. We're not going to sit on the sidelines and criticize them. But it is really the provinces that have to do that. Ultimately this involves the day-to-day administration of the system. The federal government has a funding role and it has an accountability role, but it's going to have to work with the provinces to make sure they are able to solve these problems.

Bloc Québécois leader Gilles Duceppe: La santé relève exclusivement de la compétence du Québec et des provinces, la gestion du système québécois de santé doit donc se faire par le gouvernement du Québec. De plus, il est hors de question que le Bloc appuie l'idée que le gouvernement fédéral se mette à imposer des conditions aux transferts en santé, comme réduire les temps d'attente. Le gouvernement du Québec considère lui-même la réduction des temps d'attente comme une priorité, mais il n'a certainement pas besoin qu'Ottawa vienne lui imposer une façon d'agir en la matière.

L'Assemblée nationale du Québec est même allée jusqu'à adopter une motion unanime, le 29 novembre 2002, dénonçant la vision centralisatrice du gouvernement fédéral en santé et exigeant que «toutes mesures mises de l'avant par le gouvernement fédéral dans le secteur de la santé respectent les champs de compétence des provinces en matière de santé, et que les sommes devant être ver-

sées pour assurer le financement de la santé le soient sans condition et en fonction des priorités identifiées par les Québécois et les Québécoises».

Le Bloc Québécois défend farouchement les consensus et les compétences du Québec et son droit le plus rigoureux à gérer les domaines qui relèvent de sa compétence. L'imposition de mesures pancanadiennes reviendrait à confier au gouvernement fédéral la maîtrise d'œuvre de la santé, ne laissant au gouvernement du Québec, qui est pourtant seul responsable de ce dossier, qu'un rôle d'exécutant et de gestionnaire au jour le jour.

Liberal Leader Paul Martin: A new Liberal government will take direct aim at waiting times for vital medical procedures. We will work with the provinces and territories to implement a national waiting times reduction strategy, a bold new initiative that will be supported over the next 5 years by \$4 billion in new and targeted funds.

The strategy will require the measurement and publication of current waiting times for many key procedures. At the same time, the federal government, in collaboration with the provinces, will work with doctors, administrators, the Health Council and patient groups to define timely care, and to identify the areas in which waiting times are unacceptably long. This will set the groundwork for our Five in Five plan — an all-out drive to achieve in 5 years major waiting-times reductions in at least 5 crucial treatment areas: cancer care, heart care, diagnostic imaging, joint replacements and sight restoration.

5. Is there a doctor and a nursing shortage? If there is, what is the federal role in solving that? (What would your government do about that?)

NDP Leader Jack Layton: Yes there is. It particularly has to do with an absence of training and an absence of funding in the sys-

tem. In addition, we have an awful lot of physicians trained in other countries ... Immigration rules are telling them that they're being accepted into Canada because of their training, then they arrive here and find they can't use it. There needs to be much more advanced indication to professionals coming to Canada what the requirements are going to be once they get here, so they can put themselves in a position to meet them. ... We also discovered that in many cases there are some rather arcane blockages. It just requires a number of regulation adjustments ... to allow for the transitions. We essentially have a lot of talented people out there who could be providing health care — they would love to — but [can't]. ... I think it's a question of finding out why these trained physicians aren't more rapidly incorporated into our system and getting rid of the obstacles, without sacrificing for a nanosecond any of the quality.

Conservative Leader Stephen Harper: I'm persuaded that there is, but once again, it is a matter of a combination of funding and making sure that funding translates into ... better results, and that would include more medical personnel. What we've often seen in the past is when there's a large infusion of cash, is a series of wage increases. We're going to have to get increases in the number of medical professionals and in productivity. It's not just a matter of spending money.

We are going to have to look at ways of getting more medical professionals into under-served areas. Also we're going to have to look at ways of bringing resources in [from] outside of the country and getting credentials recognized more easily than is done today. This is a difficult area because it raises a federal responsibility, and the regulation of professional trades is a provincial matter. Not just in health care but across the board, it's got to be a major priority be-

cause we have significant skilled labour shortages and we are importing people who then are not going to be able to work in their professions, and this has really got to be fixed.

Bloc Québécois leader Gilles Duceppe:

Le Bloc Québécois est conscient du manque criant de médecins et de personnel infirmier dans le système de santé au Québec. Toutefois, c'est au gouvernement du Québec de prendre les décisions nécessaires en ce sens. Le rôle du fédéral ne repose que sur la hausse des transferts en santé destinés au Québec et aux provinces puisque les problèmes qui existent actuellement dans les systèmes de santé du Québec et des provinces sont causés par un gouvernement libéral fédéral qui s'est désengagé massivement en santé depuis son budget de 1994-95.

En effet, les coupures draconiennes du fédéral depuis 1994 sont en bonne partie responsables des difficultés qu'ont subies les réseaux de santé du Québec et des provinces. Le Québec et les provinces font face à des défis majeurs en matière de santé.

Suite au passage de Paul Martin comme ministre des Finances, la contribution fédérale en santé et programmes sociaux, par le biais du TCSPS³, est passée à 15,4 % aujourd'hui, après avoir atteint un creux de 11,2 % en 1998-99. C'est Paul Martin qui a sabré dans le financement de la santé. Il a économisé sur le dos du Québec pour ensuite intervenir unilatéralement dans des domaines de compétence du Québec.

Le sous-financement en santé illustre éloquentement l'effet pervers du déséquilibre fiscal. En effet, le gouvernement du Québec doit affecter près de 67 % de ses dépenses de programmes à la santé, aux services sociaux ainsi qu'à l'éducation. Le Bloc Québécois estime qu'en 2003-04, le déséquilibre fiscal représente un manque à gagner de 2,1 milliards de dollars pour le Québec. Le Bloc Québécois

fait de la correction du déséquilibre fiscal son principal cheval de bataille. Une fois le déséquilibre fiscal réglé, le Québec aura les ressources financières pour pourvoir à ses priorités, dont la santé.

Liberal Leader Paul Martin:

A new Liberal government will work with the provinces and territories to overcome the shortage of medical providers that exists in too many parts of Canada, in part by increasing the number of medical spaces in universities and accelerating the qualification of new immigrants with medical credentials.

Our government will work with the provinces to expand the role of nurse practitioners and other health professionals and increase our national capacity to train health care personnel from specialists to technicians. For example, we will accelerate the qualification of new immigrants with medical credentials and provide \$75 million to help train 1000 of these new Canadians over time to provide first-class primary care in communities across the country.

All Canadians — regardless of where they live — need to have access to the appropriate health providers, now and in the future. Building upon the important work of Michael Kirby, Romanow and many others, the 2003 First Ministers Accord noted that appropriate planning and management of health human resources (HHR) is key. The First Ministers agreed that collaborative strategies are needed to strengthen the evidence base for national planning, promote inter-disciplinary provider education, improve recruitment and retention, and ensure the supply of health providers. These elements are fundamental to securing and maintaining a stable and optimal health care workforce in Canada, to supporting health care renewal, and to increasing the capacity of the health system to respond to infectious diseases outbreaks similar to severe acute respiratory

syndrome (SARS). Provinces and territories are already making reforms in how care is delivered, and enrollment in professional training is increasing, especially in nursing.

In Budget 2003, the federal government committed \$90 million over 5 years to improve national HHR planning and coordination. Finally, in April 2004, Health Minister Pierre Pettigrew and I confirmed the Liberal government's commitment to health care reform. This includes addressing the wait-list challenge on a long-term basis, which will require a deliberate, comprehensive and multi-faceted response. Governments and managers of health institutions will need to work together to address mismatches in the demand, supply and distribution of health human resources and service delivery capacity.

6. Do you support a national cancer control strategy (on the model of the AIDS strategy)? If so, how much would you allocate to it?

NDP Leader Jack Layton: Yes. I very, very strongly support the development of a national cancer control strategy. These initiatives are remarkably low-cost. For example, empowering municipalities to ban the use of pesticides. Canada has to stand firm to say that we have to be allowed to protect public health. ... This means ... labeling of foods [for] GMOs [genetically modified organisms], banning of trans-fats, all of these kinds of things, which we have proposed, many of which don't cost much at all. That's the remarkable thing about public health: it costs so little compared to the avoided costs. What we need is a lifecycle analysis of the costs.

Conservative Leader Stephen Harper: I've said that a Conservative government will support health care research and the development of new health technologies, and I think we'd work

within that broad envelope. I can't attach specific dollar figures to it. We obviously would continue all existing funding. When we sit down with the provinces we'll be looking at how we're going to allocate additional money and this [health care research] would be one area we're going to put it into. I think that's a separate discussion of what specific diseases or issues should be the target of that research.

Bloc Québécois leader Gilles Duceppe: Traditionnellement, le Québec ne participe pas aux multiples structures pancanadiennes, tel que le Conseil de la santé, créées par le gouvernement fédéral puisque non seulement le Québec dispose souvent déjà d'organismes similaires, mais le fédéral empiète dans un champ de compétence du Québec.

Ce qui est important pour le Québec c'est de demeurer maître d'œuvre de la gestion du système québécois de santé. Si le Canada décidait de créer une nouvelle stratégie canadienne de contrôle du cancer, le gouvernement du Québec pourrait très bien collaborer en partageant son expertise et en échangeant de l'information, mais le Québec n'acceptera jamais de se faire imposer de quelconques conditions ou normes pancanadiennes provenant du gouvernement fédéral.

Liberal Leader Paul Martin: The government recognizes the enormous burden that cancer places on Canadians. That is why in 2003–04 the Liberal government invested over \$80 million in cancer research through the Canadian Institutes of Health Research. Our government provides stable, ongoing funding of \$7 million a year for the Canadian Breast Cancer Initiative (CBCI). As well, the newly created Canada Public Health Agency has a mandate to engage in chronic disease prevention and control. Budget 2004 provides \$165 million over 2 years to build this new

Agency. This amount is in addition to \$404 million that will be transferred from Health Canada and optimally refocused, as required, to meet the needs of the new agency.

The development phase for the Canadian Strategy for Cancer Control is now complete. Health Canada is working with key stakeholders on finalizing the blueprint for implementation in this priority area, and we expect the new Canadian Public Health Agency to assume ownership of this important file.

7. Does Canada have a responsibility to the health of people outside our own borders? If so, would you increase the proportion of foreign assistance from 0.3 percent of GDP to 0.7%.

NDP Leader Jack Layton: Yes. We want Canada to be the first country in the world to fund the Global AIDS, Tuberculosis and Malaria Fund at the level prescribed in the concept. We've pushed that, and we managed to get that proposal accepted by the foreign affairs committee [though] not to be included in the budget. We would move on that.

In addition, the United Nations goal of 0.7% of GDP going into development aid is one that we support. In the context of a balanced budget in Canada, we now have a significant surplus, so we can begin to look at these initiatives, we would introduce a step-by-step phased in achievement of that 0.7%. Quite rapidly.

Conservative Leader Stephen Harper: We have some. We supported Mr. Chretien's drug bill — this is the bill that provided additional drugs to Third World countries [the amendment of the Patent Act]. But broadly speaking, our priority in health care, given our challenges, is going to have to be the health care system of Canadians, and that's where we will be focusing our energies. International assistance is important,

but you will have to balance there a number of considerations that go beyond just health care. [An increase in GDP is] something I'd like to do but I can't tell you it's among our highest priorities. Certainly increasing the funding for health care in this country is a higher priority.

Bloc Québécois leader Gilles Duceppe: À l'instar des autres pays développés, le Canada s'est engagé à consacrer une enveloppe d'Aide publique au développement (APD) qui, à terme, devrait être équivalente à 0,7 % de son PNB. Le Bloc Québécois applaudit cette initiative.

Toutefois, depuis l'arrivée des libéraux en 1993, le Canada est très loin d'être l'exemple à suivre. En effet, le Canada consacrait à l'époque 0,44 % de sa richesse à l'aide au développement. Lorsque l'actuel premier ministre a quitté le ministère des Finances, il n'y consacrait plus que 0,27 %.

Il y a eu quelques réinvestissements dont le principal dans le budget 2003 : le gouvernement fédéral annonçait alors sa décision d'accroître l'aide étrangère de 8 % par année pour la doubler d'ici 2009. Or, cet effort n'amènera l'aide publique au développement qu'à 0,32 % du PNB en 2009. En fait, si le gouvernement continue à augmenter son budget d'aide au développement à raison de 8 % par année, ce n'est qu'en 2033 qu'il atteindra l'objectif fixé par l'ONU, 65 ans après la proposition de Lester B. Pearson.

Contrairement au Parti libéral du Canada, le Bloc Québécois croit en l'apport positif que représente l'aide au développement de la part des pays développés et considère que c'est un devoir pour ces derniers d'aider les pays les moins nantis. Ainsi, le Bloc Québécois propose que le gouvernement fédéral mette en place un plan plus réaliste visant l'atteinte de la cible fixée par l'ONU - 0,7 % du PNB — en

matière d'aide internationale d'ici 2015.

Liberal Leader Paul Martin: Canada's Official Development Assistance (ODA) program concentrates resources on 6 main priorities, the first of which is meeting basic human needs. Basic human needs include: support efforts to provide primary health care, basic education, family planning, nutrition, water and sanitation, and shelter.

Canada will continue to respond to emergencies with humanitarian assistance. Canada will commit 25% of its ODA to basic human needs as a means of enhancing its focus on addressing the security of the individual (human security).

Canada is committed to doubling development assistance by 2010. Our International Assistance Envelope has increased by 8% annually since 2002-03 and will continue to do so.

The 2004 Budget took an important step forward by providing an additional \$248 million for 2005-06 (an increase of 8%), which will bring Canada's International Assistance Envelope to \$3.348 billion, up from \$2.461 billion in 2001-02.

8. Do you support user fees or health care premiums?

NDP Leader Jack Layton: No. That's not the way we think we should be going.

Conservative Leader Stephen Harper: I don't have any difficulty with premiums as long as they are not charged to people who can't afford them. I come from Alberta where there has long been a premium in place, so I'm not opposed to that in principle. No government right now to my knowledge is advocating user fees. We certainly wouldn't advocate a user fee. Any changes that any province would propose would have to be within a framework of the national health accord. I know that certainly in Alberta, there are thresholds at which you either don't pay the full premium or don't pay at all.

Bloc Québécois leader Gilles Duceppe: Depuis 1994, Ottawa récolte de plus en plus d'impôts et de taxes au Québec, mais retourne de moins en moins d'argent là où c'est nécessaire. Ce que cela signifie, c'est que le gouvernement fédéral fait de moins en moins sa part pour le financement des systèmes de santé et d'éducation, alors que ses revenus augmentent sans cesse.

Le Bloc Québécois partage en tout point les grands principes d'un régime de santé public où il n'existe qu'un seul payeur. Le Bloc Québécois s'oppose donc à la mise en place d'une taxe à la santé. La population québécoise et canadienne doit avoir accès à des services de santé de qualité et ce, peu importe leur capacité de payer. Imposer une taxe ou des frais modérateurs aux patients remettraient en cause les objectifs de la société québécoise qui cherchent à réduire l'écart entre les riches et les pauvres.

Pour éviter que la médecine à deux vitesses voit le jour, il faut que les investissements publics soient au rendez-vous. Le fédéral doit absolument réinvestir massivement en santé. Ce n'est que par un véritable réinvestissement stable et à long terme par le fédéral que le Québec et les provinces pourront offrir des soins de santé entièrement publics.

Liberal Leader Paul Martin: Extra-billing and user charges for medically necessary insured services are prohibited by the Canada Health Act and are subject to mandatory dollar-for-dollar penalties. Canadians clearly expect the federal government to exercise "national interest oversight" to ensure that the health care system continues to reflect both the letter and the spirit of the Canada Health Act. My government remains committed to ensuring that all residents of Canada have reasonable access to medically necessary insured services on the basis of need, not ability to pay.

9. Are you committed to implementing the Romanow report, *Building on Values: the Future of Health Care in Canada*? If so, what would you do first?

NDP Leader Jack Layton: The first thing to do is to close the funding gap. That's the only way you are going to successfully bring provinces to the table. Sure, you should discuss a framework and put that in place very quickly. The key thing is to make sure those health dollars go to health. This isn't a random transfer of tax points. There are very few elements in [the] report that we have a problem with.

We also view the provision of services like laundry, food and cleaning as fundamentally a part of the health care team ... We're very opposed to holus-bolus privatization of these things that are not considered core health. I've always seen the health care team as being quite comprehensive.

Conservative Leader Stephen Harper: The Romanow report is not the basis of our priorities in health care. We view the starting point for health care reform as the national health accord that was signed in 2003. It did a number of things: it restored funding for some of the core services Paul Martin had cut in the '90s, provided a dedicated health transfer from Ottawa, provided flexible delivery options within the public health insurance system, provided an accountability system in the national health council which hasn't been fully implemented, and also provided some additional priorities such as flexibility for those, primary care reform, home care and a catastrophic drug coverage as well as some funds for medical equipment and research. Those are all objectives we support. I'm not sure if the funding in the accord was adequate for those. I've said that we will make specific proposals on catastrophic drugs that we believe the provinces should

consider giving Ottawa the direct responsibility for. I'll be making [those proposals] at a premiers' conference when I am prime minister.

Home care was part of the national health accord. It's one of the things the provinces did agree to pursue, and we're certainly agreeable to pursuing that objective, probably province-by-province. That is probably the most difficult area of the entire accord to proceed with in our judgement.

Bloc Québécois leader Gilles Duceppe: Le Bloc Québécois se préoccupe grandement des problèmes vécus en santé, conséquence du sous-financement de ce secteur par le gouvernement fédéral. La Commission Romanow suggérerait au gouvernement fédéral qu'il assume 25 % des coûts des soins de santé. Le Bloc Québécois, à l'instar du consensus des premiers ministres provinciaux et du rapport Romanow, exige que le financement fédéral atteigne 25 % d'ici 2009-10.

Le Québec n'a toutefois pas besoin d'un plan à la Paul Martin, basé sur la Commission Romanow, pour continuer de mettre en place sa propre réforme en santé. Au printemps 2000, le Québec avait déjà tenu une Commission d'étude sur les services de santé et les services sociaux, la Commission Clair, dont le rapport a été déposé en janvier 2001.

Dans son rapport, la Commission Clair proposait 95 avenues de solutions permettant d'améliorer les services de santé et les services sociaux au Québec. Regroupées sous 36 recommandations et 59 propositions, les mesures énoncées portent principalement sur l'organisation des services de base, la hiérarchisation des services à domicile, la réduction des listes d'attente, l'amélioration des services sociaux et la rémunération des médecins.

Ces recommandations sont à la base des réformes présentement en cours au Québec. Le

plan d'action québécois existe, il est déjà en voie d'application et on voit mal comment le gouvernement fédéral pourrait mieux respecter les particularités du Québec.

Liberal Leader Paul Martin: I have, along with Health Minister Pierre Pettigrew, repeatedly stated our firm commitment to health care reform that starts and ends with patients and their families. Our efforts are guided by the work of Romanow and many others who have studied the health system exhaustively. Our goal is to ensure that the federal government is bearing a fair share of the cost of publicly provided health care. A new Liberal Government will begin by closing what has been called the "Romanow Gap." On the basis of the figures set out in the Romanow report, the current "gap" will be eliminated by increasing federal health transfers to the provinces by a total of \$3 billion (beyond all existing commitments) during this fiscal year and next.

It has been made very clear to Canadians that any health care reform plan must include measures to support the evolution of home and community care services and the development of a national pharmaceuticals strategy. Implementation of these important reforms will come as part of a 10-year plan that I will seek to work out this summer with the provinces and territories.

This is our chance to fix health care for a generation. That's why I am putting forth such a comprehensive plan to reform and renew our health care system. — Compiled by *Laura Eggertson, CMAJ*

Références

1. Santé Canada. *Soins de santé*. Disponible à l'adresse: www.hc-sc.gc.ca/francais/soins/index.html (consulté le 24 juin 2004)
2. Rapport de la Commission sur le déséquilibre fiscal, page 18.
3. Depuis le 1 avril 2004, le TCSPS est remplacé par le TCS (Transfert canadien pour la santé) et le TCPS (Transfert canadien pour les programmes sociaux).