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Monday, February 21, 2005

Chair

Ms. Bonnie Brown

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Ms. Bonnie Brown (Oakville, Lib.)): I would like to welcome you to meeting 22 of the Standing Committee on Health. This afternoon's agenda includes a report by the Auditor General and a presentation. You will also note that we have two notices of motion that were submitted last Thursday. It would be my choice to save those until the end of the meeting, maybe the last ten minutes, if the committee is agreeable with that.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Madam Chair, I have a point of order. The motions that I have presented I would rather have dealt with at the beginning, as I think they are relevant to the testimony we will hear from Madam Fraser.

The Chair: Certainly the first motion is relevant, but it seems to me you're drawing a conclusion before you hear the testimony. Is that what you wish to do?

Mr. Steven Fletcher: Madam Chair, all we are doing is asking for the Auditor General to have the power to investigate the foundations, which I think is very relevant.

Hon. Robert Thibault (West Nova, Lib.): Madam Chair, I have a point of order. I agree with the chair that it would be good to deal with this after we've heard the Auditor General's testimony and after she, as well as representatives from the department, have had a chance to respond to questions.

The Chair: Thank you. I've heard the point of order and I've stated my position, which will prevail unless someone wishes to challenge the chair's decision.

Mr. Steven Fletcher: Madam Chair, I would like to challenge the chair.

The Chair: Mr. Fletcher is moving a motion to challenge the chair on her decision to refer these motions to the end of the meeting so that we can proceed with the Auditor General right away. The challenge is against the chair. All those in favour of the challenge? Those opposed?

It's 4 to 4. I rule against the challenge, so it fails to carry.

Thank you very much. We'll now move on to the Office of the Auditor General. We have the Auditor General herself, and she will now have the floor.

Welcome, Ms. Fraser.

Ms. Sheila Fraser (Auditor General of Canada, Office of the Auditor General of Canada): Thank you, Madam Chair. We are very pleased to be here today to discuss chapter 4 of our November 2004 Report entitled “Management of Federal Drug Benefit Programs”. I am accompanied today by Ronald Campbell, assistant auditor general, and Frank Barrett, director, both of whom are responsible for this audit.

The use of pharmaceutical drugs is a fact of life for many Canadians and has fundamentally changed the face of health care. Federal drug programs spent $438 million in 2002-03 funding drug benefits for about one million Canadians. The cost of these programs has risen some 25% over the past two years.

Six federal organizations manage drug benefit programs: Health Canada for first nations and Inuit; Veterans Affairs Canada for veterans; National Defence and the RCMP for their members; Citizenship and Immigration Canada for certain designated classes of immigrants; and Correctional Service Canada for inmates of federal penitentiaries and some former inmates on parole.

● (1535)

[*Translation*]

Our audit identified several significant issues that deserve further attention. For example, we found that the number of Health Canada clients that received more than 50 prescriptions in a three-month period had almost tripled since our Report in 2000, even after correcting for growth in the number of clients in the program. As well, in 2002-2003, Health Canada had hundreds of clients obtaining multiple narcotics from more than seven doctors and more than seven pharmacies. Unlike that of Veterans Affairs Canada, Health Canada's system was not programmed to send alerts to pharmacists for these situations when these events occurred.

In our 2000 follow-up of a 1997 audit of Health Canada's program on First Nation's health, we found that Health Canada had been making satisfactory progress in its drug use analysis. This intervention was stopped in 1999, however, pending resolution of the Department obtaining consent from their clients. Our audit found that this analysis had not been conducted between 1999 and 2004. This is the third time we have raised this issue with Health Canada. We are disappointed that is has not been resolved.

We also found that the government is paying tens of millions of dollars more than necessary each year because it does not take advantage of some well-known cost-saving measures.

[*English*]

We made several recommendations, including that the federal government establish an arrangement to develop a formulary for the drugs they have in common, pursue cost savings opportunities, and establish a single fee schedule for dispensing fees. This recommendation also entailed that the federal government develop a common auditing process of the 7,400 pharmacies in Canada. We believe that prompt action on these recommendations is in the interests of the people who depend on these programs, and it is also in the best interests of taxpayers.

In their overall response, the federal organizations agreed with all of our recommendations. I understand that the Federal Healthcare Partnership plans to table a joint action plan representing commitments from all six organizations by the end of this month. The committee may wish to ask for this action plan and for regular updates.

Madam Chair, that concludes our opening statement. We would be pleased to answer any questions the committee may have.

Thank you.

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

We'll move on now to the Department of Health, to Madam Hélène Gosselin, associate deputy minister, and she has some other people from Health Canada with her.

Madam Gosselin.

[*Translation*]

Mrs. Hélène Gosselin (Associate Deputy Minister, Department of Health): Thank you, Madam Chair.

I am pleased to be here today to speak to Chapter 4 of the Auditor General's November report on the management of federal drug benefit programs.

To help answer your questions today, I am accompanied by Ian Potter, who is the Assistant Deputy Minister of the First Nations and Inuit Health Branch, and Leslie MacLean, who is the Director General of the Non-Insured Health Benefits Program. Also with me are Abby Hoffman of Health Canada to address the National Pharmaceutical Strategy and Marie Williams, Executive Director of the Federal Healthcare Partnership.

Health Canada welcomes the recommendations of the Auditor General and shares the concern about preventing the inappropriate use of drugs. The Non-Insured Health Benefits program aims to support safe access to needed pharmaceutical medicines for First Nations and Inuit, in a way that both respects the privacy rights of our clients and provides the best value for taxpayers. Health Canada is acting on the AG's recommendations and in fact departments are working to identify additional tools to support health care professionals ensuring appropriate drug use.

Although I have only been the Associate Deputy Minister of Health Canada for a short time — a scant eight weeks, in fact — I felt it important to be here today to clearly express to you the commitment of Health Canada's senior management to respond fully to all of the Auditor General's recommendations.The Minister has also made clear his commitment to ensuring that all of the recommendations are implemented. We are tabling with the committee today a letter from the Minister to the Auditor General which reflects that commitment.

I would like to address the work done by Health Canada to respond to the key issues raised by the Auditor General's report: first, concerns with respect to client safety; second, the need for improved cost management; and third, the need for better coordination among federal plans.

We recognize that while Health Canada has put in place remedial measures to address the recommendations made by the Auditor General in previous years, our progress has been slower in analyzing the use of drug information generated by our claims process. We have worked very hard with our First Nations and Inuit partners, and with Health professionals, to find ways to encourage appropriate drug utilization while taking into account privacy concerns with respect to sensitive health information.

I am pleased to report to you that we have put in place new measures to address clients who are potentially at risk and that we will fully implement a robust drug utilization evaluation system within the year.

● (1540)

[*English*]

In 2003 the non-insured health benefit program established an advisory committee of independent experts to provide guidance on analyzing drug use. The program now conducts analysis of drug use at the aggregate level, and, thanks to a new approach, it will address the privacy of client information at the individual level as well. This allows the program to contact health card providers to alert them to potential problems.

For example, in November 2004 a bulletin on the use of aspirin for diabetic clients was distributed to 15,000 health care providers. With the client's consent, the program now also communicates individual drug use information to pharmacists when analysis indicates a potential problem. We also continue to monitor actively and to audit pharmacists' responses to online warning messages. In 2003-04 we had 308,000 drug rejection messages, which resulted in pharmacists not filling the prescriptions in 232,000 cases.

The second issue we have been concentrating on is that of cost management. The non-insured health benefits program is the largest federal drug benefit plan. Some 8,000 pharmacies across Canada bill the federal government for claims made by some of the 750,000 people covered, many of whom live in remote areas. In 2003-04 there were 10 million drug claims totalling $288 million.

We agree with the Auditor General that additional cost management efforts are required, and we are putting in place a number of additional measures to do so. For example, we have implemented new methods to bring our fees more in line with those of the provinces. Furthermore, we have reduced dispensing fees for some drugs. We've changed the way some drugs are listed, and we encourage the use of generic drugs wherever appropriate. This alone has resulted in annual savings of $10 million.

Finally, increasing coordination among federal departments is a priority for Health Canada. We will continue to work with our federal colleagues to move in the direction recommended by the Auditor General. Through the Federal Healthcare Partnership, which is administered by Veterans Affairs Canada, departments already work together to achieve savings. The Auditor General is encouraging us to do more in this area, and we are fully committed to doing so. We feel that we have accomplished much, but we know there's a lot more that needs to be done.

The action plan we have tabled with the committee details the steps we have already taken, and our plan is going forward.

We would be pleased to answer your questions today and to provide the committee with regular updates on our progress.

Thank you for your attention.

The Chair: Thank you, Madam Gosselin.

Also from Correctional Service Canada we have Mr. Fraser McVie, acting assistant commissioner, correctional operations and programs.

Mr. McVie.

Assistant Commissioner Cheryl Fraser (Performance Assurance, Correctional Services Canada): I am Cheryl Fraser, assistant commissioner, performance assurance.

I am doing the opening remarks. I apologize if that wasn't sent to the committee, Madam Chair.

The Chair: Please go ahead, Ms. Fraser.

A/Commr Cheryl Fraser: Thank you, Madam Chair, for inviting the Correctional Service Canada here today to talk about our pharmacy program in relation to the Auditor General's November 2004 report. As you mentioned, Fraser McVie accompanies me today as the assistant commissioner of correctional operations and programs.

[*Translation*]

I would like to preface my comments with a short description of the context in which prescription drugs are provided to inmates.

● (1545)

[*English*]

CSC is legally responsible for the provision of health care to federal offenders, who, as a group, are excluded from the Canada Health Act. Prescription drugs are provided as a component of their overall health care. There is no scaled or graduated health benefit plan. CSC's mandate under the law is to provide essential health care, including mental health care, physical and dental health care, as well as reasonable access to non-essential mental health care that will contribute to offenders' safe reintegration into society.

This is the basic health care, as the Auditor General noted.

If the treating physician deems that a certain drug is essential to inmates' health, CSC makes sure the prescription is filled and provided to the inmate.

CSC has experienced escalating costs in prescription drugs in the past few years. Between 1992-93 and 2003-04, the cost of drugs to address inmate health needs has risen from $2.9 million annually to $17 million.

Needless to say, this has become a priority issue for CSC, as the costs continue to rise each year. Inmates as a group have significant health needs. In the past decade we've witnessed and had to address the impact of high levels of infectious disease such as hepatitis C and HIV, as well as mental health issues. Often these conditions exist in the same individuals, requiring complex treatment plans.

The health of these individuals is invariably further affected by substance abuse problems and other choices that have led to that poor level of health.

[*Translation*]

Treasury Board has provided relief in ongoing funding to support infectious diseases costs as well as CSC's methadone program. Moreover, it has recognized the impact of increasing pressure in the area of non-infectious diseases drugs, and provides an amount equal to the annual inflationary cost.

[*English*]

On CSC's part, in February 2003 we launched a process to identify and pursue all possible avenues to achieve cost containment with respect to drug costs. This included a review of current service delivery and the identification of the best model for the delivery of prescription drugs within our institutions.

CSC manages penitentiaries in five regions and operates with a mix of pharmacy services. These include commercial operations, on-site pharmacies, and contracts with local hospitals. In two of our five regions, we have our own regional pharmacies. These arrangements have worked well to date, but more can be done to maximize purchasing mechanisms and the potential for greater savings.

CSC is in the process of moving toward regional pharmacy operations in all regions. Our current timeframe is to start the process of implementation in the upcoming fiscal year, 2005-06. By having a common model of prescription drug delivery, we'll be better positioned to take full advantage of the government purchasing mechanisms.

Until recently, CSC was also managing five different regional formularies, with one region having two formularies. This approach has hindered us from benefiting fully from the work of the FPT pharmacy and therapeutics committee. Our objective is now to join with our federal partners in the development of a federal formulary for all departments. As an interim measure, we are standardizing the formularies used by regions. We are establishing a pharmacy expertise at our national headquarters, which will direct CSC pharmacy-related work. CSC will strengthen its dialogue in partnership with federal departments.

While there is still much work to do, CSC has had some successes in this area. Given our environment and the importance of some of our health conditions, CSC has been developing and implementing treatment guidelines that guide some of our treatment programs in order to maximize health outcomes. Our national methadone treatment program operates within very strict safety and security guidelines that are second to none. This is necessary given the potentially lethal effects of methadone if administered without some safeguards. As well, CSC has been seeking the collaboration of the Public Health Agency of Canada to adapt its guidelines in the treatment of hepatitis C.

CSC recognizes that data extraction and analysis on prescription practices in drug utilization reviews are areas requiring attention. At present, given the mix of pharmacy services and the fact that CSC does not have a national automated health information system, CSC has not been in a position to do more with respect to regionally based drug utilization reviews, and even these have not always been conducted on a consistent basis across the country.

I'm happy to say that the resources to build the health information system within the CSC offender management system have now been secured. Full information of the health information system is planned by 2008. As part of this, an automated national pharmacy system will allow for data extraction and analysis for prescription practice and drug utilization reviews. Effective medication management will ensure patient safety, prevent potential interactions, promote optimal health outcomes, and contribute to the continuity of care plans through the community supervision portion of the sentence.

In summary, CSC is moving in its own right to implement prescription drug cost containment measures in the interest of responsible fiscal management practice, but it is also actively engaging with our federal health care partners to aggressively seek out new ways of leveraging opportunities for common savings.

Thank you, Madam Chair. We'd be pleased to answer any questions.

● (1550)

The Chair: Thank you, Ms. Fraser. If you'll recall, this committee did a report last year and we actually wanted to send you more money for this particular piece of your work, particularly with regard to HIV. Unfortunately, the government turned us down, but we certainly recognize the good work that you've been doing.

We'll now move to the representative of the RCMP, Mr. Kevin Mole, assistant commissioner and director general for occupational health and safety.

Assistant Commissioner Kevin Mole (Director General, Occupational Health and Safety, Royal Canadian Mounted Police): Madam Chair, thank you for the opportunity to appear before this committee today and respond to your questions regarding the RCMP's response to recommendations in chapter 4 of the Auditor General of Canada's report, “Management of Federal Drug Benefit Programs”.

The Commissioner of the RCMP responded to this draft report in a letter dated 12 October 2004 to Mr. Ronnie Campbell, Assistant Auditor General. I am tabling a copy of this response, a copy of which has been left with the clerk of this committee.

As is reflected in the commissioner's letter, the RCMP concurs with the recommendations and observations made in this chapter. To demonstrate our commitment, we have prepared a work plan to address the recommendations that are specific to the RCMP, and we are working closely with other members of the Federal Healthcare Partnership on the recommendations that have joint implications. Our work plan reflects the work already done and outlines what steps are planned and when we expect to complete these steps. A copy of this work plan has also been tabled with the clerk of this committee.

[*Translation*]

The RCMP is responsible for providing health services to its members. Like members of the Canadian Forces, RCMP members are “non insured“ persons under the Canada Health Act. The RCMP has adopted an occupational health model to deliver health care to its members. This balances the occupational requirements of the RCMP with the health care needs of the member.

The RCMP is responsible for defining and managing its occupational health and safety program based on the advice and expertise of its RCMP health care professionals. The actual provision of primary health care is carried out by external health care providers.

I will take this opportunity to provide an overview of some of the key elements of the steps the RCMP has taken to address the recommendations.

[*English*]

For those recommendations that have government-wide implications, the RCMP is working in collaboration with other affected government departments to ensure any arrangement meets the requirements of the RCMP and the expectations the Office of the Auditor General has of the RCMP.

A health services renewal task force has been mandated to examine the entire management accountability framework for the RCMP's health services program. This task force is currently examining management information requirements necessary to effectively monitor and control the RCMP's health benefits and entitlements. This includes appropriate performance objectives and measures.

RCMP claims are paid by a third-party service provider. The RCMP has requested changes to its system to address the deficiencies identified by the Office of the Auditor General. The RCMP will continue to collaborate with the Federal Healthcare Partnership to develop a first-level action plan, which will be submitted to the Auditor General at the end of February.

Madam Chair, on behalf of the Commissioner of the RCMP, let me assure you the RCMP will continue to give full attention to all recommendations.

Thank you for your attention. I would be pleased to respond to any questions.

● (1555)

The Chair: Thank you very much.

I think the clerk has assembled the people mentioned in this report of the Auditor General.

We'll begin the question and answer period with Mr. Fletcher, who will have ten minutes.

Mr. Steven Fletcher: Thank you, Madam Chair.

Thank you all for coming and helping us understand what needs to be done.

My first question goes to the Auditor General. I gather this is not the first time the issue of the federal drug program has come up. You must find it frustrating to have to deal with this issue time and time again. Is that an accurate statement?

Ms. Sheila Fraser: This is the third time we have audited the drug program in Health Canada. We did not audit any of the other departments. We did do the drug program in the first nations health branch in 1997, and again in 2000, and now in this report. The other ones, to my knowledge, have not been audited in the past. We will continue to report to Parliament on significant issues until we believe they have been resolved.

Mr. Steven Fletcher: The Auditor General's report says that most federal organizations have neither objectives nor performance measures that are specific to their drug benefit activities. If there are no clear objectives and performance measures, how do you know whether your drug benefit activities are meeting their intended purposes and are cost-effective?

If there are no measures, how can we know how we're doing?

Ms. Sheila Fraser: The departments may wish to respond to that. This is obviously one of the findings of the audit, that there were not specific objectives. Given the rising costs, we think it's important that Parliament be informed of what is being done in these areas and that there be mention made in the performance reports that there be better performance information provided.

The departments may have comments on that.

Mr. Steven Fletcher: I wonder, would it be helpful for Health Canada or for the auditor if there was...you mentioned electronic ways of coordinating the information.

Now, we have Canada Health Infoway, which is one of those foundations that it's tough to know what's going on in, because the Auditor General doesn't have the power to go in and take a look.

I wonder, Madam Fraser, if you think it would be useful if the Auditor General did have the power to go and check Canada Health Infoway out, if you were able to go in there and audit.

Ms. Sheila Fraser: Madam Chair, we have been quite consistent over several reports on foundations that we believe the Auditor General should, as a minimum, have access to foundations. I don't think that what Canada Health Infoway does is necessarily related to the management of drug benefit programs.

Mr. Steven Fletcher: But it could help, potentially, so you don't get the over-prescribing and abuse that seem to be prevalent.

Ms. Sheila Fraser: I think much of the information we are talking about here is already available to the departments. We think there should be much more analysis of information done to detect trends to see if there's possible abuse of the system and to try to find cost-saving measures.

The departments do have much of that information now. There was a concern about confidentiality and privacy. We were able to do much of the analysis in our report by assigning codes, so you can't identify specific people through the work. We think this kind of analysis should be ongoing. It is my understanding that Health Canada has reinstated that analysis, and we view that as positive.

Mr. Steven Fletcher: Are there cases where people in first nations, or really, any remote communities, for that matter, receive prescriptions without seeing their doctor or pharmacist?

● (1600)

Ms. Sheila Fraser: I'm not sure we can answer that. We would look only at the government management of the program.

I wouldn't be able to answer that question, Madam Chair. The department might have information for you on that, though.

Mr. Steven Fletcher: Okay.

The Chair: Madam Gosselin, do you have any information on that?

Mrs. Hélène Gosselin: On that specific issue, no. But my colleague, Mr. Potter, may have some, Madam Chair.

Mr. Ian Potter (Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health): With respect to access to pharmaceuticals without a prescription or without seeing a physician, there are a number of different medical professionals that are authorized to dispense or prescribe pharmaceuticals that are a controlled pharmaceutical substance.

Our non-insured health benefit program pays only where there has been a prescription from one of those, whether it be a physician or a dentist. There are some cases where nurse practitioners have that right as well. Within our program on isolated reserves we have an expanded practice nurse who, under the supervision of a pharmacist, can prescribe medicines in emergencies or when they are necessary.

But for the non-insured health benefit program, it deals only with those from a licensed medical practitioner and a licensed pharmacist.

Mr. Steven Fletcher: Or when they're “necessary”. I find that wording intriguing. When are drugs prescribed when it's not necessary?

Mr. Ian Potter: When it would be necessary to immediately deal with it, is the point I wanted to make.

For example, if there's a trauma case, if someone's been in an accident, they've been brought to the nursing station, and it's determined that they should be sent out of the community to a hospital, in the interim there may be the need to provide analgesics, pain killers. In that period of time they would be prescribed and administered pharmaceuticals.

Mr. Steven Fletcher: The Auditor General reports that Health Canada has no explanation as to why the number of clients who have accessed 50 or more prescriptions has almost tripled in four years.

Why is Health Canada unable to explain this action by its clients?

Mrs. Hélène Gosselin: We started analyzing that situation when we resumed the retrospective drug analysis that Madam Fraser was referring to. For a number of years we stopped doing the analysis of the drug use of our beneficiaries. We've now resumed that analysis so we can address any specific issues that arise, including if some of our beneficiaries are using many prescriptions.

In some of the analyses we've done, we've noticed there are sometimes legitimate reasons for why people have many prescriptions or use many medications, but in other cases there are concerns. When we have concerns, with the consent of the beneficiary, we communicate that information to the pharmacist, sometimes to the physician, and then they take appropriate steps.

Mr. Steven Fletcher: I'd like to go back to the monitoring and identification of prescriptions. Would e-pharmacy be helpful in that? We've heard a lot about electronic pharmacies and so on. If so—

Hon. Robert Thibault: You're mixing hearings.

Mr. Steven Fletcher: Yes, well, I'm trying to be efficient.

Would that be helpful in addressing some of the abuse issues?

Mrs. Hélène Gosselin: I can say that the point-of-sale system we now use throughout our program definitely contributes to our program being able to analyze this information. So, yes, information technology definitely contributes to our capacity to analyze information.

I'm not sure if e-prescribing itself...I mean, it's one other electronic tool that will be used. Whether it's going to make it easier, I'm not sure. We already get all of our claims electronically, so we have the information and we can analyze it.

Mr. Steven Fletcher: My question for the Auditor General is, we hear a lot about the Canada Health Infoway, and it is one of those foundations. If you had the authority to go in and take a look at the foundation, since there's abuse in other areas where Health Canada or the federal government's been involved, would you be suspicious that this abuse or maybe mismanagement might be found in other foundations?

● (1605)

Ms. Sheila Fraser: Madam Chair, the concerns we have about foundations are not related to any concerns about abuse within the foundations. We have tried to make it very clear that any remarks in our audit findings related to foundations shouldn't be viewed as criticisms of the foundations, nor of the people who work there. It's really about the accountability to Parliament over public funds and the amount of information that is available to Parliament.

It's not driven by a concern that there may be something untoward going on in foundations, not at all.

I would say, as an auditor, that being auditors we think audits are good things, that hopefully audits will help to improve management practices. When we do see departments taking them seriously and improving, that is what the audit is all about at the end of the day. We try to pick areas that we believe are important and of significance to Parliament and to Canadians, and through our audits we can either give you the assurance that they're being managed well or point to areas where improvements can be made for all.

I'd just like to correct one thing I said earlier. I mentioned that I didn't think there were other audits that had been done. If you look at the very end of our chapter, in 1996 we did audit the program in Veterans Affairs. They have addressed all of the recommendations we made or are making satisfactory progress on them.

The Chair: Thank you, Ms. Fraser.

Thank you, Mr. Fletcher.

We'll now move on to Mr. Ménard.

[*Translation*]

Mr. Réal Ménard (Hochelaga, BQ): Thank you very much.

Welcome, Madam Auditor General. I have a few short questions for you.

First of all, to what do you attribute the 25 per cent increase — from $350 million to $438 million — in drug program costs in the case of these six organizations? I know the biggest culprit is Health Canada. Have you looked into the cause of this increase in drug costs?

Secondly, you seem quite hopeful that centralized buying will help to keep costs in check. If the government opted for large-volume purchasing at wholesale prices, different departments could conceivably lower their costs. Unless I'm mistaken, that was one of the recommendations made by the Romanow Commission. I'd like to hear more about this from you. It is my understanding that Health Canada is moving in this direction.

Thirdly, I'd appreciate an explanation as to data that can currently be accessed by a pharmacist when he or she fills a prescription for a program client. I thought we had solved the problem of prescriptions in duplicate, triplicate or quadruplicate. How far along are we in terms of resolving this problem?

I'll have three additional short questions for you later.

Ms. Sheila Fraser: Thank you, Madam Chair.

First of all, on the question of rising costs, we have not analysed the reasons for these increases. However, Ms. Gosselin may be able to answer your question, because I believe her department has done some comparative analyses. We're simply stating a fact, namely that this is one area in which costs have increased substantially.

We indicated that centralizing the buying process would be one possible way of reducing costs, particularly in the case of some departments that purchase drugs. For example, National Defence pays less for the drugs it purchases than do other departments. This department has tighter controls in place when it comes to buying certain types of drugs.

Mr. Réal Ménard: Does the department purchase the drugs at wholesale prices, as you mention in your report?

Ms. Sheila Fraser: That's exactly what is does. Of course, there are other ways of keeping costs down, and I believe the inter-departmental committee is examining other possible tools. No doubt Ms. Gosselin can tell you more about that.

As for the data available to pharmacists, Health Canada may be in a better position to answer...

Mr. Réal Ménard: The crux of your report, which I've read from cover to cover, is the finding that incredibly, pharmacists in 2001, 2002 and 2003 weren't able to... A single client can manage to get 15 separate prescriptions from different departments, or get duplicates of the same prescriptions. How is it that the process has not yet been streamlined? We looked into this a few years ago, specifically in 2001, as I recall. It's utterly ludicrous that the problem has yet to be corrected.

● (1610)

Ms. Sheila Fraser: Systems are in place. At the time of our audit, they were partly operational. It also depends on the warning messages that are issued. There's also the whole issue of sharing personal information that still needs to be resolved. I'm confident that Health Canada officials can explain the situation more fully.

Mr. Réal Ménard: The newer one is to government, the more one has to say.Go ahead then, Ms. Gosselin. We're all ears.

Mrs. Hélène Gosselin: Thank you, Madam Chair.

We did a cost analysis and found that one of the factors associated with rising costs was the actual cost of prescription drugs. Other factors include the increase in our client population and the relative young age of our clients. Furthermore, there is a discrepancy between their health and the health of...

Mr. Réal Ménard: Relative young age?

Mrs. Hélène Gosselin: That's correct, because the aboriginal population is relatively young compared to the Canadian population. There is also a marked difference between the health of Canadians and that of aboriginals. All of these factors lead to higher costs. We did an analysis to determine if our program cost increases were out of line. Mention was made of a 25.76 per cent increase across all federal programs. Our program costs have risen 25 per cent, which is comparable to cost increases in the case of provincial drug benefit programs. In Quebec and New Brunswick, for example, costs rose by 27 per cent, while in Alberta, the increase was in the order of 25.81 per cent. We're maintaining our program costs and increases have not been out of line.

As for finding ways of better managing our costs, yes, we do have a centralized buying system in place, we make large-volume purchases, and so forth. When we have our own distribution networks in place, we use these methods. Where we have dispensaries on reserves, we use these methods as well. The majority of transactions...

Mr. Réal Ménard: Just a moment. Let me try to get this straight. There is no single formulary of refundable drugs and there is no one centralized purchasing system in place, a shortcoming identified by the Auditor General. Health Canada can purchase certain prescription drugs, Veterans Affairs...

It's somewhat different in the case of the RCMP because, if I understood correctly, private insurance plans apply. We can come back to that later. However, as far as the other five departments are concerned, it's rather amazing that no arrangements have been made for a single buying agency.

Mrs. Hélène Gosselin: We are working on this. We want to develop a common formulary and several common purchasing methods. An inter-departmental committee headed up by Veterans Affairs is looking into this. We are drafting a detailed plan of action to guide us in the months ahead on meeting the Auditor General's recommendations.

Mr. Réal Ménard: Will you have followed up on these recommendations within one year?

Mrs. Hélène Gosselin: I don't have the action plan here with me and I wouldn't want to speak for my colleagues. The six departments will be tabling their joint action plan, most likely by the end of the month, as Ms. Bruce indicated to the Public Accounts Committee. I imagine we could get a copy of this action plan to you.

[*English*]

The Chair: Thank you, Mr. Ménard.

Mr. Savage.

Mr. Michael Savage (Dartmouth—Cole Harbour, Lib.): Thank you, Madam Chair.

Welcome to the witnesses. Thank you for appearing today.

As we spend so much money on health care across this country, and in fact an increasing amount, it's important that we understand how well that expenditure is managed at all levels. So this is important work.

I'd like to talk a little about the first nations and Inuit. It would seem to me that from the point of view of Health Canada's non-insured health benefits program, there would be some benefit in terms of consultations with the first nations and Inuit people.

I noted in your report, Madam Gosselin, that you've worked very hard with first nations and Inuit partners and health professionals to find ways to encourage appropriate drug utilization. Can you talk a little bit about the consultations and involvement you would have with first nations and Inuit people to ensure appropriate drug use, both from the point of view of costs, obviously, and drug abuse?

Mrs. Hélène Gosselin: We consult extensively with first nations and Inuit people, especially when we try to implement the approach to consent so that we can communicate to pharmacists and physicians the information that our analysis of drug use indicates.

I would ask my colleague, Mr. Potter, who took part in these consultations, to perhaps go through some of the steps we took. I would note that they're detailed as well in the action plan we've tabled with the committee.

● (1615)

Mr. Ian Potter: I'd be pleased to give you an idea of the kinds of consultations. For example, the branch management, or executive, committee of the First Nations and Inuit Health Branch has members on it from the Assembly of First Nations and the Inuit organization, the Inuit Tapiriit Kanatami. So they're part of our general executive decision-making.

With respect to this program, there is a subcommittee that reviews all of the benefits and the approach, particularly with how we manage the safety issues and deal with respect for privacy. We've had ongoing discussions with first nations and Inuit organizations, both at the national level and within each region.

What we have found is that the first nations organizations, particularly the chiefs and band councils, are very concerned about the safety of their members. They are also very concerned about privacy rights. When we tried to initiate the work that was recommended by the Auditor General in earlier reports, we adopted an approach that sought general consent from all of the beneficiaries of our programs. That was not received well by the first nations and Inuit organizations, who felt we were interfering with treaty and aboriginal rights. A number of them wrote to the Privacy Commissioner. The Privacy Commissioner worked with us, addressed their issues, and issued a letter in early 2004 setting out the principles upon which we could address the program.

We've subsequently taken those principles from the Privacy Commissioner, met with the first nations and Inuit organizations, and have now arrived at an approach to deal with drug utilization and possible abuse. It's an approach that allows for the protection of privacy. It works on the basis that we can assume that when a person approaches our program for a benefit, they are giving consent for the use of their information for the filling of the administrative requirements for paying it, and it allows us to do what the Auditor General had suggested, which was the analysis of drug utilization or the pattern of individual behaviour.

Only when we want to pass on that information to others, like health providers or pharmacists, do we then need consent. Our approach is to ask for that. We have a number of people; in fact, many of the people who have been identified as being at risk have actually given us consent for their information.

In our approach that will be fully implemented this fall, we will alert the pharmacist where there has not been consent to share the information, and we will not process any further claims from that individual until such time as they either talk to us or allow the pharmacist to speak to us and get the information.

This is an approach that we have now worked out with the Assembly of First Nations and the Inuit Tapiriit Kanatami.

The Chair: Thank you, Mr. Savage.

We'll now go to Ms. Crowder.

Ms. Jean Crowder (Nanaimo—Cowichan, NDP): Great. I would also like to thank all of you for your presentations.

I also want to follow up on some of the questions about the first nations and Inuit populations.

My community of Nanaimo—Cowichan in British Columbia has a significant first nations population. The pharmacy folks have actually met with us about some concerns with the first nations' non-insured health benefits.

I noticed in the report that the Auditor General has identified some issues around the fact that the NIHB should increase its informational demands, yet we're hearing from the pharmacies that there's already a burden placed on them in terms of the kind of information required. A couple of the points that came up from the pharmacy people were that the population is an at-risk population, that there are some significant challenges in working with the population. The pharmacists are challenged in terms of gathering the kind of information that's required. Also, there are some very complex health issues with many first nations patients. On the one hand, more information is being required, but the pharmacies, on the other hand, are already spending significant amounts of time trying to gather information.

I don't know if you have any suggestions on how to reconcile those challenges.

● (1620)

Ms. Sheila Fraser: Madam Chair, I could just begin to try an element of response.

Our major recommendation is about the analysis of the information that Health Canada already has. They do all of this management of this program, but we're not doing any analysis for five years. We're not looking at trends. We're not seeing if there was abuse. We're not seeing if there were potential drug interactions, looking at trend lines. So that's one of the major issues we were trying to bring forward.

As well, I think we say in the report that in some of the systems that are in the pharmacies, there are alerts that can be activated. Some of those alerts were not activated. So we're not saying that the pharmacies necessarily have to have a different system. Things within those systems need to be activated so there can be better detection of perhaps drug interactions or inappropriate use of drugs.

Ms. Jean Crowder: In your experience, given that all of this information has been gathered and not looked at, I'm wondering about the burden on the pharmacists. I presume they're submitting information that isn't being used.

Ms. Sheila Fraser: They are submitting the information in order to receive payment under the program. The information is going into various data banks. For example, the analysis we did in this report showing the number of people who received 50 or more was all from that information. So we conducted that analysis as part of our audit and we would have expected.... The department used to do it; they stopped doing it. They've now resumed doing it.

Ms. Jean Crowder: Did you specifically look, then, at the kind of interaction that the pharmacists have with NIHB? The pharmacists are complaining quite loudly about delays in processing, about, in their view, the somewhat arbitrary turning down of claims, lack of response time, those kinds of things.

Ms. Sheila Fraser: We addressed the interaction. My team can perhaps respond—I don't believe we actually interviewed pharmacists in doing this audit. But we looked at the interaction from two aspects. One is the dispensing fees that are being charged. We think there are measures the departments can take to also analyze the dispensing fees and to perhaps reduce that cost.

The other one is on the audit. Perhaps I can ask Mr. Campbell to give you more specifics from the audit.

Mr. Ronald Campbell (Assistant Auditor General, Office of the Auditor General of Canada): Madam Chair, just to clarify, I think there are two areas where the pharmacists will be having interactions with Health Canada, and one of those, of course, is in billing. When they fill a prescription, there's information that goes to Health Canada in order for them to get paid, and that's the information, as the Auditor General was saying, that rests in Health Canada's data banks and can be analyzed, and our auditors have analyzed it. So that information is already there.

The other area of interaction I think the member might be referring to is in terms of Health Canada's audits. In fact, all of the departments, or the majority of them, have audits of the pharmacists. Certainly, in that area, there'll be a significant amount of interaction, but it would be quite a different thing from the transmitting of the information required to get payment, and that's the information that Health Canada has available in order to do the analysis.

The Chair: Thank you, Ms. Crowder.

We'll move to Mr. Thibault now, please.

Hon. Robert Thibault: Thank you, Madam Chair.

Distinguished guests, thanks for your presentation. This is a little bit of déjà vu, because I was at the public accounts committee and essentially the same information was provided, the same questions were asked, the chair remembers what happened, and the same answers were given. The consistency is there all around.

My first point is to the Auditor General. I hesitate to put words in your mouth, so please correct me if I'm off base. My memory of that meeting is that you responded, and I think you've said that today, that you're "cautiously optimistic", is the term I use, that the direction the Department of Health and the agencies are going in, in responding to your recommendations, will meet the intent that you put forward.

● (1625)

Ms. Sheila Fraser: Yes, very much so, Madam Chair.

We are pleased with the level of commitment that the departments are indicating to addressing the recommendations and already some of the improvements that we can see, and we look forward to the action plan. But as I said in the other committee, auditors like to have proof that things have changed, so we will go back, I'm sure, at some point in the future, to see if the actions have addressed the concerns that we raised in this audit.

Hon. Robert Thibault: My second point would be to the department. Again, I don't want to put words in the mouth of Madame Gosselin, Mr. Potter, or Madame MacLean, but from the answers I heard the last time, I don't think your frustration, if there was frustration, was with the recommendations in the previous two reports of the Auditor General but in the ability to implement them.

The question of privacy requirements and the need to work with the clientele community were very difficult. There had been some change in thinking at the Privacy Commissioner's office. I think when this started the Privacy Commissioner's office was a relatively new organization, and now you're using, if I remember correctly from that meeting, a principle called "implied consent" on the question of the privacy requirement.

Could you explain that to the committee, how that would work and how that would be different from what you had understood or how you had been guided by the previous Privacy Commissioner?

Mrs. Hélène Gosselin: Thank you.

Yes, in fact, we haven't been frustrated with the recommendations from the Auditor General. We have accepted the vast majority of them, and we've moved to implement the vast majority of recommendations in the three reports. We've taken a number of measures in the 1990s to respond to some of the first recommendations, and the action plan we've tabled with the committee details a lot of those steps. So you're quite right, the frustration was more in how to implement some of these recommendations.

The particular area of privacy rights was problematic. The department had started doing the retrospective drug analysis after the first recommendation, if my memory serves me correctly, and stopped after a couple of years when we were advised by our legal services that we might be breaching the privacy rights of our beneficiaries. So it was a serious issue that the department wanted to look at. In fact, it took some time before we got views from the Privacy Commissioner—but not only the Privacy Commissioner. I want to make the point that some of the provinces—in fact, most of the provinces—were also struggling with this issue, and we were looking for a common framework that would help in the various plans for use. We have developed one with the help of the Privacy Commissioner.

What they defined was that "implied consent" is consent that is implied when we do normal transactions under the program. So when people submit their claims and are reimbursed, the beneficiary has given us consent without having to give it to us formally.

When we wanted to do something beyond the intended use of the information, when we wanted to look at the overall pattern of drug use of a particular beneficiary to see if there was a problem and then communicate that information back to a pharmacist or to a physician, that was where we needed more than implied consent. That was the advice we were getting. We needed explicit consent from the beneficiary at that point.

We tried to go forward with a system where we would have written consent with these forms that were developed, which Mr. Potter referred to earlier, and that generated a lot of the concern with first nations, because we were seeking consent for pretty broad application.

We have ended up with a system where we can seek consent of the beneficiary for sharing particular information. We have to explain what we're doing, what the information will be used for. So we narrow down the consent so that the beneficiary understands what we're going to do with the information and for what purpose.

We have had success with that. The vast majority of the people we contact do provide us consent to share information, because at the end of the day it's for their own safety and security.

● (1630)

Hon. Robert Thibault: Merci.

My time is up, I presume. I wish to return later.

The Chair: I believe it's now Mr. Penson's turn.

Mr. Charlie Penson (Peace River, CPC): Thank you, Madam Chair.

I'd like to thank the panel for being here today. I thought it was an informative session. I'd like to address my remarks, though, to the Auditor General.

I've been here for 12 years. I know I'm not the longest standing of members in this House, but certainly I've heard many of these types of stories about the audit that you conducted for the federal drug benefit program before, regarding lack of coordination and failure to take advantage of cost savings. I think we always have to remember whose dime we're spending here and whose dime we might be wasting. I hear it all the time from my own constituents, and they're concerned when their money is not being well spent.

Just to advance this a little bit further, I know departments have internal audits, and they're important. I don't think anybody denies that. But when as Auditor General, Madam Fraser, you come out with your report—it's a public document—I think it puts pressure on departments to clean up their act. I know sometimes you go back to see what kind of success we've had in doing that, and I think it's a very beneficial process. To the extent that your office does that, I think we're all better off for it if we can get a better system coming out of it.

Therefore, the question I have—it's a rhetorical question, I guess—has to do with the foundations. It seems to me that we're probably going to go into another round of foundations in a couple of days, and that bothers me, and I understand it bothers you. I don't think you would advocate, Ms. Fraser, that we would pre-fund or give foundation funding to all the departments. In fact, I think that's not allowed under parliamentary rules, except in the case of the foundations. Regarding the ones that are still subject to this exception, can you tell us how you see the fact that Parliament could become more accountable and better informed from your process if you were able to examine these foundations?

Ms. Sheila Fraser: The member is correct that, as a general principle, government does not allow pre-funding of programs, and that relates, of course, to the annual parliamentary appropriations process. There is, in fact, a Treasury Board policy that clearly states that money should not be paid in advance of need.

For the foundations, exceptions have been given by the Treasury Board to allow pre-funding. As you may know from our last report, there was some $9 billion transferred to some 15 foundations, and $7.7 billion is still in their bank accounts. The government argues that it is important to pre-fund so that they have stability in their programming, and their programming, in many cases, does cover a very long period of time, ten years and perhaps even more. I should also make the point that all of those transfers were, of course, voted on by Parliament and approved through the appropriations process.

We believe it is important that there be performance audits done, like this kind of auditing we're talking about today in the drug benefits program. And one of the things that the Auditor General's office can do that individual departments or internal audits can't do is to look at a broader picture, if you will. In this audit, for example, we could look at the drug management programs of several departments and see how well they are managing them, as a group. What we're saying is when we audit an issue in which the foundations play a very significant role, for example, innovation or education or climate change, it would be important to have access to them to see how well they are coordinated with other government programs and whether they are reaching the objectives for which the money has been allocated. And that's the basis of our point.

Mr. Charlie Penson: Thank you, Ms. Fraser.

Isn't it also a fact that you do take the lead from Parliament, in some cases, when there are suggestions made that certain sections or programs in a department may need auditing, and you therefore then look into them?

Ms. Sheila Fraser: It is the prerogative of the Auditor General to decide what audits to do, but certainly if there is a recommendation by a committee, we obviously will take that into account in our planning. So if a committee recommends that we do a certain audit, we will generally conduct that audit.

● (1635)

Mr. Charlie Penson: I have just one further question. I think you've already identified that of the $9 billion that has been put into the foundations, only $1.3 billion has been spent. That leaves $7.7 billion sitting there drawing some interest. But, really, doesn't that represent $7.7 billion more in taxes that Canadians would not have had to pay had these moneys not been allocated to the foundations?

Ms. Sheila Fraser: I'm sure the member knows, Madam Chair, that the Auditor General doesn't get into issues of policy. The question of whether to spend funding on programs such as education, climate change, and innovation or reduce taxes is very much a policy issue.

Mr. Charlie Penson: But, Madam Fraser, how did the government get that $7.7 billion?

The Chair: Mr. Penson, your time is up, and the Auditor General does not have to answer questions that do not fall within her purview.

We'll now go to Mr. Savage.

Mr. Michael Savage: Thank you, Madam Chair.

I'm referring to your opening comments, Madam Gosselin, in which you state:

> We also continue to monitor actively and audit pharmacists' responses to online warning messages. In 2003-04, we had 308,000 drug utilization rejection messages which resulted in pharmacists not filling the prescription in 232,000 cases.

And in the action plan, I guess to resolve this, you state, "Implementation may be limited by third-party point-of-sale software as well as security and privacy issues."

Are those some of the issues Mr. Potter spoke about before? Could you explain what could slow that process?

Mrs. Hélène Gosselin: These statistics refer to the online, real-time warning messages that we have in the system. Going back to the question Mr. Ménard asked earlier, we do have warning messages in our system program so that pharmacists, when they fill a prescription, for example, will get a message if there's possible interaction, if it's a duplicate drug prescription, or if there are duplicate therapies and multiple pharmacies. So we're already using these.

We are introducing new warning messages that will target some specific drugs of concern. Where we say we have limitations, we have to work with the pharmacists' associations because their point-of-sale systems interact with ours. I'm not a very technical person, but we need their cooperation so that they can program into their systems these new warning codes that we want to use. It's really a question of making sure we have the pharmacists' associations working with us so that they can modify their systems to interact with ours and we can provide pharmacists with the information they need.

Mr. Michael Savage: So it goes to the issue of the availability and the implementability of the system.

Mrs. Hélène Gosselin: Yes, it does. It goes to the issue of needing the cooperation of the various partners so that the measures we want to put in place actually are effective. We need them to update their own systems so that they can receive the additional warning codes we want to put in.

Mr. Michael Savage: Thank you very much.

According to the audit, hundreds of clients are receiving two or more narcotics from multiple doctors and pharmacists, and in some cases from dozens. I know that in some areas, like northern communities, there's a lot of turnover in doctors and pharmacists and people like that, but I wonder if that is as serious as it sounds. Is that as much of a concern as it seems to be? How does that compare to perhaps other countries? Is anybody similar to us in that way?

Mrs. Hélène Gosselin: It is serious because it's always a question of concern when you have indicators like that. You have to look at whether they hide a bigger problem. The situation affects only a very small proportion of the clients we serve, so it's generally not a widespread program. It does point to a potential risk area, though, and that's why we've resumed doing the retrospective drug analysis.

I would like to note that we've had online warning messages that would alert pharmacists to potential problem areas. We've have those since the 1990s. With the retrospective drug analysis that we've resumed, we can look at these individual situations and we can, through our clinical review program, see if there's a legitimate reason behind them. For example, you mentioned that many doctors sometimes go up north. Sometimes that's based on a rotation, so you would expect that people have prescriptions from many doctors. This analysis allows us to look at whether or not there's a legitimate reason. Where there's not a legitimate reason, then with the consent of the beneficiary, we can communicate with the pharmacist or the physician and then they have additional information to carry out whatever steps are appropriate.

Mr. Michael Savage: Thank you very much.

Do I have time for one more quick one?

The Chair: Very quick.

● (1640)

Mr. Michael Savage: My question is for CSC.

You mentioned that you have an offender management system that's secured and is planned for 2008, "an automated nationalpharmacy system [which] will allow the data extraction and analysis". Is this something that would be coordinated with the rest of the health system or just while the offender is in the system?

Mr. Fraser McVie (Acting Assistant Commissioner, Correctional Operations and Programs, Correctional Service Canada): It would be our intent to work closely with our partners in the Federal Healthcare Partnership to identify where there could be linkages between the outside system and our own, especially as those linkages pertain to those who are due for release into the community—for example, aboriginal or Inuit offenders for whom there would be a clear linkage or handover to the Health Canada system. We'll be looking at those kinds of exchanges of information as we build this.

Mr. Michael Savage: And perhaps to other health systems as well—provincial?

Mr. Fraser McVie: Yes. We have a committee, actually, with our correctional health partners in the provinces and territories, and they're interested in the development, to see whether we can harmonize that.

The Chair: Thank you, Mr. Savage.

Madam Demers.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): Thank you, Madam Chair.

Thank you for coming, ladies and gentlemen.

Ms. Fraser, you indicated that previous reports contained recommendations. I was surprised to see that different organizations followed rather different procedures in the case of their respective drug programs.

This committee seems to have been around for some time and I'm wondering if any of your previous recommendations have in fact been implemented. The will to act may not be quite as strong as it once was, but do you have the impression that there is a genuine desire to correct the problems that you have identified?

Ms. Sheila Fraser: Thank you, Madam Chair.

At the end of our report, you'll find an appendix containing past recommendations targeting Health Canada and Veterans Affairs Canada. We do a follow-up analysis to ascertain if progress is satisfactory.

As you will see, action has been taken on a number of recommendations. However, in other cases, we are not quite as satisfied with how things have progressed and again, we focus on the system in place. As Ms. Gosselin mentioned, the department has already taken steps to implement some of the recommendations, notably with respect to analyzing information. Therefore, I can see that the department is committed to following up on these recommendations. Just look at the letter that the minister has tabled to the committee. It's the first time I've seen a letter like this one.

So then, I feel that departments genuinely want to address our concerns. Nonetheless, auditors are always looking for evidence. Therefore, we will be evaluating the progress made during our next audit.

Ms. Nicole Demers: Thank you, Madam Fraser.

My next question is for Mr. Mole from the RCMP.

Could you possibly give us a few reasons why the RCMP basically spends as much as Health Canada on its drug benefit program?

[*English*]

A/Commr Kevin Mole: Thank you, Madam Chair.

The RCMP provides an occupational health program for its membership. The costs of the drugs themselves are, of course, a matter of concern; we are working with the Federal Healthcare Partnership on a number of action items. We currently have a population in over 750 offices across the country, in all provinces and territories. In a number of locations we provide for our membership to have their choice of pharmacy, and their physician has the opportunity to prescribe the drugs required for members' health care. As such, the drugs provided for our members are often the drugs prescribed directly by the doctors, and the choice is limited in the provision of the health care.

● (1645)

[*Translation*]

Ms. Nicole Demers: Like RCMP members, veterans and aboriginals can be found just about anywhere in Canada. Then why is it that the RCMP's drug benefit program is more costly, on a per capita basis, than other programs?

[*English*]

A/Commr Kevin Mole: The RCMP's formulary for its drugs is a very generous one for its membership. It's important for the organization, for the RCMP, to ensure its members receive quality health care, as expediently as possible, and that they are provided with an opportunity to obtain the prescription drugs as provided by their health care provider as prescribed.

[*Translation*]

Ms. Nicole Demers: Thank you.

[*English*]

The Chair: Thank you, Madam Demers.

I'll now go to Mr. Thibault.

Hon. Robert Thibault: I think Mr. Savage is next.

The Chair: Yes, it's Mr. Savage, sorry.

Well, we're going back and forth. It's unfortunate, but we have absentees, so the Liberals who have been coming regularly have complained that they are not getting enough turns for the Liberal point of view.

Mr. James Lunney (Nanaimo—Alberni, CPC): You guys have opened up twice already, and there are members of the committee who haven't had a first round yet.

The Chair: That's true, but only yourself and Mr. Goodyear, who isn't a regular member....

Mr. James Lunney: And it will be back here momentarily?

The Chair: Yes. I'll think we'll get right around to Mr. Lunney. Don't worry, you're after Mr. Thibault.

Hon. Robert Thibault: I'll go.

Thank you, Madam Chair.

Just on that last response from the RCMP, I recognize that it's true the RCMP need to have good medical coverage, and so do veterans. So do all the others. So do our civil servants, and so do Canadian generally. I wouldn't put the argument forward that they deserve or need an enhanced drug formulary or enhanced medical services other than those all other Canadians have who are providing service to Canadians, economically or otherwise—or directly.

One question I have, though, is this. You said in your presentation that the question of working through a third-party provider.... That's not only on your drug care; it would be on all of your health insurance services, I would presume?

A/Commr Kevin Mole: As I said, the RCMP has a benefit program for its employees where our dependence is on a third-party provision of health care services, both for its physicians and for its dental and drug coverage.

Hon. Robert Thibault: Would that apply to long-term disability and that type of coverage also?

A/Commr Kevin Mole: That is correct.

Hon. Robert Thibault: And is that different from the case with other sectors of the federal civil service or of the other agencies, or is it common?

A/Commr Kevin Mole: The RCMP participates in a program for occupational health and health care services for its membership wherein the member visits a physician to seek his health care—

Hon. Robert Thibault: Perhaps we could ask that question of Health Canada.

On the question of the third party in long-term disability and all the others, is that common throughout the federal civil service and the agencies, or is it a special provision for the RCMP? Would the military, for example, have a third-party long-term disability provider?

Mrs. Hélène Gosselin: I think it's different in other areas, because for the RCMP you look after the health care services for your members—or some of the health care services. I don't have detailed information on what other departments have, but I suspect it's different. We can get you that information.

Hon. Robert Thibault: I would be interested in knowing whether there is a difference, whether there is a premium provided to one agency as opposed to the others in government. I would be interested, and I'm sure other members of the committee would like to know that.

Another question: the government and others have spoken much about the national pharmaceutical strategy in the last few months. I think this phrase was mentioned today again. I frequently hear about a common drug review in the federal-provincial-territorial pharmaceutical issues committee. These seem like many pieces in a puzzle. Could you clear the air as to how that will respond to provide part of the solution?

The other question I have that perhaps you can deal with at the same time, while it might sound like part of the solution, is that any time I hear about the three levels of government having to negotiate something together, it can also be part of a problem. It can also slow the implementation of the Auditor General's recommendations. Could you elaborate on how you work through that?

● (1650)

Mrs. Hélène Gosselin: We have different processes under way, but we are working with the provinces to look at many of the issues and problems we've raised in the Auditor General's report or that first ministers have raised in their discussion on health care. The national pharmaceuticals strategy, for example, will be looking at issues such as the formulary and whether or not we can move even with the provinces toward a more common formulary.

At the federal level, that's why, with the Federal Healthcare Partnership, the various departments have been working together for some time. The federal government is a health care provider as well.

I think the two processes are looking at similar issues. Some of them are a bit different, but they're looking at similar issues. What we're trying to do is make sure we're moving in the same direction. The Federal Healthcare Partnership, as a representative of the federal health care providers, is also part of the national pharmaceutical strategy.

The process has just been launched for the national pharmaceutical strategy, and the various jurisdictions are to report back to first ministers in June 2006.

Hon. Robert Thibault: Thank you, Mike. Perhaps you could use the remainder of my time.

The Chair: He'll get another chance. But now we go to Mr. Lunney.

Mr. James Lunney: Thank you very much, Madam Chair. We're jumping in late and we've heard a lot of things already.

The first question I'd like to ask is on something we heard partly addressed, that we heard partial answers to. This has to do with the data collection that has been going on systematically for five years, an analysis that was going on and then was dropped for five years and then restarted. We're glad it's restarted, but we haven't heard anybody explain why was it dropped. So, Ms. Gosselin, can I ask you that? Why was this program stopped in the first place?

Mrs. Hélène Gosselin: The data we collect is the data we collect to reimburse the prescription, so we don't collect additional data. We collect the data we need to reimburse the prescription, which is the benefit of our program. What we started doing in 1997—and I'd ask my colleague to correct me if I don't have the right dates—was a retrospective analysis of the drug use of our beneficiaries to identify potential problems, potential trends or potential problems. That was basically analyzing the data we've collected through our reimbursement of prescriptions.

In 1999 we stopped doing that when we were advised by our legal services that we could be, or might be, breaching the privacy rights of our beneficiaries because we had not sought their explicit consent for using that information in this way.

Mr. James Lunney: Thank you. So that's it. It was basically over privacy concerns.

Mrs. Hélène Gosselin: Yes, it was.

Mr. James Lunney: There are huge concerns about accountability. I'm concerned that we've seen such huge increases in these drug programs, $430 million now. It's a lot of taxpayers' money. It's a 25% increase in just two years, and when there's no observation and no data collection and no accountability, it certainly leads to excesses and abuses. So we certainly thank the Auditor General for shedding some light in this area, on what can only be described as an area of confusion between the departments here in the management of these drugs.

I wanted to ask the Auditor General this. Going back to Health Canada, I see that in 2004 the Canadian Association of Journalists awarded Health Canada the Code of Silence Award as the most secretive government department in Canada, and it seems the only person able to get any information out of there has been the Auditor General.

We've had whistle-blowers like Shiv Chopra, who was recently fired. We hope to get him before this committee to find out why he was dumped, along with others, during the election period when Parliament was not in session and members were not here. We might add to that list others like Michelle Brille-Edwards, who was the head of the Health Protection Branch and made allegations of external influence over the drug approval process in Health Canada.

The CMA has just criticized Health Canada over Vioxx. They say they knew for four years the dangers and the risks in this drug and yet they failed miserably in sounding the alarms. It sounds like confusion.

Given the secrecy there seems to be in the department...I think, Madam Fraser, you used the term that the data that was put forward is data rich, but information poor, if I quote you correctly on that.

I am wondering, since the second motion the committee is being asked to consider here is that Health Canada provide full and transparent details of its activities as they pertain to the delivery of health care services, the costs associated with their delivery, in terms of the reporting, do you have some suggestion to us as to how reporting mechanisms can be enhanced?

● (1655)

Ms. Sheila Fraser: We have, in response actually to recommendations by the public accounts committee, reviewed departmental performance reports over a number of years. I must admit, I don't remember if we have looked at the one specifically for Health Canada. I can certainly go back and repass reports and see if we have made specific recommendations. But in many of those audits that we have done of departmental performance reports, we have found that—as we mention in this one—objectives are not sufficiently clear and the performance information is not all there, that there needs to be better information given. But I will certainly go back and look to see if we have done any specific work on the departmental performance report for Health Canada. I'd be pleased to provide that to the committee.

Mr. James Lunney: Thank you very much. That would certainly be helpful.

I am quite astounded when I look at your report, Madam Fraser, and the details. We've talked a little bit about it, but some clients are obtaining more than 15 drugs during a 90-day period. Others are obtaining multiple narcotics from multiple doctors and multiple pharmacies. There are clients with combinations of 11 or more doctors using 11 or more pharmacies in a year. It seems to me incredulous that this kind of situation could be happening. Who's minding the store?

I'm glad to hear officials telling us that they are responding. But we have to ask, how could this happen for so long that so much money can be going out in the name of helping clients? Not only is this lack of accountability creating problems with taxpayers' money being used, but it puts the patients at a huge risk as well. Certainly, in this day, when we're learning about the adverse reactions to drugs, and the very serious complications that arise, especially with multiple drug exposures, we have to ask how Health Canada, purporting to help these people, could be exposing them to such risk.

The Chair: Mr. Lunney, you are over your five minutes. If you want an answer, please pose your question.

Mr. James Lunney: Would somebody like to try to answer that?

Hélène.

Mrs. Hélène Gosselin: Madam Chair, I'll try to answer that.

First of all, I would like to say that we do publish in our performance report detailed information on our program. The Auditor General had asked us to address some specific areas, for example, the monitoring of pharmacists' override codes, and we have done that. She's reported that we've complied with her recommendation in this report. I also point out that we publish a detailed annual report on our program. We can certainly make it available to members if it's of interest.

Finally, on the issue of patient safety, we've just started to resume the retrospective drug analysis. But I'd like to point out that we've had the online warning messages, which would alert pharmacists to problems with duplicate drugs and duplicate therapies, in place since the early 1990s. We've always taken safety very seriously. What we're doing with the retrospective drug analysis is adding another layer, if you will, of safety. By analyzing this, we're trying to catch other issues that aren't caught in the safety measures we already have in place.

Unfortunately, it took us a number of years to resolve the consent issues,but we had other types of safety measures in place during those years. We're now pleased that we've been able to resume the retrospective drug analysis because that's going to provide us with a good number of measures to enhance patients' and beneficiaries' safety.

The Chair: I don't think we're going to have time to do another round because we have, essentially, 12 questioners.

Mr. Savage, and then we'll go to Mr. Goodyear.

● (1700)

[*Translation*]

Mr. Réal Ménard: Madam Chair, I simply want some assurances that we will have time to review our colleagues' motions. Specifically, I want to speak to Bill C-206. We have 30 minutes remaining. I trust your ability to chair this committee, but I think we need to discuss the two motions that have been tabled.

[*English*]

The Chair: Mr. Ménard, I thought about 15 or 20 minutes for the motions and 5 minutes for your points around Bill C-206. As long as we're finished by ten after, I think it will work.

Do you agree?

Hon. Robert Thibault: I have a point of order, Madam Chair.

I think a lot of us are going to want to speak on these motions. I don't know that 15 minutes is going to do it.

The Chair: Perhaps the committee might have to go a little beyond the closing hour. I don't think we have to vote at 5:30 tonight.

I'm told there is another meeting in here at 5:30.

[*Translation*]

Mr. Réal Ménard: I think we should leave it at this.

[*English*]

Mr. Michael Savage: Madam Chair, I'll cede my five minutes then.

The Chair: I think Mr. Goodyear has been waiting.

Mr. Gary Goodyear (Cambridge, CPC): Thank you, Madam Chair.

I would like to go back to a question that was asked earlier that the Auditor General was denied answering.

On the $7 billion that is hidden in these foundations, do you know where that money came from?

Ms. Sheila Fraser: The money was transferred to the foundations from various departments through the parliamentary appropriations process.

Mr. Gary Goodyear: Was the Auditor General's department aware of those transfers when they happened?

Ms. Sheila Fraser: Yes.

They would have been recorded in the public accounts each year. We have actually made comments on foundations every year going back probably to 1986, 1987.

Mr. Gary Goodyear: It's my understanding that approximately $7 billion of $9-point-something billion is still sitting there. It's sitting in bank accounts earning bank rate interest. These are tax dollars. What exactly is this money doing?

Ms. Sheila Fraser: I say this under all reserve. The funds are invested. Many of the funding agreements—actually, I believe probably most of them, if not all of them—between the federal government and the foundations do have clauses about how the funds should be invested. So they are being invested and are earning interest. They're not sitting in a bank account earning no interest.

Mr. Gary Goodyear: Another concern I have is that Health Canada seems to be fairly preoccupied with patient confidentiality. First, why is Health Canada, versus, for example, Veterans Affairs, so preoccupied with patient confidentiality at the expense of patient safety? Could you comment on that?

Mrs. Hélène Gosselin: Yes. First of all, I would like to note that patient safety or beneficiary safety—because they're beneficiaries of our program—has always been a concern. As I noted in my previous answers, we've had a number of measures in place to address safety issues that did not give rise to privacy concerns. The privacy concern we had was when we wanted to use information that was in our data bank for uses other than that for which it was collected.

I believe Veterans Affairs has the same preoccupations as we do, but I can't speak for my colleague. I think Madame Verna Bruce will be testifying here before your committee in early March and you might want to raise that question. But I know when she testified before the public accounts committee she said they had similar issues and concerns as Health Canada.

Mr. Gary Goodyear: I just make a note that given the difficulty of ensuring full and complete patient confidentiality, do you find any surprise or any concern that Infoway, one of these foundations, has already received $1.2 billion and has stated that unless confidentiality and privacy can be guaranteed, they don't intend to move forward, or they won't move forward?

Does it seem to you that we're funding something that may not happen, to the tune of $1.2 billion so far?

Mrs. Hélène Gosselin: We are working with the provinces on issues such as privacy, because as we move forward with, for example, electronic health records for patients or a lot of the information technology initiatives that the various governments are interested in, we believe ensuring the privacy of sensitive health information will be key. It's an issue that is of concern to the provinces as well, so we've been working with them to try to address these issues.

As part of the work we're doing, we're going to be looking again at whether or not we need a legislative approach to this issue. We're exploring that right now.

● (1705)

Mr. Gary Goodyear: That's it. Thank you.

The Chair: Thank you, Mr. Goodyear.

On behalf of the committee, I'd very much like to thank the Auditor General for her work.

When you go to kindergarten, you learn that the policeman is your friend, but when you come to Parliament Hill, you're taught that the Auditor General is your friend. We all see it that way and very much appreciate the information you turn up for us, and we feel sorry for the people in the departments who have to hop to and do the best they can to respond positively.

I think it has happened very well, where we've heard about it today, and unfortunately, Health Canada was trying to do it with two hands tied behind their backs on the privacy issue, so they really couldn't do as much as I'm sure they would have wanted to. But it sounds like we're on the right foot now, so we will be very interested in the work plan of this group, Madame Gosselin. In a month or so, when it's ready, we'd really very much like to see it.

So I thank you very much for coming.

As you've heard, there's another meeting in this room at 5:30 p.m. The committee has some business to take care of, so I'm going to ask the witnesses and the visitors to take their leave as quietly and as quickly as possible so that we can get on to these motions that we have to deal with.

Mr. Steven Fletcher: People don't have to leave. It is public.

The Chair: Oh, yes, but a lot of them are from the health department.

Thank you very much, members of the committee. We'll now move to the next thing, which is two motions submitted by Mr. Fletcher on not exactly that part of the Auditor General's report we've heard about, but on an extension of that idea. I'm going to ask Mr. Fletcher to put his motion forward and speak to it.

Mr. Steven Fletcher: Thank you, Madam Chair. I'd like to move the motion so that we can vote on it.

This motion is not a demand, but a request that the Auditor General be allowed to audit health-related government foundations such as Canada Health Infoway, Canadian Health Services Research Branch, Genome Canada, and the Canada Foundation for Innovation.

These are foundations that the Auditor General does not have access to at this time. I think it would be in Canada's interest, in the interest of taxpayers, and in the interest of the people who receive services from these foundations that the Auditor General have access to this. Her testimony this afternoon was that she thinks this would be helpful. The Auditor General stated that she often follows committee recommendations, and I think this would be very helpful.

I have discussed this motion with the opposition parties, and both the Bloc and NDP are in favour of this motion. I assume that everyone who's interested in transparency and accountability would also be in favour of this motion. So to save the committee time, because I understand time is short, I'd like to call the question as well.

The Chair: What is the rule around that?

We can debate it before we call the question.

I think there's one mistake. In the English of motion number one, it says, “Canadian Health Services Research Branch”. I believe it's a foundation, isn't it? Shouldn't it say “Foundation”? “Branch” implies a part of the department.

● (1710)

Mr. Steven Fletcher: Okay.

The Chair: It's fine in the French. Do you see? It says, “la Fondation”.

Mr. Steven Fletcher: Okay, so there's a typo there. That's fine.

The Chair: So we're correcting that with the agreement of the mover? Thank you very much.

We'll let Mr. Ménard speak now.

[*Translation*]

Mr. Réal Ménard: We will be voting in favour of the motion, but as agreed to with the mover and the parliamentary secretary, we need to make one thing clear: if ever the Auditor General tabled a report, everything related to the operation of foundations would be the responsibility of the Public Accounts Committee. I checked with my colleague Benoît Sauvageau, who is the Public Accounts critic. He himself has tabled a private member's bill aimed at giving the Auditor General broader powers.

The mandate can be assigned to the Auditor General, but the House committee responsible for examining such matters is the Public Accounts Committee. I just want to make that clear.

[*English*]

The Chair: Yes.

Mr. Thibault.

Hon. Robert Thibault: Thank you, Madam Chair, for the opportunity to speak on the first motion from the honourable member.

As you know, the Government of Canada is committed to strengthening public sector management by ensuring regular stewardship of public funds, increased accountability for results in transparency, while at the same time respecting the independence of these not-for-profit organizations in pursuing legitimate public policy objectives.

The accountability of foundations is a long-standing concern. There have been a number of recommendations from the Auditor General and the Standing Committee on Public Accounts on the subject over the years.

The government has responded to many of the recommendations, and a variety of measures were announced in Budget 2003, which resulted in strengthening funding agreements with most foundations. Nevertheless, the Auditor General does not believe the government has gone far enough.

Transfers to foundations are accounted for in a manner that is consistent with the treatment of other transfers, such as those to provinces, which the Auditor General has accepted. Such transfers provide long-term, stable funding that is needed to attract financial resources and expertise into areas of strategic importance. Decisions relating to such transfers take place once the government has financial flexibility to fund these priorities. Such decisions and announcements have been made throughout the year and not only at year-end. The audit and evaluation framework for foundations includes independent audits of their financial statements, compliance audits, independent evaluation, and comprehensive performance reports in their annual report. The framework is similar to that of many other federal transfer payments.

I would like to spend a few moments dealing with the accountability of a couple of the foundations mentioned in the member's motion.

The Chair: Mr. Lunney.

Mr. James Lunney: While we're entertaining discussion on this matter, I think if the member wants to read a prepared statement he could just say "etc." and table it for the committee's benefit. I think the committee is prepared to vote on it if he has some discussion he'd like to enter into, but to read a prepared speech, I don't know that—

The Chair: Mr. Thibault, I'm wondering if you could, instead of reading it, give us the salient points. I know you feel obligated to do this. You've already—

Hon. Robert Thibault: Madam Chairman, I feel it's my responsibility. I have received in written form the motion. I have done some research. I don't want to speak for half an hour on it, so I've written out the form in which I want to present it, in as concise a manner as possible.

I have sat at committee, Madam Chairman—and I know you know it well, but I would remind the members—and I've seen people spend 20 minutes, 30 minutes, or an hour, doing these things. I have advised the chair that I would take less than 10 minutes, and now I've wasted 4 minutes in responding to Mr. Lunney's objections.

The Chair: People have the right to hijack the agenda by putting forward motions and taking over half an hour of the meeting, even though we should have probably had another half an hour with the Auditor General. It's a terribly important meeting. Then someone has received it and writes a speech—to make the point.

Mr. Steven Fletcher: I have a point of order, Madam Chair. The question was called. I'm not even sure that debate is necessary.

The Chair: Well, you may not be sure, but the clerk assures me that even though you have asked for the question to be called, it doesn't have to happen.

Yes, Mr. Penson.

Mr. Charlie Penson: Madam Chair, this is quite an old issue. We've been discussing it for quite some time in this Parliament, and I think the facts are fairly well known with respect to Mr. Thibault wanting to go on with his statement. I think the committee is fairly well informed about this particular topic. And I think further, Madam Chair, that this is a delaying tactic that you as chair should not condone. If he would like to summarize his points, I think he should be allowed to do so, but I don't think he should hijack the agenda. We should call for a vote as soon as he can deal with this matter in a very condensed fashion.

● (1715)

The Chair: I've heard two speakers, one speaker twice—that's a third—and a fourth speaker from the opposition side. I so far only have one speaker on this side, and he would like to make his point. I'm going to ask him to make it as quickly as he can.

Hon. Robert Thibault: I'll do that, Madam Chair, and I'll remind you and the committee, through you, that I would have been finished had it not been for the points of order raised.

Madam Chairman, I would like to spend a few moments dealing with the accountability of a couple of the foundations mentioned in the member's motion: the Canada Health Infoway and the Canadian Health Services Research Foundation.

Infoway is an independent, not-for-profit corporation, which is accountable to its members: the federal government's, the provincial governments', and the territories' deputy ministers of health.

The board of directors of Infoway is composed of up to 13 directors who are appointed or elected by the members; six of these are independent, non-governmental representatives from areas of expertise, including IT, health care providers and administrators, and others as needed by the board.

Infoway's accountability is addressed through funding agreements governing the use of the funds and includes reporting requirements such as annual progress reports, corporate plans, financial audits, compliance audits, and evaluation reports. Infoway regularly provides progress reports and plans with members, and all of these may be shared with ministers. In this way the federal-provincial-territorial ministers are kept informed of Infoway's progress and issues.

In my view, Madam Chairman, this foundation already has the required mechanisms in place to address the Auditor General's concerns.

The other foundation I wish to discuss is the Canadian Health Services Research Foundation. It is an independent, not-for-profit corporation, established with endowed funds from the federal government, Health Canada, the Medical Research Council—now the Canadian Institutes of Health Research—and the Social Sciences and Humanities Research Council. This foundation is governed by up to 15 trustees, comprising an ex-officio representative from two of the funding contributors, Health Canada and the Canadian Institutes of Health Research, and others representing researchers, research organizations, and decision-makers in the health sector. The foundation's accountability is addressed through the March 2003 funding agreement for the executive training for research application programs. Provisions governing the use of funds identify key requirements for accountability and reporting, including annual reports, audited financial statements, corporate plans, compliance audits, and evaluation reports.

Again, Madam Chairperson, I think that any fair individual would conclude that this foundation has appropriate accountability mechanisms already in place.

In summary, both Infoway and the Canadian Health Services Research Foundation have accountability measures in place to meet Treasury Board guidelines and the Government of Canada's commitments regarding the foundation.

In light of the above information, Madam Chairman, I will not be supporting the motion of the honourable member, and I point out for the committee that many of the other foundations that are named have no link with health services or Health Canada, or the services we provide. In any case, I believe that any such motion—and the question of having the Auditor General look at those is valid, I agree with that—should be looked at by the government operations committee or the public accounts committee and not the health committee.

Merci.

The Chair: Thank you very much.

We've had all the speakers. Seeing no further hands, I'll call the question.

(Motion agreed to)

The Chair: On motion 2, Mr. Fletcher, may we have a brief outline of your idea?

Mr. Steven Fletcher: Thank you, Madam Chair.

I found it very disturbing when we had Michael Decter here in front of the health committee. It became very apparent that the federal government has not lived up to its fiduciary responsibility to ensure its moneys are spent in a proper manner, as the federal government is the fifth-largest provider of health care in Canada.

My motion is that the Standing Committee on Health request that the federal government, as the fifth-largest provider of health care in Canada, provide full and transparent details of its activities as they pertain to the delivery of health care services and the costs associated with their delivery.

This motion is in the best interests of Canadian taxpayers. Canadians will support this. I would be shocked if anyone would oppose this motion. I could only assume that if they do, they're not supportive of transparency or accountability and are supportive of government waste, lack of transparency, and poor services to our northern and first nations communities.

● (1720)

The Chair: Thank you, Mr. Fletcher.

Mr. Thibault.

Mr. Thibault, I do want to save five minutes for Mr. Ménard, who has a point to make about our future business.

Hon. Robert Thibault: Certainly, Madam Chair. I can do it in well below five minutes, but I think it's important I remind you that the clerk makes the rules of the committee. When a member starts a debate, the other members have the right to take the time necessary.

The Chair: Yes, but I'm saying that if you could do it in five minutes, I'd be grateful.

Hon. Robert Thibault: I will, to assist the chair. I remember a member.... To listen to an individual take a run at government and not to defend would be contrary to my personal honour.

The Chair: There are two sides to every story, so let's hear it.

Hon. Robert Thibault: When Health Canada appeared before the Standing Committee on Finance in November 2004, we provided full and transparent details of our activities pertaining to the delivery of health care to first nations living on reserve, the delivery of health promotion and disease prevention programs to first nations living on reserve, and Inuit living in Inuit communities.

Health Canada is working with other federal departments, under the leadership of the Treasury Board Secretariat, to complete a report card to identify all spending on programs targeted to, or that include, a specific aboriginal component. The President of the Treasury Board recently committed to aboriginal people to share these horizontal review results with them for increased transparency. Furthermore, as to all other federal departments, Health Canada provides the public with full budget information, including details of its activities, delivery costs, and outcomes, in such reports as the departmental performance report, reports on plans and priorities, and Canada's performance.

Madam Chairman, as the department is already doing, and has always done, exactly what the motion puts forward, I would not have any reason not to support it.

The Chair: Thank you.

Seeing no further speakers, I'll call the question on motion 2 by Mr. Fletcher.

(Motion agreed to)

The Chair: Thank you very much.

Mr. Ménard had spoken to me. He's concerned with Bill C-206, about labelling bottles that have alcoholic content. He has seen the plan laid out as to how many meetings and he's worried we will not have time or room for some people he wants.

If you give us the names and we can fit them in, will that be okay, Mr. Ménard?

[*Translation*]

Mr. Réal Ménard: I'm just wondering if we had scheduled two or four meetings. I'm not so sure we need to hear from the Auditor General again. Perhaps it would be more useful to hold a meeting on Internet pharmacies or on Bill C-206. I don't know how my colleagues feel about that.

As far as Quebec is concerned, it's important that we hear from two witnesses. I'm not suggesting, however, that we won't support the bill. We do support this initiative.

[*English*]

The Chair: Mr. Ménard, at the previous meeting I tried to sell this very idea to the committee. They didn't buy it, because the second meeting with the Auditor General is about a whole different set of issues, with different officials to explain what they're doing. Whenever she reports on the health department, we're supposed to hear her. Today we heard about one set of things and the next meeting is for another set of things.

Anyway, I don't think I can change that now. Those people have been getting their presentations ready. I'm thinking that if you give these witnesses' names to the clerk, we'll try to fit them into one of the meetings we're already having.

Now I do want to suggest something to the members. You may be lobbied by certain people who are coming on this bill but who don't want to come on the day allocated; they want to come a month later. In some cases it's a logical request they're making because they have an international conference, but I don't think you want to be doing this bill halfway through April. We're hoping to have it finished by March 21, but some of these people want to come a lot later. Don't forget, we only sit for three weeks in March.

● (1725)

[*Translation*]

Mr. Réal Ménard: Madam Chair, if we require only two meetings to dispense with this matter, then we won't have a problem. However, if we realize we need more time, we mustn't be constrained by a timetable. It's not just a question of my engaging in any kind of lobbying.

[*English*]

The Chair: Absolutely.

Mr. Réal Ménard: You love me, huh?

The Chair: Yes.

I just want you to resist the blandishments of some of these groups you already know are coming. For example, one group does not want to sit in with other, similar groups. They want everybody else to leave the table so they can sit at the table by themselves. We've had all these silly requests from people, instead of them just falling into the normal pattern here.

Mr. Fletcher.

Mr. Steven Fletcher: Thank you, Madam Chair.

I'd just like to say I agree with the chair about the Auditor General's report, but I also agree with my colleague from Quebec. There are concerns from Quebec, and there are concerns for everyone. I would certainly welcome an opportunity to discuss these issues. I know my colleague is a reasonable man; he wouldn't be making this request if it wasn't important.

The Chair: Yes, I agree with you both.

I would point out to you that we have not filled that Wednesday afternoon meeting on March 23, which is always a possibility for us. My feeling is that we should hear witnesses on the days suggested. If we feel we haven't heard enough, we could hear witnesses on March 21 and move to clause-by-clause on the 23rd, if that's okay.

I'd prefer not to do that. I don't think you need an extra meeting that week, but if we can't move through all the witnesses carefully....

I'm very grateful to Mr. Ménard for pointing out that we did not have representation from Quebec on this bill. I think it's very important that we hear it, so the clerk will do everything she can once you give her the names.

Mr. Thibault.

Hon. Robert Thibault: Madam Chair, I just want to point out that I essentially agree with what both these members have said. And while I appreciate that it's good to have representation from Quebec, I think we should all have our opportunity to see who wants to make presentations and see how they are.

Now, I—

The Chair: No, no, that's—

Hon. Robert Thibault: I would like to finish, Madam Chair.

I remember that last time when we discussed this you suggested there were very few votes in the House in opposition to this bill. I've had a lot of discussions with a lot of members from all parties who, while they're generally supportive, have reservations and have questions. A lot of people want to make presentations. I'm just suggesting that maybe we not rush this.

As far as the Auditor General's second presentation is concerned, I've heard that second presentation. As I told this committee a while back, it is the same one that was done at the public accounts committee with the same things. So the committee might....

No. Well, we don't have agreement. There's no choice.

But I don't think it's necessarily an issue you can rush, because there's more interest and there are more diverse views out there than one would think from the result of the first—

The Chair: Believe me, I'm totally aware of it from the number of people who phone my office. Every distiller and every brewer in Canada is worried that they're going to have to do something they don't want to do, and they're lobbying me as the chair and lobbying each and every member of Parliament. That's why I'm saying you can decide to hold these hearings from now till next September if you want, because we would have enough witnesses who'd want to come.

Mr. Steven Fletcher: As a point of information, Madam Chair—

The Chair: Just a minute. I think it's Mr. Savage's turn.

Mr. Michael Savage: The people who are going to be most dramatically affected by this legislation are the brewers and the vintners, and the people in the industry are going to have to react to it. I don't think one hour—if I'm reading this correctly—split between two industry groups is enough time for us to seriously hear their point of view as compared to how much time proponents of the bill will have. I'd like us to have at least a full meeting with people who have information on how this bill affects their industry.

Mr. Steven Fletcher: I just want to inform you, Madam Chair, that all the members of Parliament have conspired to send their calls to you on this issue.

● (1730)

The Chair: Apparently not, because I keep getting stopped in the halls and being lobbied by members of Parliament whose local brewery has told them they want to come and speak to us.

The clerk and I and the researchers had worked.... We had the Canadian Vintners Association, which represents all winemakers, the Association of Canadian Distillers, the Brewers Association of Canada, and the microbrewers, so we were going to hear from every single business's professional organization at the national level. But what I'm finding out from this is that the individual members of those national associations don't seem to have faith in their national association. They all want to come and speak for their own little brewery.

Mr. Michael Savage: I don't have a problem with how many you choose to bring in; I just think it's worth at least two hours. These are the people who will be affected by this bill. A lot of people in the House of Commons were voting, when it came to the House the other day, on whether they're for or against fetal alcohol syndrome and drunk driving, but that's not what this bill is about.

Hon. Robert Thibault: Or they were sending it to committee for full study.

Mr. Michael Savage: They're sending it here and we should give it full study.

The Chair: So will we put another meeting in on March 23 so we can have a full meeting with all the people who purvey liquids with mood-changing possibilities?

Mr. James Lunney: Oh, let's not go there.

A voice: There's crystal meth and....

Some hon. members: Oh, oh!

The Chair: Are there any other comments? Is everybody agreed that we put the extra meeting in? I'm going to ask Mr. Merrifield, perhaps, to chair it, and all the proponents of this extra meeting will make sure to be in attendance, I'm sure.

This meeting is adjourned.

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