House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 046 • 1st SESSION • 39th PARLIAMENT

EVIDENCE

Wednesday, March 28, 2007

Chair

Mr. Rob Merrifield

Standing Committee on Health

Wednesday, March 28, 2007

● (1535)

[*English*]

The Chair (Mr. Rob Merrifield (Yellowhead, CPC)): I will call the meeting to order.

We want to thank the witnesses for coming.

We have two subjects this afternoon. The first one is on the Patented Medicines Prices Review Board, and we thank Mr. Benoit for being here. And Barbara Ouellet, thank you for coming here.

Then in the second half we're going to be talking about the Canadian Institutes of Health Research. We have, no stranger to the committee, Dr. Bernstein. It's good to have you here.

We will start. Mr. Benoit, I believe, has to catch a flight, or be gone by 4:30. Is that true?

Dr. Brien Benoit (Chairperson, Patented Medicine Prices Review Board): I have to go to my day job, which is at the Civic Hospital.

The Chair: Do you have limited time, or are you okay?

Dr. Brien Benoit: We're okay for an hour. I have to be there at 5:30 or 6 o'clock.

The Chair: Okay.

We will start with your presentation and then open it up to questions. Then we'll go to Dr. Bernstein's presentation and open it for questions, if that's okay with the committee.

We will proceed right away, then, with your presentation. We look forward to what you have to tell us with regard to the estimates for the Patented Medicine Prices Review Board.

Dr. Brien Benoit: Thank you, Mr. Merrifield.

Bonjour. Good afternoon.

I'm pleased to have my first opportunity to appear before you as the chairperson of the PMPRB. I was appointed as chair last summer, but I've been a member of the board for almost two years now. Today we're going to discuss main estimates and undoubtedly a number of other issues of interest to committee members relating to the pharmaceutical pricing and pharmaceutical environment in Canada.

It's been almost two years since we appeared before this committee. Two years ago the then-acting chair, Réal Sureau, appeared before you in a similar capacity.

With me today is Barbara Ouellet, the executive director of the PMPRB. Following my opening remarks, we would be pleased to answer any questions you might have.

At the outset, please permit me to provide a bit of context concerning the role and mandate of the PMPRB. It is not the most widely known organization within the Government of Canada, but we believe we do significant work.

We were established by Parliament in 1987 under the Patent Act, and the PMPRB is currently part of the Health portfolio. However, as a quasi-judicial, independent body, we carry out our mandate at arms' length from the Minister of Health.

The PMPRB has a dual role, which includes both regulatory and reporting responsibilities. In terms of the first of these, the PMPRB reviews the prices of more than 1,000 existing patent medicines already under our jurisdiction, to ensure that the prices are not excessive.

At present, the PMPRB also is completing its review of 100 new medicines that came under the board's jurisdiction during the last year, 2006. As part of the PMPRB's regulatory responsibilities, the staff carries out investigations in cases where non-compliance has been identified. When we refer to non-compliance, we're referring to guidelines that we have developed, and I'll say a few words about those a little later.

Over the past 18 months, the PMPRB has issued eight notices of hearing into prices of patent medicines that appear to be excessive. The board staff is currently involved in some additional 33 ongoing investigations.

[*Translation*]

The second part of our mandate is our reporting role. The Board reports annually to Parliament, through the Minister of Health, on its activities and on pharmaceutical trends relating to all medicines. We also report on the R&D spending by pharmaceutical patentees.

Our report for 2006 will be submitted to the Minister of Health on May 31 next. Under section 90 of the Patent Act, the minister also has the authority to direct the Patented Medicine Prices Review Board, the PMPRB, to inquire into any other matter. Under this provision, the minister has twice directed the Board to carry out additional initiatives.

In 2001, federal, provincial and territorial Ministers of Health announced the launch of the National Prescription Drug Utilization Information System. Working in partnership with the Canadian Institute for Health Information, known under the acronym CIHI, the Board was charged with conducting an analysis of price, utilization and cost trends for prescription drugs.

[*English*]

Some examples of our current activities in the area of the national prescription drug utilization information system—our acronym is NPDUIS—include an analytical report on pharmaceutical trends; a study to forecast pharmaceutical costs; the development of a methodology and reporting guidelines to assist the pharmaceutical industry in meeting requirements of federal, provincial, and territorial drug plans for more transparent budget impact analyses; and the monitoring of new drugs in the pipeline that are expected to potentially have an important impact on drug therapy and underlying drug plan budgets.

On November 2, 2005, this role was expanded further when the federal Minister of Health, on behalf of the FPT ministers of health, directed the PMPRB to report on prices of non-patented prescription drugs, usually referred to as mostly generics.

This new responsibility in support of the national pharmaceutical strategy has resulted in two reports issued by the PMPRB to date. The first one is “Canadian and Foreign Price Trends”, and the second is “Trends in Canadian Sales and Market Structure”. In April this year, the third study on the market of new off-patent drugs will be released. This report tracks market development for drugs immediately following their patent expiry. Basically, we want to know if they're going to be picked up by generic manufacturers or not or simply abandoned. The fourth report of the quarterly series will focus on non-patented single-source drug prices.

I would like to focus for a moment on a couple of matters reflected in the main estimates that demonstrate the evolving nature of the environment in which the PMPRB finds itself now and how this is affecting our work. Figures for 2007-08 along with those of the previous fiscal year 2006-07 show that the total PMPRB budget has increased from $6.5 million to $11.5 million, which is almost double. It's an eye opener, and there are reasons for this. It would not be unreasonable to ask why such substantial change has occurred.

There are several factors that have contributed to this budgetary increase. These additional funds were allocated to the PMPRB to enable the board to conduct an increased number of public hearings to determine whether certain patented medicines were or are being sold in Canada at prices that may be excessive. In addition, these funds were needed to enable the board to undertake a comprehensive review and public consultation on our excessive-price guidelines.

These guidelines were last revised in 1994—so some 15 years ago. Although not binding on the board and on the patentees, the guidelines provide clear, predictable, and transparent information on how the prices of patented medicines will be reviewed and have historically greatly facilitated voluntary compliance in setting prices that are not excessive.

● (1540)

[*Translation*]

With respect to the matter of public hearings, I have personally taken decisions to issue eight Notices of hearing in the last 18 months. By way of comparison, this number is equal to the total number of notices of hearing issued by the Board going back to its inception in 1997 through to 2005. Moreover, of these eight notices of hearing issued between 1987 and 2005, only one full hearing was held, five were resolved through voluntary compliance undertakings, while two others are pending.

This relatively recent increase in the number of notices of hearing may not necessarily represent a longer term trend, but is a departure from the previous history of the Board. It is the reality currently being faced by the PMPRB as it seeks to ensure that patentees' prices for all patented medicines sold in Canada are not excessive.

[*English*]

One could speculate on the reasons for an increase in the number of hearings—for example, the shift in the drug pipeline away from blockbuster new chemicals to more incremental innovations. In part because of notices from third parties about price increases after a period of considerable price stability and our own experience with the shift toward more hearings, the board is currently undertaking a comprehensive review of its excessive-price guidelines. I'd like to remind you that in past years these guidelines were very effective in ensuring compliance; there were very few hearings. The pharmaceutical manufacturers seemed to follow them.

This review has involved a process through which we are seeking to address complex and wide-ranging issues. It is not a process that can be accomplished quickly or by cutting corners. Analysis has required a phased-in approach that reflects the broad scope of the review itself.

The primary purpose of the review of the guidelines is to ensure that the PMP's excessive-price guidelines appropriately reflect the board's interpretation of the price determination factors set out in the Patent Act and that the board's price review process remains relevant and responsive to the current pharmaceutical environment.

At the same time, we must make every effort to make certain that this review is carried out in a transparent and effective manner that encompasses opportunities for input from all interested stakeholders. This is a significant, important, and timely review. It addresses issues that go to the heart of price determination.

Here are two examples, to name a few. The first is the categorization of new drugs. We determine price tests, depending on which drug category a particular medication fits into. Some stakeholders feel they no longer adequately recognize the current type of innovation in the pharmaceutical environment. Then the price tests are used to determine if the price of a patent medicine is excessive or not. Concerns have been expressed that these tests, at one extreme, may not result in an appropriate price premium for the value of the drug in question, and at the other extreme are a major cost driver of public drug plans.

● (1545)

[*Translation*]

From our core regulatory and reporting functions, to our expert analytical support for F/P/T Ministers of Health, to major undertakings such as the review of the excessive price guidelines, the Board is engaged in a broad range of activities that ultimately touch the lives of all Canadians. We are committed to carrying out these responsibilities in a manner that is transparent, effective and accountable.

[*English*]

On behalf of the PMPRB, those were my opening comments. I would be pleased to answer any questions—and if I don't have the answer, she does, we hope.

The Chair: That's the principle of leadership—make sure you have enough people around you, so you can blame somebody. That's good.

We certainly want to thank you for your presentation and for coming.

We now open it up for questioning. It's one of the first times we've had an opportunity to question somebody on a topic other than childhood obesity for some time, so this is going to be a fresh new subject. We'll open it up with Ms. Brown.

Ms. Bonnie Brown (Oakville, Lib.): Thank you, Mr. Chairman.

Welcome to representatives of the PMPRB.

From your description of your activity level and the budgetary reflection of that, may I say that I welcome what I sense to be a more aggressive and activity-oriented stance from the last few times we've had your organization in front of us.

I'm wondering about the source of these eight notices of hearings and 33 ongoing investigations. Are you getting complaints from the public, from pharmacists, from doctors, or from provinces that run drug plans, or is it simply the time in the history of the board when it is looking inward and reflecting on whether it's being aggressive enough?

Dr. Brien Benoit: We get very few complaints from the public. We get some complaints from provincial drug plans, but mostly the reason we're having these hearings and more investigations is that there's a tendency toward non-compliance with our guidelines. We believe the reason is there are fewer blockbuster drugs. A blockbuster drug would be one of a kind that would cure a particular disease and it would command a premium and the drug company would be very happy to get that. Rather, what we're seeing now—to use the colloquial expression—is tweaking of already existing medications. They change the number of times a day that you take it—instead of the same chemical three times a day, they wrap it up in a coating and you take it once a day, and the drug companies want quite a high premium for that.

Ms. Bonnie Brown: Do these voluntary compliance undertakings through which you resolved five of these situations really boil down to your suggesting to the manufacturer that their price is a little high and you would suggest a lower one, and then they agree to it, or is it a process of negotiation and then an agreed-upon conclusion?

Dr. Brien Benoit: There's a process of negotiation. As the chair—and it's the same for the other board members—we are not party to any of the negotiations because we may at some time have to sit on an adjudicative panel, but our staff does do a lot of negotiation.

The staff will point out that the price is excessive; the company will respond that they didn't count this or that, and then there's a lot of middle road. If the company agrees to the staff's position, then this voluntary compliance undertaking goes on, and usually a VCU will result in some payback of excessive revenues.

Ms. Bonnie Brown: Oh, that's excellent. Okay.

Towards the end of your presentation you talked about your role as interpreting the price determination factors set out in the Patent Act. Those go back quite a way, as you have told us. Do you think those price determination factors are all right the way they are, or do you think you might be moving towards suggesting amendments to them?

Dr. Brien Benoit: Madam, that is a very obvious good question.

Changing a statute in Parliament would require I don't know how much pulling of teeth. When we sit on these panels, we feel the wording of the Patent Act is too vague; it's not sufficiently prescriptive. However, changing the Patent Act would be very difficult, and the elements in there are what we're now discussing in these guidelines we have—the interpretation.

● (1550)

Ms. Bonnie Brown: This group you're meeting with today is pretty good at pulling teeth, so should you come up with some suggestions for reforming that act and reforming those guidelines, you might wish to come back here. Maybe we could help you.

I'd like to move on to that portion of your mandate that reviews the amount of R and D done essentially in exchange for the patent. What is the ratio of R and D to sales for 2006, if you have it? If not, could you give me 2005?

Dr. Brien Benoit: We could give you 2005; it's 8.8%.

Ms. Bonnie Brown: How did that compare with the year before?

Dr. Brien Benoit: The year before was roughly the same...8.3%, 8.8%. As we go further into the past, it was 9%, 10%, and there were even some 11% years here. In the past four or five years there has been a trend towards less R and D expenditure as a percentage of total gross sales.

Ms. Bonnie Brown: Is there any way you have the authority to compel the pharmaceutical industry to achieve the 10% target mentioned in the act?

Dr. Brien Benoit: No; we have no such authority.

Ms. Bonnie Brown: If you can't do it yourselves, do you think the idea is to inform the minister, and the minister is to do it? What are your options? I can understand the government's not giving a free-standing semi-judicial body, an adjudicative body, that kind of sanctioning authority, but they must have talked about a way to get at this if in fact the patentees failed to live up to their agreed-upon responsibility.

Dr. Brien Benoit: As I understand it, the agreed-upon responsibility was to put 10% of their gross total sales into R and D in Canada—

Ms. Bonnie Brown: Yes.

Dr. Brien Benoit: —and they started out close to that. Then they came up to it and exceeded it, and now they're tending to drift back down.

Ms. Bonnie Brown: Yes.

Dr. Brien Benoit: There may be many complex factors relating to that, and as you just heard earlier, there are fewer breakthrough drugs. Is that a reflection of less research, or what? I'm not really sure.

Ms. Bonnie Brown: Do you ever try to investigate it? Surely they talk to you about why they are not meeting their targets. It has never happened that every company has hit the same numbers—say, 9%—in a year.

Dr. Brien Benoit: Some companies do.

Ms. Bonnie Brown: Some companies do well and some companies don't. Do you ask them what percentage of their profits they're investing in research?

Dr. Brien Benoit: They are obliged to report to us. I can't tell you the technical details of that, but some companies do better than others.

If you asked a large drug manufacturer why they aren't investing more in research and development in Canada they may not tell you, or they may tell you it's because they find the regulatory environment on prices too oppressive. In other words, if you got rid of the PMPRB they would charge what they want and invest relatively more here.

Ms. Bonnie Brown: Thank you.

Do you have any other suggestions for us as we receive information from the PMPRB? I'm quite excited by the fact that you seem to be doing more and doing it more aggressively. Do you have any other ideas for improving this regimen that was set up that many years ago?

Dr. Brien Benoit: We were asked in 2005, after the national pharmaceutical strategy initiative got started, to start reporting on non-patented medicines—generics. We are wondering whether we will be given greater responsibility in that area. In terms of the patented medicines themselves, we feel we have sufficient tools to do the work.

Ms. Bonnie Brown: Have you started to investigate generic prices?

Dr. Brien Benoit: We report on them.

Ms. Bonnie Brown: You already report.

Dr. Brien Benoit: That's part of this NPPDP initiative. We're asked to report and we put out quarterly reports. Some of the findings in these reports are fairly interesting. You may be surprised.

● (1555)

Ms. Bonnie Brown: So that's in your annual report.

Dr. Brien Benoit: Yes. We publish this separately, but it's in our annual report.

Ms. Bonnie Brown: I have one other question before we close on this whole rule about the comparator countries and the fact that we are not supposed to exceed the median price. I understand that in the last year or so we have gone one percent above the median price.

Dr. Brien Benoit: Actually we haven't. The median international price is sort of our benchmark, and we have a hard and fast rule that the Canadian price cannot be the highest in the world. We are actually 92% of the median international price. So we're basically 8% below the seven countries to which we're compared.

Some ask why we aren't compared to Japan, Australia, and New Zealand. In any event, the Patent Act set up seven countries and we're bound by that.

Ms. Bonnie Brown: What would happen to that calculation if you eliminated the United States as one of the comparator countries?

Dr. Brien Benoit: I couldn't tell you offhand what would happen. The United States is almost always the highest, and Italy is the lowest. The others are in there. Presumably the international median would go down if you excluded the United States.

Ms. Bonnie Brown: Thank you very much.

Thank you, Mr. Chair.

The Chair: Thank you.

For the committee, your annual report comes out in June.

Dr. Brien Benoit: We're going to submit it to the Minister of Health in May. We're sort of one year behind for 2006.

The Chair: Fair enough.

Monsieur Luc Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Mr. Chair.

I will pursue the same line of questioning, on the sales price of drugs. Could you tell me how the countries that are part of the comparison group have been selected?

Dr. Brien Benoit: Mr. Malo, this comes out of the Patent Act. The seven countries have been determined 20 years ago, in 1987. These seven countries are Great Britain, France, Italy, Switzerland, the United States... They are the Western European countries.

Mr. Luc Malo: Is it still relevant to use these same countries 20 years later?

Dr. Brien Benoit: These countries have been selected because their health system is similar to ours. I believe that its on this basis that they have been selected in 1987.

Mr. Luc Malo: Would it not be interesting to review this matter? For example, do these countries have a medicine prices regulation system?

Dr. Brien Benoit: All countries, except the United States, have price regulation systems, which are different from one country to the other. We are precisely studying these various systems right now in order to check whether there are components that could be applied here in Canada. The United States do not have any regulation, except for payees such as Medicare and Medicaid. These two organizations negotiate prices that may be somewhat lower than what the average consumer might pay at the drugstore.

Mr. Luc Malo: But what about you? Is it not part of your role to make sure that this group of countries can still be used as a benchmark to compare with the sales prices here in Canada?

Dr. Brien Benoit: We are acting pursuant to the Patent Act and these countries have been selected for us. So this cannot be changed. If you ever decide to amend the Patent Act, you may then be able to change the list of countries.

Mr. Luc Malo: Earlier, in your answers to my colleague, you said that it was written in the act that pharmaceuticals must report to you as to the percentage of research and development they are doing.

Does it happen that some companies do not comply with this provision of the act and do not provide you with any figures?

Dr. Brien Benoit: I must say that the answer is no because we have the necessary tools to require them to provide us all the information that we need. Some of them may sometimes be late and we must encourage them somewhat, but I believe that they all comply with the act.

Mr. Luc Malo: Is the definition of research and development activities very restrictive, or is it rather wide ranging?

Dr. Brien Benoit: No, it is rather well defined. Promotion, for example free medicines given to doctors, is not included in research and development. So it is rather well defined.

Mr. Luc Malo: Is it limited to fundamental research?

Dr. Brien Benoit: No, it covers clinical research as well.

Mr. Luc Malo: Earlier, you told us in your introductory remarks that the number of public hearing requests has increased rather rapidly in the last year. Do you know why?

Dr. Brien Benoit: We suppose that it is because pharmaceutical companies do not have what we call blockbuster medicines that they can sell at high prices and so they are simply bringing minute changes to their existing medicines. They want to give some return to their shareholders. So they are sort of sending trial balloons, so to speak. There certainly was a climate change in the pharmaceutical industry. This may be encouraged by parent companies in the United States, but we do not know for sure.

Mr. Luc Malo: Why, in your introductory remarks, did you see fit to indicate that this movement might not be repeated in future years, that it might have been limited to a specific period?

● (1600)

Dr. Brien Benoit: Because we are presently considering changes to our guidelines. I am not saying that we will do this, but if we decide to change our guidelines to allow a price premium, a slightly higher price for relatively minor innovations, this might perhaps calm things down. But we do not know yet, we are not there yet. We are holding public hearings. We have had five of them until now on the changes to our guidelines.

Mr. Luc Malo: On this very point, are you able to tell us about a number of preliminary recommendations that might come out of these meetings?

Dr. Brien Benoit: Mr. Malo, I am not able to do that. This is a very complex situation and we are presently hearing not only from the pharmaceutical industry, but also from provincial governments, from the federal government and from people who utilize the drugs, patient groups, and so on.

Mr. Luc Malo: Do you have a specific timetable?

[*English*]

The Chair: Thank you, Mr. Malo. Your time has gone.

Go ahead.

[*Translation*]

Dr. Brien Benoit: Let us say two years.

[*English*]

The Chair: Thank you.

Mr. Fletcher.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Mr. Chair.

My questions are in three areas. I'm wondering how regulatory changes have affected the PMPRB. On June 17, 2006, the government introduced some regulations dealing with data protection, increasing the time for data protection but also reducing the ability to evergreen. I wonder if that has affected your operation in any way.

I will expand on Ms. Brown's comments on the 10%. It is irritating that the 10% commitment is not being followed. I'd like you to discuss that a little more, expand on it, and share with us how we can better deal with that challenge.

Finally, why are generic drugs generally more expensive in Canada than patented drugs? Perhaps you could share some of the surprising results you alluded to. If generic drugs are more expensive, do the big pharmaceutical companies extend the sale of their drugs beyond the patent expiry date? They might as well.

Dr. Brien Benoit: If I can remember that multifaceted question, first of all, the regulation changes in June of last year do not affect us, really—not at all. It was an interesting thing, and there were pros and cons expressed by the industry and the stakeholders and so on.

With regard to the question about the R and D, the reason they're not investing more in Canada is very complex, and we don't have the answer for it. It may be the subject of some inquiry by an organization other than ours. We have no regulatory power with regard to research and development. We simply report, and we're reporting basically what the pharmaceutical industry tells us.

Finally, regarding the generics, when we started reporting on generics, we were surprised to see that Canada is actually higher than, let's say, the United States. So the prices of generic pharmaceuticals in Canada are quite a bit higher than those in the United States. With regard to patented medicine, as you've heard, we are below the international median, so we're doing well on patented medicines. On generics, however, we're not doing so well. When you dig down into the subject, you'll realize that in Canada there's very little competition in the generic pharmaceutical industry. Basically, 90% of sales are by two manufacturers, and I believe one of those does actually quite a bit more than the other, so there's no competition.

● (1605)

Mr. Steven Fletcher: Were there other surprising results that came out of your studies?

Dr. Brien Benoit: Those are the main highlights. We are now, as is mentioned in our fourth report, which will soon come out, going to study what happens when the patent expires. Some medications are big sellers, and you would expect that when the patent expires, the generics would enter the market and run with it, but that's not always what happens. The reason for that isn't totally clear. It has something to do with profits.

Mr. Steven Fletcher: Are you able to provide any suggestions on how to deal with the generic pricing?

Dr. Brien Benoit: Our mandate now is to report, and that's what we're doing. If you want to give us more work, we're going to need more money.

Some hon. members: Oh, oh.

The Chair: Okay, your time is gone. Just for clarification for the committee, you said that in your report, you compared it to the United States. Do you do the median as well? Do you compare it to other countries for the generics?

Dr. Brien Benoit: Yes, we do for the generics.

The Chair: Thank you.

Mr. Batters, you have five minutes.

Mr. Dave Batters (Palliser, CPC): Thank you very much, Mr. Chair.

Mr. Chair, because I have only five minutes, I'm just going to go as quickly as I can, so if you could give me just short, succinct answers, that would be great.

Thank you both very much for appearing.

The first question is, please list for me all the brand-named drugs that PMPRB is currently examining or the drugs that you are currently examining as potentially being excessively expensive. Exactly what drugs are we talking about? If you could read them into the record as quickly as possible, that would be great.

Dr. Brien Benoit: Do you want the name of the manufacturer also?

Mr. Dave Batters: No, just the drugs is fine.

Dr. Brien Benoit: The first one is Adderall XR, which is a drug for attention deficit hyper—

Mr. Dave Batters: I don't need to know what they're for. I only have five minutes.

Dr. Brien Benoit: The others are Airomir, Concerta, Copaxone, Penlac, Quadracel and Pentacel, which are vaccines, Risperdal, Risperdal Consta, and Strattera. Then there are NicoDerm and Dovobet, which are ongoing from the past.

Mr. Dave Batters: Excellent. Thank you, Dr. Benoit.

You've received a 46% increase in funding in the 2006-07 fiscal year, and you're asking for a further 76% increase in your funding this year. I know that the provinces are involved in regulating prices within their own provincial formularies, and isn't there significant overlap between what you do and the price determinations that are made by the provinces?

Dr. Brien Benoit: What we regulate are the ex factory prices, so somebody may say, well, I pay a lot more than that in the drugstore. What happens after it leaves the factory and goes through all kinds of middlemen until finally it gets to the person who puts it in their mouth is that there are added amounts that go in there that we have absolutely no control over. The provincial drug plans, the big ones like Ontario's, for example, that have a lot of clout, will negotiate prices, which some of the smaller drug plans have difficulty negotiating. This is causing some angst out there. For example, Atlantic Canada has higher drug prices.

Mr. Dave Batters: Okay, so there are some separate functions. There is some duplication, but there are some separate functions as well. Is that fair to say?

Dr. Brien Benoit: That's right.

Mr. Dave Batters: Perfect. What percentage of sales revenue do generic companies devote to research and development?

Dr. Brien Benoit: I don't know the answer to that.

Mr. Dave Batters: Would it be fair to say none, or virtually none? For generic companies versus R and D companies, companies that do excessive research and development—and I can name a litany of them—versus say, Apotex, is it fair to say that they spend much less of a percentage of their revenue on research and development?

Dr. Brien Benoit: I don't know the answer, and that may be a politically wrong thing to give a wrong answer to. If we could, we'll look that up for you, Mr. Batters.

● (1610)

Mr. Dave Batters: If you could get back to the committee on that, I'd really appreciate that, Dr. Benoit.

Dr. Benoit, earlier you said that pharmaceutical companies would claim, perhaps, that they invest less in this country, perhaps because of over-regulation by PMPRB. That was just a hypothetical you threw out there. If someone were to say that to you, how would you answer that question?

Dr. Brien Benoit: Well, there has to be a balance, and the balance between excessive prices and increased investment is one that some political body needs to sort out. The target of 10% was chosen. You might say that 8.8% is not far off of 10%, but it is less than 10%.

Mr. Dave Batters: Okay.

I have one final question. Is it fair to say that, at least to some extent, there are fewer new revolutionary medicines being introduced in Canada because the process and the length of time to get a DIN number in Canada is very arduous and there is a enormous backlog? Is that fair to say?

Dr. Brien Benoit: I don't know if it is fair or not, but the DINs and all of that are delivered by Health Canada, which is.... We're in their portfolio, but we have nothing to do with that.

Mr. Dave Batters: The companies are still discovering new molecules, but I hear from companies time and time again that the problem is actually getting them approved to bring to market because of the enormous backlog that exists. Do you hear the same thing?

Dr. Brien Benoit: You would have to ask a witness from Health Canada that question, because it's beyond our purview.

Mr. Dave Batters: Okay, thank you very much.

The Chair: Thank you very much.

We'll go to Ms. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thank you very much.

Could you tell me if you know offhand the percentage of drugs with expired patents that have not yet been genericized?

Dr. Brien Benoit: I don't know that, Dr. Bennett, but that's something we could also get to you. That's the subject of our ongoing and next report, because we're very curious about that.

Hon. Carolyn Bennett: Okay.

In terms of the generic companies, you're so far just reporting. But eventually, according to Romanow, if you were going to be assessing whether prices are fair.... My understanding is that most of the generic companies are private companies, and you can't actually look at their books. Can you see how much profit the generic companies are making?

Dr. Brien Benoit: No, we can't.

Hon. Carolyn Bennett: So how can you decide what's a fair price? For the brand-name companies, at least there's an annual report, and you can say, “Oh my God, look at all the money they're making.” But if the books aren't transparent, because it's a private company, how can you actually do your job?

Dr. Brien Benoit: We're not regulating the prices of generics. We're only reporting them.

Hon. Carolyn Bennett: I think the recommendation in the Romanow report was that eventually, the review part of your mandate would include generic drugs. That was the intent, eventually. At the moment, you're just reporting, but eventually you would be able to give an opinion based on international examples about whether, for this huge amount of our public dollars that are going to generic drugs, we're paying too much for them.

Dr. Brien Benoit: I'm just being prompted here by my boss that—

Hon. Carolyn Bennett: Perhaps you can let your boss answer.

Dr. Brien Benoit: —the generic companies would file with us, but the generic industry is different from the patent medicine industry.

I'm having my eyes opened every time I listen to discussions about it, because there are a lot of free goods that are delivered in the generic business. And what is the value of those goods? There are all kinds of free goods that go back to pharmacy chains, and especially the big chains that control 500 drug stores. They negotiate very hard with the generics.

Hon. Carolyn Bennett: Has a product placement enticement or whatever been thought to be there? Somehow that's all part of their marketing budget.

In order for you to be able to do a non-patent medicine review process as you do for brand names, do you feel that you need to be able to look at the books of generic companies? My personal opinion is that if we're going to spend all of these public dollars on drugs, if we're going to buy stuff from them, in terms of whether it's first nations, whether it's all of these things, shouldn't we as parliamentarians be able to see their books? I would like to know how much profit there is, in terms of being able to review whether we're spending taxpayers' money in an accountable way.

● (1615)

Dr. Brien Benoit: Dr. Parrish, we don't regulate the profits. And if we were to have any kind of a regulatory function, then for sure they would have to report to us more than they're currently reporting. We would have to have regulations that they would be obliged to report.

Hon. Carolyn Bennett: In order to do a price review?

Dr. Brien Benoit: Yes.

Hon. Carolyn Bennett: Okay.

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

We will move on to Ms. Davidson.

Dr. Brien Benoit: I'm sorry, I mixed up your name.

Hon. Carolyn Bennett: That's okay. We want to know why they don't get the Bobs and the Jims and the Mikes mixed up. It's kind of hockey sweaters, I've decided.

The Chair: She's very forgiving. You're fine.

A voice: It's kind of disparaging—

Hon. Carolyn Bennett: Disparrishing.

Some hon. members: Oh, oh!

Dr. Brien Benoit: My glasses aren't strong enough and the names are sideways.

The Chair: That's okay; there are some similarities.

Anyway, Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Mr. Chair.

Thank you very much, Dr. Benoit, for your presentation. I have certainly learned a lot about your operation here this afternoon that I wasn't aware of before.

The one thing I am quite curious about is the 76% increase that you're looking at for this fiscal year. How are you going to divide that increase? You have this planned spending, so how is that going to be divided between your two core responsibilities?

Dr. Brien Benoit: Well, we now have an average price of the cost of each hearing, and I hope you don't ask me how much it is, because it's.... Well, I'll tell you. The average price of a hearing from start to finish, and we're not finished there, is estimated to be something like $600,000. So it's a serious undertaking. That's the cost to the taxpayer, as it were, not the cost of the pharmaceutical industry.

The terms of the revision of our guidelines, if they are revised.... We had five public consultations in five different cities in November 2006, and there was a cost associated with that. I can't tell you the precise number. We hope to have at least one other public consultation, probably here in Ottawa, and we're consulting with various experts in the field, which all carries a certain cost. But most of our price increase is for the hearings.

Mrs. Patricia Davidson: Okay. So can you tell me, then, about your current human resources numbers, as opposed to what you will be having? You have this huge increase in budget amount. How about your numbers of employees?

Dr. Brien Benoit: Barbara knows the exact number.

Mrs. Patricia Davidson: Okay.

Ms. Barbara Ouellet (Executive Director, Patented Medicine Prices Review Board): As a result of the additional funding, there will be 15 additional staff, many of whom have already been hired, because this funding actually began in the fiscal year we're currently in. That would be added to the 47 we already have, so it will bring us up to 62.

Mrs. Patricia Davidson: Okay. Thank you.

So your main priorities, then, for this coming year, what are they going to be?

Dr. Brien Benoit: We hope to complete most of our hearings. We have two notices of hearings that were just issued in the past couple of weeks, and these will obviously not be completed this year, but most of the others will be completed this year. We'll have made some major advances in terms of the revision of our guidelines if we do that. By the end of this year we'll be much more focused on what, if anything, we're going to do.

Mrs. Patricia Davidson: Okay. Thank you.

The Chair: Thank you very much.

Madame Gagnon?

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): No, thank you.

[*English*]

The Chair: Madame Beaumier.

Ms. Colleen Beaumier (Brampton West, Lib.): I want to go on the record as saying that when governments and most insurance companies encourage the purchase of generic drugs, I know that if you have a government contract in private business, they have the right to go in to inspect the books, look at the profit margin, and audit what you're doing. I'm not really sure if it was a will on the part of the insurance companies or on the part of the governments purchasing these products that it could be done.

I don't understand why—and I don't think you do either—generic drugs aren't significantly cheaper than brand-name drugs. Are you anticipating having the generic drugs assigned to your organization?

● (1620)

Dr. Brien Benoit: There has been talk that they would be, but we'll accept the responsibility if it's given to us.

Ms. Colleen Beaumier: On what we're talking about here, is there a will on the part of government?

Dr. Brien Benoit: It's a question you'll have to ask the government.

Ms. Colleen Beaumier: Okay. Thank you.

The Chair: Mr. Dykstra has a couple of questions, and then we'll move on.

Mr. Rick Dykstra (St. Catharines, CPC): I only have a couple, Mr. Chair, and I'll be brief.

One of the overall questions I had was on the involvement of the PMPRB in the common drug review. How does it work, or how is it facilitated?

Dr. Brien Benoit: We're an observer on the common drug review. The common drug review is the organization that recommends drugs to provincial formularies for provincial drug plans. As a result, we sit as an observer, but we have no direct role in the determinations.

Mr. Rick Dykstra: For example, if a new chemotherapy drug were introduced or requested by a province to be on their formulary, would you actually investigate to determine whether or not you thought it would be a positive recommendation, and then you'd take it to the province, or would you act once they've asked you to take it on?

Dr. Brien Benoit: If the company begins to sell it in Canada, we will then look at the price it is being sold at to see whether it's excessive. We compare it to drugs in the same therapeutic class, and sometimes we then go to the international media. That is our role.

Mr. Rick Dykstra: I have another question with respect to prices internationally. I guess I've noticed this personally, but I've also had people talk to me about the comparison of the cost of generic drugs in Canada versus the cost of generic drugs in the United States. Are we lower or are we higher than the average?

Dr. Brien Benoit: We're higher.

Mr. Dave Batters: By what percent?

Mr. Rick Dykstra: We are higher. As my colleague is wondering, what percentage might that be?

Dr. Brien Benoit: We could get those numbers for you, but we are higher. We think the reason is that there is much more competition in the United States.

Mr. Rick Dykstra: You don't have a figure off the top of your head. Would you prefer to come back to the committee with a hard figure.?

Dr. Brien Benoit: We can certainly look it up and get it to you.

The Chair: They will get us the information.

While you're looking it up, I want to say thank you very much for coming. We found it very interesting, and I believe the questions reflected that.

We may want to have you back when the report is published. We may have some comments in regard to the report and what we do or do not see there.

Ms. Priddy, if you have a couple of quick questions, I'll allow it.

Ms. Penny Priddy (Surrey North, NDP): I only have one question.

I apologize for my absence, but I was speaking to the very important Bill C-42, on the proposed quarantine act put forward by the Ministry of Health. I knew you would want an articulate speech on that.

I gather from some earlier discussion that what you hear about drug costs usually comes from the pharmaceutical plans, such as the insurance plans or from the provincial government plans or agencies. Of course the questions I get are obviously from individual constituents.

Within the government, where is that responsibility and what is happening? If we're hearing from provincial plans that it's too expensive, I'm hearing from constituents that it's too expensive, and I can see some people here in the audience today who represent people who can't afford some of the medications they're prescribed, how is it addressed, knowing that you have two groups of people? Where does it land inside government? Who picks it up and says we should do something with this? What is it?

● (1625)

Dr. Brien Benoit: The easy answer is that we regulate the prices only as they leave the factory gate. As I said earlier, there are a lot of add-ons between the factory gate and the actual consumer. Those add-ons we have absolutely no jurisdiction over. We can have an idea of what the add-ons are, but we have absolutely no authority to change it.

So if your druggist decides he's going to charge an excess amount, then presumably he has freedom to do that. Then the provincial drug plans negotiate with the pharmaceutical companies.

The Chair: That takes us into a subject that we'll be approaching next in committee, when we come back.

I want to thank you for coming. We'll dismiss you now and put you on notice that when your report comes out, perhaps we would entertain it as an opportunity to bring you back.

Thank you very much.

Ms. Barbara Ouellet: The answer to the earlier question is that the foreign-to-Canadian price ratio for the United States is 0.65 for generics.

The Chair: So 65%?

Ms. Barbara Ouellet: The U.S. prices are 65% of Canadian prices, so about two-thirds less.

Mr. Rick Dykstra: Okay, thank you.

Ms. Barbara Ouellet: Or no, it's about one-third less.

The Chair: Right.

Dr. Brien Benoit: A significant difference.

The Chair: Yes, a significant difference.

Again, thank you very much.

We'll go now to Dr. Bernstein.

Dr. Bernstein, you're no stranger to this committee, or no stranger to health care in Canada, as CIHR chairperson and president. We want to thank you very much for being here. We look forward to your presentation with regard to the estimates. We will follow it with our series of questions.

The floor is yours.

Dr. Alan Bernstein (President, Canadian Institutes of Health Research): Thank you very much, Mr. Chair.

[*Translation*]

It is a pleasure for me to be here before the committee once again.

[*English*]

I was last here in May of 2005, when the committee recommended my nomination as CIHR president for a second five-year term.

[*Translation*]

Thank you.

[*English*]

I would like to start by acknowledging and introducing two officials, who are my colleagues, with me here today: Jim Roberge, CIHR's chief financial officer; and Dr. Pierre Chartrand, CIHR's vice-president for research. I may ask them to answer any of your tough questions that come up today.

On Monday I spoke to the Canadian Club in Toronto. I spoke there about the revolution that's taking place in health research; about the importance of research generally, and particularly health research, to Canada's future; and about the exciting new opportunities for improving health.

These changes are resulting in changing views of human health and health care in the 21st century, and it was in the context of this changing landscape that CIHR was created in June 2000 by Parliament. Since then, we have moved quickly and deliberately from our origins as a largely reactive biomedical granting council to an outcomes-driven, excellence-based strategic research organization capable of capitalizing on and leading this revolution. I think it's fair to say we are no longer a granting council.

Today we have 13 health research institutes, each led by an internationally recognized scientific director, and each advised by 13 institute advisory boards, each made up of 18 individuals from across Canada and abroad. Over the last year, many of our scientific directors have appeared before this and other parliamentary committees to assist in developing evidence-based policies to address the health challenges facing Canadians.

For example, Dr. Diane Finegood, who is no stranger to this committee, the scientific director for our Institute of Nutrition, Metabolism and Diabetes, has discussed the latest research and knowledge translation activities on obesity, including, importantly, childhood obesity—and of course I will come back to that.

Dr. Anne Martin-Matthews, the scientific director of CIHR's Institute of Aging, spoke on the implications of Canada's aging population on all kinds of things, including the health care system.

Dr. Rémi Quirion, who's the scientific director of our Institute of Neurosciences, Mental Health and Addiction, has appeared on issues such as autism, fetal alcohol syndrome, and mental health.

As you may know, CIHR has a strategic plan that was the culmination of broad national consultations with health researchers and other stakeholders. Within that plan, each of our institutes has their own strategic plan from which research agendas have been implemented on everything from obesity, to wait times, palliative care, aboriginal peoples' health, training the next generation of researchers, health in children, cancer, and environmental issues.

Beyond our development as an organization, the creation of CIHR has had a profound effect on Canadian health research, and increasingly and most importantly, on Canadians. Today, CIHR-funded researchers are working in all health-related disciplines, from the biosciences to engineering and bioinformatics, to the humanities and the social sciences.

We are leveraging CIHR funding through many important new partnerships, both within Canada and internationally—and I'll mention one shortly—which have contributed well over $500 million in the support of common national and international priorities in health research.

New programs in knowledge translation and innovation, such as CIHR's “Knowledge to Action”, “Proof of Principle”, and “Science to Business”, have been developed to fill key gaps in the pipeline from academia to the health system, to the clinic, to the marketplace, and to Canadians.

New companies and new health policies are already in place because of these new, innovative programs. School children in Saskatoon and Kahnawake are involved in intervention and research focused on diet and diabetes research. I was very pleased that you mentioned the work going on in Kahnawake in your recent report that came out two days ago.

As another example, Amorfix Life Sciences was recently nominated, and actually received, a Technology Pioneer 2007 award by the World Economic Forum in Davos, the only Canadian company selected for that award. Amorfix builds on the CIHR-funded discoveries of Dr. Neil Cashman at UBC and Dr. Marty Lehto at U of T. Amorfix's business plan is to help in early diagnosis and treatment of diseases such as Alzheimer's disease.

● (1630)

Just yesterday, the *New York Times*, as well as virtually every Canadian newspaper, ran on the front page a story on CIHR-funded research comparing the efficacy of coronary stents versus drugs for heart disease. Today, in the *Vancouver Sun*, the Minister of Health for British Columbia, George Abbott, announced that on the basis of that research, he was going to re-examine the need for doing angioplasties for coronary heart disease.

We did a back-of-the-envelope calculation this morning, and let me just walk you through some numbers.

We spent $2.7 million over six years on that trial. That was a partnership with U.S. partners, who invested $22 million in that trial. These are the calculations: Canada does roughly 80,000 angioplasties a year, and they cost roughly $10,000 per angioplasty; so conservatively, if we could prevent only one-third of those, we would save roughly $300 million a year for Canada's health care system.

I am sure the reason the Minister of Health in British Columbia is looking at that is first because of safety issues around stents, and second because of cost issues.

Today about 30% of our funds are going to strategic initiatives that directly respond to health challenges of high priority to Canadians. These initiatives are developed and led by our 13 institutes after very broad consultation with various stakeholders and our built-in multi-partnerships with other federal departments, provincial health research agencies, the provincial and territorial ministries of health, international partners, as I've just alluded to, industry, and the health charities.

These initiatives are timely. They align with government's broader agendas and priorities. They are built on Canada's scientific strengths, and they promise to drive urgently needed improvements in Canada's health care system.

For example, after consulting with many stakeholders, our Institute of Nutrition, Metabolism and Diabetes declared obesity to be its priority area. As a result, we now spend about $20 million a year to support research, in all its translations, looking at all aspects of obesity, from the social and cultural issues to the genetic, physiological, metabolic, behavioural, and psychological.

I know that this committee is also interested in pharmaceutical policy—we just had a discussion on that—an area in which we have invested almost $20 million since 2000. For example, we fund Dr. Steve Morgan at the University of British Columbia, who has developed a very innovative drug utilization atlas that is an important first step in understanding and containing rising drug prescription costs. It is an atlas, like zip codes right across the country, of drug costs from area to area. This atlas reveals differences in the pattern of drug utilization across Canada and is providing a powerful tool for ministries as they move to contain rising drug costs.

In 2006 we embarked on a significant and comprehensive evaluation by a prestigious international review panel. That panel applauded CIHR for what's been accomplished to date, noting that Canada is setting an example to the world.

I'd like to turn some attention now to our main estimates for 2007-08.

Our main estimates have increased by a net amount of $36.9 million over last year. The CIHR grant vote has increased by $35.7 million over the previous fiscal year, and the CIHR operating expenditure vote has increased by $1.2 million.

The increase is partly due to the increase of the CIHR budget by $17 million, as presented in the 2006 federal budget, $16.3 million of which is allocated to our grants and awards for 2007-08 and $0.7 million, or $700,000, of which is allocated to operating expenditures.

Other budgetary grants and award increases include $11.6 million for Fabry's disease, $2 million for the federal initiative on HIV/AIDS, an incremental increase in the Canadian graduate scholarships program of $5 million, and new funding for pandemic preparedness research and training of $3.8 million.

Furthermore, CIHR is very grateful to have received a budget increase of $37 million in the recent federal budget of 2007. Our governing council is now deliberating on how to best allocate those funds.

As I have outlined, impressive gains have been made by health research. However, there is still a very formidable list of diseases, conditions, and health system issues for which there are no cures. More research is necessary to understand their origins and progression. Nature and social change also continually provide new challenges to our health: the emergence of new diseases like AIDS and SARS; the re-emergence of tuberculosis; cancer; obesity—again highlighted by this committee; the growing dilemma of dementia in the elderly; and autism. Most importantly, or equally importantly, building an evidence-based, sustainable, and accessible health care system is obviously a high priority for Canadians.

● (1635)

I know this committee is also very concerned about the epidemic of obesity among young children, and I congratulate you on your report that was released a few days ago. To me, obesity is a perfect example of the alignment of the government's concerns and CIHR's research and knowledge translation agenda. It illustrates and demonstrates the importance of solid research evidence to drive changes in policy, in practice, and in individual behaviour. That's why I think your support of CIHR and of health research has been and, I think, will continue to be so important.

Thank you. I'll be very pleased to take your questions.

The Chair: Thank you, everyone, and particularly Dr. Finegood for her testimony before the committee with regard to what we feel is a very important study or report. It was very valuable to us as we sat to deliberate the recommendations we came up with. If you'd pass that on to her, we'd certainly appreciate that.

We now will open it up to questioning, starting with Ms. Carolyn Bennett.

Hon. Carolyn Bennett: In the main estimates, it looks as though your spending will increase by about $40 million, or 4.4%, over the next year. There seems to be a difference between funding health research and funding health research and trainees. Dr. Bernstein, I would like you to explain to the committee what the differentiation is there, and also in light of the fact that most of us are hearing in our ridings from research institutions that are very worried that some of their best and most promising researchers have been turned down. They're worrying about the situation we were in, in 1998, when we were worried that people would be going elsewhere to get funded.

● (1640)

Dr. Alan Bernstein: Okay, there are two questions there, Dr. Bennett. Let me try to answer each of them.

Regarding the first one, about trainees, although in the main estimates it looks as though we're decreasing the amount of funding going to trainees, in fact the reality is otherwise. The reason it looks like that is that we're getting considerably more money through the Canadian graduate scholarship program, which is not shown in the main estimates for CIHR. Most of our students are actually funded through grants, so the more grants we fund, the more graduate students and post-doctoral fellows are actually being supported. Also, for our strategic training initiative, the same is true. In fact, we've actually more than doubled the number of trainees since we started, because we recognize the importance of young people to research and to the future.

Turning to the second part of your question, you're absolutely right: we're not able to fund a very large and growing number of outstanding and excellent grants. I commented on that the last time I was in front of this committee. I think there are a number of factors that are contributing to that. I think one is the tremendous expansion in the health research enterprise in this country that has taken place, and is still taking place, since we started. Virtually every major university and teaching hospital is building new facilities. Health research is unquestionably the most exciting area of science today, so young people are being attracted to it. Our broader mandate, relative to the old Medical Research Council, means that we are funding areas of research that the old MRC never would have funded before. So all of that together has meant that we're simply not able to fund a lot of really outstanding grants.

Hon. Carolyn Bennett: The other thing we're hearing from the researchers is that they don't really have the expertise, or that they'd actually rather be researching than trying to find partners and avenues for commercialization. Do you think there is a sort of one-stop shop to help the researchers of this country do commercialization in a better way? What would be the next step, do you think, in terms of getting some of these great discoveries to market?

Dr. Alan Bernstein: There are a couple of parts to your question. Let me try to answer each of them.

For almost all of our programs, we don't require partnerships. We actually line up the partners ourselves. We would go to the Juvenile Diabetes Foundation, the Heart and Stroke Foundation, or a drug company and would line up the partnerships for our programs. That's the first part of the question.

The second part is about commercialization. Commercialization is a complex issue. It involves many players in a complex ecosystem. It involves venture capital, the local institutions, physical facilities for actually setting up a company, management expertise, seed capital—all kinds of things.

What we have tried to do initially is ask what our role is in that very complex ecosystem. I think our roles are several-fold. First is to fund the research—if you will, to put the oil in the ground so that it actually makes sense to have a pipeline—and secondly, to provide some early seed capital, almost, to allow some of that research to move down toward something that is commercially of interest.

We started a new program—I didn't mention it in my talk—called the proof of principle program. The proof of principle program or POP has been extremely well received by the research community and by industry as an extremely innovative program. The intent of that program is not to fund more research, but to add more value to the research, so that the researcher can go out and find a commercial partner. We don't require a partner for the POP program.

Another program, just as an example—which I did mention—is "Science to Business". Again I think it's a very innovative program. We've recognized that there aren't enough people in this country who are familiar and comfortable both with science and with business. These are two silos. With science to business, what we're doing is taking young graduates with a PhD in research and science and in partnership with business schools in Canada providing them with an MBA, provided it's in biotechnology. That started two years ago.

I've met, actually, with a number of these students at the Rotman School in Toronto and at the Ivey School in London, Ontario. It's just a fabulous group of young people. I think as we develop a cadre of these individuals who can straddle both worlds, it'll go a long way to solving some of these ecosystem issues I've been alluding to.

● (1645)

Hon. Carolyn Bennett: If you were going to dream in technicolor about where this would go, what would be the next step for health research in Canada, and what would be the role of government?

Dr. Alan Bernstein: Other than money.... We're building on strengths here. Both the budget statement and Advantage Canada, which came in the fall—

Hon. Carolyn Bennett: Maybe you could say, rather than "other than money".... Can you remind us about public dollars spent on health research in Canada versus public, government dollars spent on health research, say, in the United States or other countries?

Dr. Alan Bernstein: The comparisons are somewhat difficult, because there are different programs, et cetera. Our total budget, if you include the Canada research chairs, the networks of centres of excellence, and indirect costs, is approaching now $900 million. Per capita, the United States is still about fourfold beyond Canada in per capita terms. But also take into account that our mandate is much broader than that of the equivalent agency, the National Institutes of Health.

So on the one hand, we still have a long way to go; on the other hand, we've come a long way. Our budget has increased, I think quite remarkably, over the last seven years since CIHR was first launched. Certainly I am personally very grateful for that. I think the research community is.

So I think we're on the right trajectory. We have to stay the course; that would be my advice. We are building on excellence. I think the Council of Canadian Academies noted that health sciences broadly is an area of exceptional strength in this country. So we are building on strength, and I think we are building on what matters to Canadians, which is their health and their health care system.

The Chair: Thank you very much.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you, Mr. Chair.

Thank you, sir, for being with us this afternoon.

Doctor, in your presentation, you told us that the Board of Directors of the Canadian Institutes of Health Research was presently discussing the best way to utilize the new funding allocated in the federal budget. Do I understand that these are funds that you were not counting on, that this money was unexpected and that, given that there presently is a debate, the members of the Board of Directors do not have a list of priorities?

[*English*]

Dr. Alan Bernstein: That's a very good question. Let me try to answer it.

We do at least two kinds of planning every year. One kind of planning of course involves strategic planning, the strategic priorities. The second kind is our budgetary planning, what our budget expenditure is going to be for the next year.

Because of the way we're funded, which is one year at a time, we have to assume, as we are doing our planning, that we will get no increase in our budget. To do otherwise would be I think irresponsible. Now, when we have our board meetings, we also discuss what happens if we get a small increase or if we get a large increase. We construct scenarios of various increases that the budget speech might contain.

When we actually get the real number, we have to revisit it. With an actual number we're no longer doing risk management. We're now doing real budgeting. I think you can appreciate, if you look at your own personal life and business life, that when we actually see the real number—let's say $37 million, in this case—we have to revisit how we're actually going to spend it.

So yes, we very definitely have strategic priorities. This is not a gift horse that we in the research community were not expecting. We were hoping for it. We desperately need it. Now we have to actually decide, in a responsible way, the best way in our judgment to allocate those funds.

● (1650)

[*Translation*]

Mr. Luc Malo: Are you now in a position to tell this committee about the nature of that debate and the conclusions that could be drawn?

[*English*]

Dr. Alan Bernstein: I can't tell you what the conclusions are yet because we're not finished. It would pre-empt what council will be discussing, so it's not appropriate.

The nature of the debate divides along several lines. One line is what's the right proportion of allocation of our funds to our various programs? In broad strokes, our various programs are what we call the "open grants" competition. These are grants that researchers make to us in any area of health research.

The second bulk area is the strategic initiatives our institutes have developed and are developing with partners.

The third area is our commercialization programs and knowledge translation programs more broadly.

You'll appreciate that there are not necessarily clean lines between each of those programs. They overlap quite considerably.

The other consideration, independent of which program, is risk management for 2008-09 and future years. A major job of my colleague Jim Roberge is to advise council on this, because as we make commitments....

Research commitments are typically multi-year. When we commit, we typically commit for three to five years—on average, about four and a half years. If we fund a grant that you would apply to us for, you would get a grant for five years. And yet we get funded only one year at a time. We're constantly having to mitigate risk.

[*Translation*]

Mr. Luc Malo: Thank you very much, Mr. Bernstein.

[*English*]

The Chair: Thank you very much.

Mr. Batters.

Mr. Dave Batters: Thank you, Mr. Chair.

Thank you, gentlemen, for appearing before this committee. It's much appreciated.

I have three very general questions and one very specific one.

First, is primary prevention research a major focus of CIHR? I'm thinking of primary prevention of coronary artery disease as an example. Is that a major focus of CIHR? Because that seems to be the way in which medicine has progressed over the past number of years.

Dr. Alan Bernstein: I think the honest answer is that it's increasingly becoming a primary focus. I think it's the nature of both the science and where the public is—there's a convergence here—that there are opportunities for actually focusing on prevention. I can give you some examples.

I've alluded to two of the obesity projects we're funding. Those are primary prevention ones. We have a large investment in programs in tobacco prevention, smoking cessation, for example. We have a large program on occupational health and safety in British Columbia, called the Bridge program. It deals with prevention issues in the workplace. In Newfoundland we have a major program called SafetyNet. Researchers are working hand in glove with the fishing industry to deal with health and safety issues in the workplace.

Mr. Dave Batters: So you'd agree that primary prevention efforts are probably the best way to contain costs of our health care system, ultimately?

Dr. Alan Bernstein: An ounce of prevention.

Mr. Dave Batters: Absolutely, an ounce of prevention.

Second question: Do you do extensive research to identify the respective costs of primary versus secondary prevention? I know you talked a little bit in your introductory remarks about the costs of angioplasty, for example, versus primary prevention. It's obviously a corollary to the first question. Do you do substantial research to determine the differences between primary and secondary prevention in terms of cost?

Dr. Alan Bernstein: Again that's an excellent question. It's a new area of research for us that is in our expanded mandate, relative to that of the old Medical Research Council. So we have been building up this area of research, of both health economics and health care systems research generally, and cost issues are clearly a major concern there.

So I think the answer is yes, but it's not nearly at the level I think a country of our size needs to be at.

Mr. Dave Batters: You may not have an answer for this question; it's a very general question. In your opinion—and I'd welcome an opinion from anyone who wants to answer—given the fact that maybe you haven't delved into this as much as you'd like, does your research show that prescription pharmaceuticals, on the whole, are a net cost or a net savings to our Canadian health care system?

● (1655)

Dr. Alan Bernstein: That's an extremely complex—

Mr. Dave Batters: Extremely complex, extremely loaded question, but in your medical opinion, it's a basic question. We just talked about the value of primary prevention to the system. Prescription pharmaceuticals: net cost or net savings?

Dr. Alan Bernstein: To me it's not an either/or, number one; and second, there's no one answer, because it depends on what disease we're talking about. For example, one can talk about primary prevention of breast cancer. We are a long way away from primary prevention of breast cancer. In the meantime, women with breast cancer want a drug.

Mr. Dave Batters: Okay, I understand. And within the question I have to say that there are certain conditions where drugs would be considered primary prevention. There are other conditions where drugs would be considered secondary prevention. For instance, drugs that are anti-hypertensives, before someone has had a heart attack or a stroke, that's primary prevention.

Hon. Carolyn Bennett: No, that's secondary prevention.

Mr. Dave Batters: Anyway, my last question is that you received an extra $37 million in this year's budget. Now, the Juvenile Diabetes Research Foundation didn't receive money in the budget, but I know that they plan to meet with CIHR for seed capital to help them in their search for a cure for juvenile diabetes. Given that Canada is a world leader in diabetes research, is an investment in or with JDRF something that will be seriously considered by CIHR?

Dr. Alan Bernstein: I already have met with the executive director of JDRF, and we have many partnerships with them. In fact, as you may know, I think the world-famous Edmonton protocol that was developed by scientists in Edmonton was funded jointly by JDRF, among other players—JDRF, CIHR, Alberta Heritage—so it really is illustrative of partnership in funding really great science.

Mr. Dave Batters: But they're asking for additional money now. They were looking for $1 million from the Government of Canada. There was an envelope of money given to CIHR. Are you giving strong consideration to joining JDRF in their partnership to find a cure, sir?

Dr. Alan Bernstein: The answer is yes, but let's be clear: we don't give money to organizations; we give money to research. So I will not give money to JDRF, but what I will do and what we've been discussing—and we do this with hundreds of partnerships that we have, including with JDRF—is develop a joint research program that we're both interested in, and we'll call for proposals from the research community and jointly fund it.

Mr. Dave Batters: I'm sure that will be great news.

Thank you, Mr. Chair.

The Chair: Thank you very much.

Ms. Priddy.

Ms. Penny Priddy: Thank you, Mr. Chair.

I think a year or so ago you had an external evaluation of CIHR, and a number of recommendations were made. Do you think you could comment on—and maybe this is hard to pick—the top three, or ones that you see as the top three you are moving forward with currently?

Dr. Alan Bernstein: Okay, sure. This is in no particular order. I'm trying to think of what's prominent in my own mind, about what's important to me and to moving forward on the international review panel report.

The first one was that they recommended some clarity of governance issues. Where are some of the funding decisions being made? Is it a governing council? Is it at the scientific directorate table?

We've accepted that recommendation of clarity. So what we've done already is reorganize the committee structure under governing council. We've created a new committee called the research and knowledge translation committee, which will be the point place where final funding decisions are made on grant allocation, after council makes its envelope decisions.

They also recommended that council devolve that border between governance and management decisions down to management, so that council becomes more of sort of a governing body. Council has a retreat in the summer to discuss that, and has already accepted that, and we are moving forward with that. I think that's a very important recommendation.

I would just say for both of those that one has to keep some history in mind here. For the new organization, not surprisingly, governing council was very hands-on in the early years to make sure that in their judgment this important new organization was moving forward in the right direction.

So the IRP has said everything is going well. It is time for council to devolve down more to management of those issues. Those are two.

On peer review, the IRP also recommended a fresh look at how we do peer review. Peer review involves having other scientists sit around a committee like this and review grants that come in.

It is an issue everywhere in the world. It is a particular issue for us because we've stressed outcomes-driven research, and we've stressed multi-disciplinary research and knowledge translation, and these are more complex to review. So we have struck a committee called planning and peer review that will move forward in looking at how we restructure peer review in this country.

● (1700)

Ms. Penny Priddy: Thank you.

Do you have a plan of evaluation, according to which you want to be in a certain place at a certain time on those three things, that you'll go back to? If the committee were to come back and ask you where you were on this, you could report in 12 months? I'm not suggesting you don't; I would just like to know that you do.

Dr. Alan Bernstein: Yes.

Ms. Penny Priddy: Thank you.

Did I have more than one?

The Chair: Yes, you can go ahead.

Ms. Penny Priddy: The question earlier was about focus on primary prevention, and that it is a growing area, as it is everywhere, I think, that you look in the health community.

Regarding the area of population health, can you talk a bit about how that fits into whether you see that getting more attention or less attention?

Dr. Alan Bernstein: Population health, like health services research, is actually one of the four pillars of CIHR, as stated in the parliamentary act that created us.

Ms. Penny Priddy: It's the smallest pillar, though, is it?

Dr. Alan Bernstein: It depends how you measure it. We have an Institute of Population and Public Health that is led by John Frank. In fact, Dr. Frank is now meeting with the Senate Committee on Health, with Senator Keon's committee, as we speak, to discuss public health issues.

So the area of public health and population health is one of those areas that is growing. It has been a very small community in this country historically, so you don't all of a sudden have a public health and population health initiative unless you have people. You don't grow people overnight. They have to be trained, and they have to have positions to go to.

So we are very much in the business of doing that. Dr. Frank has created centres of excellence in population and public health across Canada that are being supported. There are training initiatives in this area, etc.

In addition, the increase—although it is small in absolute dollars, and I agree with you there—in the funding of population and public health since we started is in the order of sixteen-fold in the last seven years. It is a pretty steep increase. In absolute dollars, it is still small, but again I think it reflects the small but growing size of the community.

Ms. Penny Priddy: Can I ask an addendum question to that? It is pretty easy.

The Chair: Okay. Your time has gone, but go ahead, very quickly.

Ms. Penny Priddy: Thank you.

Fraser Mustard and people like that tell me that part of the reason is that we're not training, that there aren't enough people selecting to go into that, and that's why we have a smaller pool.

You can answer just yes or no. Are you doing some work with universities about encouraging people to get into that area?

Dr. Alan Bernstein: Yes, we are. As I said earlier, we've doubled the amount of money going to training generally. Dr. Frank's institute has created these centres for, really, capacity building on population and public health. Every year, also, that institute has a summer institute on population and public health, again to try to build capacity in that area.

Dr. Frank is a real proselytizer for the importance of population and public health. I think he's doing a super job in trying to do that. I would actually suggest, if I may, that you invite him to come in front of the committee to talk about what he's doing.

The other thing I would add is that I've alluded to obesity, and I think this is one of the strengths of CIHR as being led by our Institute of Nutrition, Metabolism and Diabetes. But as your report demonstrates, you appreciate that much of obesity is a population and public health issue. So although it's led by our diabetes institute, it really is involving everybody, from clinicians to public health researchers, on that important issue.

● (1705)

Ms. Penny Priddy: Thank you.

Thank you for your patience, Mr. Chair.

The Chair: Thank you very much.

Ms. Davidson.

Mrs. Patricia Davidson: Thank you, Mr. Chair.

I have a couple of very quick questions.

You're looking at an increase in planned spending of almost $36 million, I think—is that correct?—and a great deal of that will be devoted to grants and awards.

I see in your presentation that you talked about research on Fabry's disease. Is there $11.6 million going to that research itself?

Dr. Alan Bernstein: Yes.

Mrs. Patricia Davidson: Okay. Has there been money go into that research up to this point, or is this a brand-new study?

Dr. Alan Bernstein: This is a new study. The vast majority of the funds are actually to purchase the drug that is being tested in this case. This was money allocated through Health Canada for us to do that study. It's being done in partnership with Fonds de la recherche en santé du Québec, our counterpart program in Quebec.

The objective of that one study is to evaluate the efficacy of that drug for children with Fabry's disease.

Mrs. Patricia Davidson: So it's going to be used on children only, or on adults, with this study?

Dr. Alan Bernstein: I have to check. My guess is that it's largely children, but I'm not sure. I could get back to you on that if you'd like.

Mrs. Patricia Davidson: Okay, I would appreciate any information that you could get on that. I happen to have a young gentleman in my riding who is suffering from this disease and has been certainly advocating for years to try to get some support for the drug because of the huge expense that's involved with it.

Dr. Alan Bernstein: Definitely.

Mrs. Patricia Davidson: The other thing is that I see in the estimates they talk about the expensive drugs program. Could you tell me a little bit about that? I don't remember you talking about it when you—

Dr. Alan Bernstein: Sorry, I'm not quite sure what you're referring to.

Mrs. Patricia Davidson: It's in the main estimates. They talk about Fabry's disease and expensive drugs. But maybe it's the same thing, is it?

Dr. Alan Bernstein: Yes, it is the same thing.

Mrs. Patricia Davidson: All right, thank you.

Those were my only questions.

The Chair: Thank you very much.

We have one further questioner, Bonnie Brown.

Ms. Bonnie Brown: Thank you, Mr. Chair.

Welcome, Dr. Bernstein.

In your four main sectors of research, where would projects that bring together environment and health fit? Do you have an accommodation for that?

Dr. Alan Bernstein: It's a good question. When Parliament created these four pillars, to some extent I think it's a construct. Ideally, what I'd like to think about, many of the things we do don't fall neatly into any one of those four pillars. I actually like that, and I think environment and health is a very good example of that. We don't have an institute, either, of environment or health, but we do have an institute on cancer research. We do have an institute on population and public health. So issues such as environment and health, and other major issues, such as a clinical research initiative we're developing at the moment, global health research, are initiatives that transcend those four pillars and also transcend our institutes. They are championed by one of our 13 institutes, but they don't necessarily fall into any one.

So many environment and health issues are population and public health issues. Some of them are biomedical issues, some of them are clinical issues, and some of them are health services issues.

Ms. Bonnie Brown: Do you have any idea of how many projects, say, were funded last year that would fall reasonably within that description? In other words, they are not necessarily chasing the cancer answer, as Wendy Mesley puts it, but are looking for those connections between a variety of diseases and the environment in which we live.

Dr. Alan Bernstein: I don't have that number in my head, Ms. Brown. I'll have to get back to you on that one in particular, if I may.

The other thing I should point out, and Dr. Chartrand just reminded me, is that we're going forward, in very active discussions with the Natural Sciences and Engineering Research Council and the Social Sciences and Humanities Research Council, with tri-council issues on environment and health, because, again, many of these issues are not neatly even within the health area. They spill over into the natural sciences or into the social sciences and humanities.

● (1710)

Ms. Bonnie Brown: I understand, yes. There's a lot about behaviour and all that sort of thing.

We're aware of the $1 billion the government is looking for in savings for 2006-07 and again for 2007-08. Has CIHR been subject to the 2006 expenditure restraints? In other words, health has been asked to save $62.4 million. Has CIHR been asked to save a specific amount of money in the year we're still barely in and in the next year that's coming?

Dr. Alan Bernstein: I'll let my colleague Mr. Roberge answer that one.

Mr. James Roberge (Chief Financial Officer, Canadian Institutes of Health Research): The $62.4 million of savings is across the entire health portfolio, and of course we're a member of that portfolio. The Deputy Minister of Health, on behalf of the minister, is forming a working group to examine where savings can be found.

The focus is going to be on policy and corporate services across the health portfolio. No specific targets or amounts have been identified for CIHR or any other members of the portfolio at this time.

Ms. Bonnie Brown: So even though we're almost at the end of fiscal 2006-07, and there's a commitment to get $62.4 million out of health, nobody's been asked to come up with it, other than a working group. But how can you then save the money at the end of the fiscal year in a couple of weeks?

Mr. James Roberge: I can't answer that, except to say that for CIHR there's been no reduction. So I can only assume that it's in one of the other members of the portfolio, presumably in Health Canada, but I don't know that for a fact.

Ms. Bonnie Brown: If no plans have been made other than a working group in Health Canada, could it mean that health is going to be asked to take twice that in 2007-08? I don't expect you to know the answer to that, but this seems strange to me that it's announced that there's going to be $1 billion taken out of the budget, and that the health portion is $62.4 million, and in March, at the end of the fiscal year, there's only a working group.

Does that not sound strange to you, Mr. Chair?

The Chair: What I would suggest to you is that you're asking the wrong people. The minister is actually going to be here, I believe—

The Clerk of the Committee (Mrs. Carmen DePape): It will be on May 16.

The Chair: —May 16, which would be the appropriate time to ask, because I just don't think you're going to get the appropriate answer here.

Ms. Bonnie Brown: I just have one more quick question for Dr. Bernstein.

I'm glad you alluded to the fact that you're starting to do this cross-work with the humanities and social sciences granting councils and all that sort of thing. What about addictions, which also kind of go across that spectrum? I know Dr. Quirion, who you mentioned in your presentation, is very interested in that field. Is he working on something like that now? Does he lead that institute?

Dr. Alan Bernstein: He leads that institute.

Just to remind members of the committee, the Institute of Neurosciences, Mental Health and Addiction is really unique in the world in the sense that it's bringing together neuroscientists who work on the bench, who work in the lab, with people who are doing mental health research, including addiction research.

In the National Institutes of Health in the U.S., those areas are separated into four different institutes. I think the vision behind it, the reason we did that back in 2000, was a prediction, and I think it's a right prediction, that at the end of the day, all of this is going to come together under one science, if you will. So we are very committed to that.

For example, our tobacco prevention initiative is led by that institute. It's not led by the Institute of Cancer Research, because we recognize that as an addiction problem, just as one example.

The Chair: Go ahead.

Ms. Bonnie Brown: I had another question, but now I've forgotten it.

● (1715)

The Chair: It couldn't have been too important, then.

Ms. Bonnie Brown: Just let me say that of all the health researchers I've ever met, Dr. Quirion and the way his mind works and his vision is tremendously inspiring. So I want to make sure they get enough money to do what they're doing, because it's super-important.

Dr. Alan Bernstein: I want to make sure they do too.

The Chair: On behalf of the committee, I want to thank you for coming. We want to wish you the very best in using that $37 million the best way you possibly can for the benefit of all Canadians. You have been making Canada proud with the research you've been doing and the way you've led this institution. We want to congratulate you on that and thank you for coming and sharing the estimates and their concerns today.

With that, thank you to the committee.

The meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

Also available on the Parliament of Canada Web Site at the following address:
Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante :
http://www.parl.gc.ca
