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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon, ladies and gentlemen.

I'd like to welcome our guests today. We thank you very much for appearing at the committee today.

Before we start I wish to inform our honourable members that we have a parliamentary delegation in the room today from Pakistan. The delegation consists primarily of members of the National Assembly's Standing Committee on Finance, and is led by the Deputy Speaker of the National Assembly. The primary goal of their visit to Canada is to strengthen the role played in Pakistan by parliamentary committees and political party caucuses in the national budget-making process.

The delegates plan to use the knowledge and insights they have gained to make practical and realistic plans to strengthen the part that they and other parliamentary committees play in the budget process, particularly with respect to public consultations and engagements.

The delegates are primarily members of the Standing Committee on Finance in Pakistan's National Assembly. They are interested in all aspects of the budgetary process.

The meeting of our committee, the Standing Committee on Health, on this day, May 12, on the subject of the study of the main estimates for 2009-10, will give them yet another insight into the parliamentary budgetary process in Canada.

I would please ask the delegation to stand up so everyone can recognize you. I am very pleased and honoured on behalf of all members of the national health committee of Canada to welcome you to observe the meeting. Thank you.

I would invite you to observe part of our meeting. If you can't stay for the full two hours, we fully understand, but you're very welcome for any part you can stay for.

Today we have our witnesses, in terms of main estimates. I'm going to ask, with the indulgence of the committee, if we could stop at 5:15 because I have some committee business that has to do with travel and a couple of other issues.

Is it the will of the committee to suspend at 5:15?

Some hon. members: Agreed.

The Chair: Thank you.

Now we'll go to the witnesses. Pursuant to Standing Order 81(4), main estimates 2009-10, we will now go straight to the witnesses.

From the Hazardous Materials Information Review Commission, we have the president and chief executive officer, Sharon Watts. From Assisted Human Reproduction Canada, we have Elinor Wilson, the president and chief executive officer, and Margaret Strysio, the executive director of planning, communications, and outreach. Welcome.

From the Patented Medicine Prices Review Board, we have Brian Benoit, the chairperson, and Barbara Ouellet, the executive director. From the Canadian Institutes of Health Research, we have Karl Tibelius, the director of the targeted initiatives research portfolio, and James Roberge, the chief financial officer and the vice-president of resource planning and management.

We will start with our first witness, Sharon Watts, from the Hazardous Materials Information Review Commission. You have a ten-minute presentation. Once we hear all of the presentations, we'll go into Q and A.

Ms. Sharon Watts (President and Chief Executive Officer, Hazardous Materials Information Review Commission): Thank you very much, Madam Chair.

I would like to thank the committee for the opportunity to provide information to you again on my agency, the Hazardous Materials Information Review Commission, and to speak to the main estimates, of course, for 2009-10.

I was appointed president and CEO of the commission in August 2007, but I am by no means a stranger to the commission, as I was the vice-president for many years prior to my appointment.

I would like to give you just a brief overview of our role and mandate, and then some background to the main estimates of 2009-10. First, just by way of introduction, I would like to describe to you how the commission fits into Canada's overall system to protect the health and safety of workers and how we protect the industry's right to commercial assets.

[*Translation*]

In 1987, the Workplace Hazardous Materials Information System (WHMIS) was established through a consensus of industry, organized labour, and the federal, provincial, and territorial governments. The goal was an integrated and coordinated approach to ensuring that workers using hazardous materials had the information they needed to minimize risk of illness and injury.

The system ensures that appropriate information on the handling of hazardous materials is provided to workers through product labels —material safety data sheets—and that workers receive necessary education and training.

● (1535)

[*English*]

When WHMIS was established it was recognized that there was a need to balance the right of workers to have accurate and complete health and safety information with the right of industry to protect their commercial assets or trade secrets. The commission was set up as an integral part of this WHMIS system to provide that balance. Like WHMIS, the commission is a joint undertaking on behalf of labour, industry, and the federal, provincial, and territorial governments.

I'll give you a brief overview of our roles and responsibilities and our unique governance structure.

The role of our commission is to impartially render decisions on claims for exemption, hence the quasi-judicial nature of our agency. Full information on the chemical identity and concentration of all ingredients must be provided on a product, as well as protective measures workers need to take to prevent injury. The exception to full disclosure is when it would reveal a trade secret resulting in either an economic loss to the claimant or an economic gain to their competitors.

[*Translation*]

That is exactly why the Hazardous Materials Information Review Commission was created as an independent quasi-judicial body under the authority of the Hazardous Materials Information Review Act. Our mandate is to review economic documentation and health and safety information in all situations in which a hazardous material is a trade secret or purported trade secret.

The commission is unique because it is a single organization of government that serves all jurisdictions. The commission receives claims for trade secret protection, reviews health and safety documentation, issues compliance orders, and provides appeal mechanisms on behalf of federal, provincial, and territorial jurisdictions.

The commission's legislative mandate has been incorporated by reference into federal, provincial and territorial legislation. For example, the Commission is named in Saskatchewan legislation on workplace health and safety. The same is true of other provinces and territories.

[*English*]

I generally describe our activities as addressing three main areas. First, we conduct an economic analysis to determine whether the claimant's information provided to us is truly a trade secret based on regulatory criteria, and whether disclosure would have economic consequences. Second, we conduct a scientific analysis to ensure that the health and safety information being supplied to employers and workers about the product is accurate and complete. Third is administration of an independent appeals process. When a claimant or any affected party challenges a decision of the commission, we appoint an independent appeal board to hear that appeal.

The governance of our commission is unique, in the sense that our oversight is by a tripartite 18-member board representing all our stakeholders. There are two representatives of organized labour, two representing industry, one representing the employers who use those hazardous products in the workplace, and one representing the suppliers of those hazardous materials to the workplace. There is a representative from each province and territory across Canada. There is also a representative of the federal government, and that is the Ministry of Labour.

[*Translation*]

Under the Act, our Council of Governors is responsible for making recommendations to the Minister of Health about claims review procedures, appeal procedures, changes to the fee structure, and related matters. A critical part of our mandate is to strike a balance between the right of workers to know what is in the materials they deal with in the workplace and why they are hazardous, and industry's right to protect trade secrets.

I would like to talk about the commission's work and discuss the main estimates.

● (1540)

[*English*]

Fiscal year 2007-08 was a challenging one for the commission—one of change and transition. We worked very hard with all of our claimants and stakeholders to streamline our operations through regulatory, statutory, and administrative means. This culminated a ten-year renewal program that we had embarked upon in 1999. This was the ten-year project to amend our legislation that came before this committee last year and came into force on October 1, 2008.

However, with all these excellent initiatives, the capacity issue still plagues this commission. It's the single most chronic issue facing our commission, and it jeopardizes our ability to deliver on our statutory mandate. This capacity issue, coupled with a substantial increase in the volume and complexity of claims brought towards the commission, has resulted in a claims processing backlog of over two years.

In light of the scientific review this commission performs in order to review the material safety data sheets, the backlog has caused considerable delay in providing information to workers. The purpose of our work is not only to provide claimants with an exemption to disclosure, but also to review their MSDSs, correct them when necessary—95% of the time—and put them in the hands of workers in their workplaces.

When we look at the violation rates we continually report on in our annual reports, there is still 95% non-compliance. Generally, about 60% of those violations would be considered to be significant and of concern. We're talking about the presentation of toxicology information, whether it's respiratory issues or the absence of proper toxicology information, incorrectly describing the ingredients or the absence of an ingredient disclosure, and proper first aid measures. This backlog, in the context of that information, presented a risk to the commission that needed to be mitigated.

Through our business case we presented a case to the Treasury Board and to the Ministry of Health for an increase in resources to address our claims backlog. We presented a three-year backlog reduction plan. The first year was funded last year through a transfer from the Ministry of Health to this agency. The second and third years will be funded through the increase you will have seen in the main estimates 2009-10, representing about $2 million to this agency.

It's important to note that these funds are sunsetted. They will disappear in 2010-11, and at that point we will retain $800,000 to sustain our ability to continue to work without a backlog of claims. It's our plan that the resources we have received to date will address the elimination of the backlog. The workers who were hired to do that work will be let go at the end of the three-year period.

By September we will be halfway through our three-year backlog reduction plan. I'm very pleased to report that we're right on target for clearing up the backlog of claims.

[*Translation*]

During the coming fiscal year, we will be focusing on the important goal of eliminating that backlog, but we will also continue to work on information sharing and partnerships with other national and international jurisdictions in our role as a WHMIS centre of excellence for review, claims and assessment of material safety data sheets for compliance with WHMIS legislation.

[*English*]

In conclusion, the commission has built a relationship with its council of governors representing all of our stakeholders based on trust, respect, and a shared vision. Our approach is simple and straightforward. Canadian taxpayers' interests are best served by considering and balancing the needs of workers and industry alike. The solution is one that protects both of them.

● (1545)

The Chair: Thank you so much, Ms. Watts, for that very insightful presentation. We appreciate it.

We'll now go to Elinor Wilson, president and chief executive officer of Assisted Human Reproduction Canada.

[*Translation*]

Dr. Elinor Wilson (President and Chief Executive Officer, Assisted Human Reproduction Canada): Thank you, Madam Chair. I appreciate this opportunity to talk to the committee about Assisted Human Reproduction Canada's role and responsibilities.

[*English*]

Assisted Human Reproduction Canada is the newest member of the health portfolio. It is a regulatory agency that reports to Parliament through the Minister of Health. The agency administers the Assisted Human Reproduction Act and has a mandate to protect and promote the health, safety, dignity, and the rights of Canadians who use or are born of assisted human reproduction technologies. It also fosters the application of ethical principles in the use and development of these technologies.

Let me take a moment to distinguish between the role of the agency and that of Health Canada. Health Canada is responsible for developing policy related to assisted human reproduction and regulations under the Assisted Human Reproduction Act. The agency's role is to oversee the implementation of the act and the associated regulations. Most of the prohibitions under the act came into force in April 2004, and the consent-to-use provision with its applicable regulations came into force in December 2007.

As part of AHRC's mandate to promote and ensure compliance with the act, the agency has been encouraging and facilitating this role, based on a cooperative approach involving clinics, physicians, and other organizations. Once the other provisions of the act and regulations being developed by Health Canada come into force, the agency will be responsible for licensing, inspecting, and promoting compliance relating to activities controlled under the legislation.

I want to point out that the agency is fully engaged on other fronts. In addition to its compliance and regulatory hat, it wears other hats under the AHR act. In the two years since the agency became operational, much has been accomplished towards laying the groundwork and building the capacity that is vital for the successful implementation of the regulations. This means that as soon as the regulations are ready the agency will have in place all the mechanisms it will need in order to assume its full regulatory role. This entails doing the preparatory work to help our stakeholders understand the regulations and their effects.

Equally important is the work that we are doing to develop a national personal health information registry, as mandated by the act. This secure registry will contain prescribed health information on donors, persons who undergo AHR, and persons who are conceived by means of these procedures. The personal health information registry is necessary in order for AHRC to fulfill its mandate relating to the identification of health and safety risks and its obligation to provide information to Canadians.

We are also working on the development of a research agenda that will help inform policy. We are monitoring and evaluating developments in Canada and throughout the world, and we are consulting with interested individuals and organizations. Finally, we are providing information to the public and the professions on AHR, including risk factors associated with infertility. This is done through our website, in publications, and via a toll-free information line.

The agency is guided in its work by a board of directors. It is responsible for the overall management of the agency, including the provision of advice to the minister, approval of the agency's goals, operational policies and budget, and evaluation of the agency's performance.

Shortly after I took office in February 2007, we decided to make it a priority to meet with various people and organizations across the country who represented the interests of those who have a responsibility to comply with the provisions of the AHR act and its regulations, or who might be affected by the provisions of the act. Taking the time to hear what they had to say was invaluable to us. Health professionals, patient groups, and other partners contributed valuable information.

It has been 30 years since the birth of the world's first test-tube baby, and in those 30 years we have witnessed a scientific revolution in assisted human reproduction, which has challenged us on many levels. It has sparked fierce debates about the application of IVF and has led to innovative practices and procedures allowing Canadians to benefit from these technologies and related research.

● (1550)

I believe the agency has an important role to play in helping Canadians make informed choices, because the bottom line is that AHR is a public health challenge. It directly affects about one in eight Canadian couples struggling with infertility, as well as individuals who are dependent on non-conventional methods to build their families.

We have so much more to do. The agency remains committed to working closely with Canadians to build the strong and open relationship that allows us to work with them to protect the health, safety, rights, and dignity of those who turn to AHR to create the families they desire.

[*Translation*]

That concludes my presentation, Madam Chair. Once again, thank you very much for having given me the opportunity to talk to you about Assisted Human Reproduction Canada.

[*English*]

The Chair: I thank you for your comments, Ms. Wilson.

Now we'll go on to the Patented Medicine Prices Review Board. Mr. Benoit, the chairperson, will be presenting.

Dr. Brien Benoit (Chairperson, Patented Medicine Prices Review Board): Thank you, Madam Chair.

The other presenters have stated a bit of their mini-CVs, saying how low they've been with their various organizations. I should probably tell you that I've been with the PMPRB for four years as chair. I was appointed chair in the fall of 2005.

We are pleased to appear before this committee. We were here a few months ago, and the only thing that's really different is that the snow is gone. But undoubtedly you have some questions for us relating to these main estimates.

[*Translation*]

I am here today with our executive director, Barbara Ouellet. We would be happy to answer your questions following our opening statements.

[*English*]

Our board was established by Parliament in 1987 under the Patent Act as a quasi-judicial tribunal. We are part of the health portfolio, but we are independent in an operational way from the health portfolio and act at arm's length from the Minister of Health.

The PMPRB has a dual role. The first, and the one that has the highest profile, is to regulate the prices of all patent medicines sold in Canada. I wish to emphasize the word “patent medicine”, because there are 6,000 medicines sold in Canada, and we only regulate those that are under the Patent Act and currently under patent, which is approximately 20% of those. However, that 20% is a large chunk of the total expenditures for medicines in general.

Our other role is to report to Parliament annually on pharmaceutical trends of all drugs and on research and development spending.

[*Translation*]

The Board's budget for fiscal year 2009-10 is $11.4 million. We have 76 people on staff.

The evolving nature of the environment in which the board operates has led to a substantial increase in the workload, and consequently, our budget.

[*English*]

The evolving nature of the environment in which the board finds itself is now affecting its work and has led to a substantial increase in our workload and consequentially our budget. Several factors have contributed to this budgetary increase.

The first is decreased compliance, leading to more investigations and hearings. You will read from our annual report, which is due to be published shortly, that in 2004 the rate of compliance with our guidelines was around 95%, and now it's slightly less than 90%. So there's been a trending down towards decreased compliance. This, of course, has increased the number of investigations and to a lesser extent the number of hearings and generally has contributed to our increased workload.

We are also making a major revision of our excessive price guidelines. We hope to complete this exercise by June 2009 and implement it in January 2010. There is an evolution in the pharmaceutical environment in general. There are fewer breakthrough drugs being introduced in the Canadian market now, but there are many that have incremental innovations and that are better in certain relatively minor ways and deserve a premium. Our new guidelines hopefully will reflect this.

As an example of our increased workload—and I think you have these notes before you—in 2008 we had 125 investigations, which means drugs that are triggering our staff to look at their price, and in 2004 there were only 43. So by that percentage we have increased the number of investigations.

The excess revenues that have been paid out by the pharmaceutical manufacturers under voluntary compliance undertakings and board orders has increased significantly also. The figures you have in your notes are based on a fiscal year, but just to put it in context, prior to 2006 approximately $25 million was recovered in excess revenues. Since 2006, that amount has increased to approximately $50 million. I'm rounding out these figures for emphasis' sake here.

The number of notices of hearings has also increased. Between 1987 and 2005 we had eight, and in the few years since then that number has doubled.

● (1555)

[*Translation*]

The Board is about to complete its in-depth review of the excessive price guidelines and a broad public consultation process on the guidelines.

The guidelines explain, clearly and transparently, how patent medicine prices are reviewed, thus making the results of the review more predictable for patentees. In the past, our guidelines encouraged voluntary compliance by helping patentees set prices for their medicines that were not considered excessive. As I said before, compliance has diminished recently.

[*English*]

The issues raised go to the heart of price determination. For example, categorization no longer adequately recognizes the current type of innovation in the pharmaceutical environment. Prior to our current guidelines review we had three categories of medicines, based on their effectiveness and safety. Now, hopefully, we're going to introduce a fourth category with an associated price test that is going to generally recognize the incremental innovations in new products that are on the market. As the notes say here, the price tests are going to reflect these new four categories.

The new guidelines have been the subject of many consultations with our stakeholders, who include not only the pharmaceutical industry, but also the federal-provincial-territorial governments, the private payers, and patient care groups. These consultations are all done now, and we hope to publish the final product at the end of June.

For practical reasons and at the request of several stakeholders, rather than implement in the middle of a fiscal year we're going to put off the implementation until January 2010. During that six-month period, there will be a lot of outreach, educational sessions, and consultations with the stakeholders on how these new guidelines are going to apply.

[*Translation*]

The board continues to carry out various activities that affect Canadians' lives, whether through its mandate to regulate and report, specialized analyses for provincial and territorial ministers of health, or major projects, such as the recent review of our excessive price guidelines.

[*English*]

Basically, those in summary are my comments. We are continuing, hopefully committed to carrying out our responsibilities in a manner that is very transparent, effective, and accountable.

We'll be ready to answer your questions whenever you get there.

Thank you.

The Chair: Thank you very much.

For the Canadian Institutes of Health Research, Mr. Tibelius is going to be answering questions rather than giving a presentation.

What we are going to do now is go into our first round, of seven minutes for questions and answers. We're going to start with Ms. Murray.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you, Madam Chair.

Having just had the benefit of some comprehensive remarks from a number of agencies, I'm going to direct my questions to the agency we didn't hear from.

Mr. Tibelius, I understand that there are reductions in funding for CIHR. While the reduction is 0.5%, I presume this hasn't been adjusted for inflation. If inflation has been taken into account, perhaps you have the figure for what the actual real dollar reduction is.

My question is, which research programs and initiatives will be receiving fewer funds this year?

● (1600)

Mr. James Roberge (Chief Financial Officer, Vice-President, Resource Planning and Management, Canadian Institutes of Health Research): I'll be pleased to answer the question. Thank you.

This year, strategic review will result in a reduction to our reference levels of approximately $1.5 million. That is as a result of our no longer holding competitions under the open team grant program. Existing team grants will continue. Those recipients will continue to receive their funding according to our previous arrangements with them.

This means that over the next few years, as those grants fall off, the amount of reductions related to this will rise and reach a maturity at around $27.5 million. That is for the open team grant program.

In addition, the intellectual property mobilization program is being terminated. That program will result in no reductions in this estimates year; however, next year and in subsequent periods that program will be eliminated, with a result in savings of $2 million.

Ms. Joyce Murray: Was inflation adjusted in, or was this more like a 2.5% decrease if inflation and adjusted dollars are taken into account?

Mr. James Roberge: These are the nominal dollars, and they will continue to be. So over time, inflation would reduce and affect the amount of the reduction.

Ms. Joyce Murray: I'm interested in the process the institute goes through to determine where to make the cuts. What kind of process is used? Who's involved? What kind of consultation happens? What criteria are you using to determine what to cut, what to eliminate? Is there an impact on any multi-year projects that are currently under way?

Mr. James Roberge: In answer to your question, the process of strategic review is determined by the Treasury Board. It's the same process for all entities that undergo strategic review. They identify the criteria, which are those you would normally see in an evaluation: Is the program relevant? Is it effective? Is it efficient? Are there alternatives? Is this part of the federal role? The questions are of that nature.

You're asked to review 100% of your spending, so you're required to write a Treasury Board submission for each program, answering those very questions and providing recommendations on which reductions you're proposing to ministers. Through that process, ministers make a decision on which of your proposals they will accept or reject.

In terms of consultation, again there were very strict instructions that there was to be no consultation with stakeholders. It was really an internal exercise. However, we did have an external advisor appointed by the minister to give us another perspective. Internally, of course, we consulted with staff, with our governing board as well.

Ms. Joyce Murray: Was there consultation with provincial and regional deliverers of the—

Mr. James Roberge: No, there was no consultation with any outsiders at all.

In terms of the impact on existing multi-year grants, the nature of our reductions is such that no existing grant holder is affected. If you are a current recipient of a program that's terminating, you will continue to receive your funding until that funding expires.

Ms. Joyce Murray: I understand now that there was no consultation outside of the organization, but how did you create a sensitivity to issues and needs and programs in, say, the north compared with British Columbia, compared with Ontario? Did the people based here in Ottawa have information that would enable them to factor in regional issues?

Mr. James Roberge: One of the considerations for any proposed reduction is that you do an impact assessment. The impact assessment looked at, among other aspects, regional distributional effects.

Many of our programs are open, meaning that they're commonly available to all Canadians, so researchers from any province in any discipline can apply for assistance. It is really impossible to tell who might be affected by a reduction of that program, except by sort of using averages. For many of our programs, regional distribution was not really a major consideration because of the nature of the program itself.

● (1605)

Ms. Joyce Murray: Could you tell me, in terms of the CIHR's objective to work with other jurisdictions with partnered initiatives, what, if any, impacts there were on those kinds of partnerships? Further to that, do you have any concerns about Canada's reputation in terms of health research on the international stage, based on budget reductions?

Mr. James Roberge: As I mentioned earlier, by far the largest reduction was to the open team grant program. That program is not a partnered program by design. There is a corresponding program, the strategic team grant program, which has more of a partnered nature, so that program was preserved. Again, there really was not much of an impact in terms of partners. That was one of the things we looked at in terms of our choices. So there should be really no impact on partners.

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

We'll now go to Monsieur Malo.

[*Translation*]

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

I would like to thank the witnesses for being here with us today.

Dr. Benoit, you are right in saying that we met not long ago. We met in February when we were discussing supplementary estimates. Allow me to take up where we left off back then.

In the graph on page 16 of the main estimates, the line representing funds allocated to the board you chair is very steep. As such, we have reason to wonder why there has been such a sharp increase.

You said that the 2008 annual report was on its way. It is unfortunate that we do not have it here now. According to what you said, patented medicine manufacturers have adopted a new approach to the Patent Act and now tend to be a little less cooperative. I would like to know exactly which provisions of the act enable you to tell us that today. When I look at the graph on page 10 of your 2007 report, the numbers for new patented drug products for human use tend to be relatively stable. I do not see significant fluctuations, but your budget has increased significantly.

When you appeared before us, I asked you whether a lot of the additional money went to pay for litigation. You told me that there was an SPA fund with money for hearings, and that the money was refundable.

Can you tell us whether money from the previous budget placed in the fund was returned to the government, or did you use it?

Dr. Brien Benoit: I cannot answer your technical question specifically, Mr. Malo, but I will ask Mrs. Ouellet to address it.

Right now, we are spending that money. We have eight hearings underway, one of which has been going on for 10 years. This is an unfortunate way to have to resolve certain issues. A hearing should never go on for 10 years, but there are all sorts of legal reasons for it.

Right now, eight hearings are active. When they are finished, any extra money will be returned.

As I said in my opening statement, there has been a slight decrease in compliance. Over the past five years, the rate of compliance has dropped from 95% to a little under 90%. The numbers will be available in a month. Our annual report must be submitted to the Minister of Health before being approved by Parliament. You will see that the rate of compliance is dropping.

We have returned significant amounts of excess revenue to the federal government. We sign up to $15 million worth of voluntary compliance undertakings. That money goes into the federal treasury and is redistributed to the provinces according to a rather complex formula.

Our hearings produce positive results with respect to compliance with our mandate.

● (1610)

Mr. Luc Malo: You are saying that, in most of the cases in which you are involved, the Federal Court rules in your favour.

Dr. Brien Benoit: Yes. When a patentee appeals one of our decisions to the Federal Court, rulings are rarely against us. We did get one negative ruling from the Federal Court concerning jurisdiction. It involved a drug being sold in Canada with limited distribution to specific patients. The case went on for several years. The party selling it never received a notice of compliance from Health Canada. The product was being sold in Canada at prices we considered to be excessive. We held a hearing, which was then appealed to the Federal Court, which did not rule in our favour based on a question of law. The case was then referred to the Federal Court of Appeal.

Mr. Luc Malo: How much of your budget is allocated to litigation?

Dr. Brien Benoit: About $2 million out of a total budget of a little over $11 million.

Mr. Luc Malo: With the new guidelines you will be releasing shortly—I believe you said that you held in-depth consultations with all interested parties—will you be needing less money to conduct investigations, go to court, and so on, because there is consensus around the new guidelines?

Dr. Brien Benoit: You have just summed up the goal of our consultations. We hope that, with the new categories and all of the changes to our guidelines, compliance rates will rise and we will have fewer investigations and hearings.

Mr. Luc Malo: Will it be ready in June, as you told me in February?

Dr. Brien Benoit: The process will be finalized in June, and we will begin to enforce the new guidelines in January 2010. Mr. Malo, we really hope that the new guidelines will significantly reduce the number of appeals.

Mr. Luc Malo: Perfect.

Ms. Watts, can you tell us why you have a two-year claims processing backlog? Is it because of poor planning when the commission and the program were set up? In your comments, you seemed to suggest that cases were a little more complicated than expected. Am I right in thinking that there was poor planning?

Ms. Sharon Watts: I hope not. In fact, the backlog is due only in part to the complexity of the claims we have received. The primary factor is the number of claims, which has doubled in the past five years. Before, we were getting about 200 claims for exemption per year, and suddenly, in the middle of our renewal program, we received 400 claims for exemption.

Mr. Luc Malo: Was that not foreseeable?

[*English*]

The Chair: Thank you, Mr. Malo.

We'll now go to Ms. Wasylycia-Leis.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

[*English*]

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Madam Chairperson, and thanks to all of you for coming back to our committee.

I want to go to the Patented Medicine Prices Review Board. I think we have lots of questions here. I know you've given some explanation for a doubling of the budget, but it sure doesn't seem to resonate with folks when they see brand-name drug prices going up all the time, drug prices skyrocketing, no controls at all. So I'd love further explanation on a doubling of the budget.

First, I'd like to start with your present mandate and how you're executing it, especially with respect to setting the maximum in terms of therapeutic class. When generic drugs come on the market, it doesn't seem that the brand-name drug companies actually reduce their prices to compete with the generic companies. So it means that the maximum price in the therapeutic class doesn't drop, and it means nobody is getting a break. We waited patiently all these years for the extended and extended again patent protection, and finally generics get a chance to go on the market and there's no change in the brand-name drug prices.

I want to know what you're doing to address the situation. Are you doing anything to restrict this high level of pricing to be only on new brand-name drugs—I know there aren't very many—or new patented drugs coming on the market?

● (1615)

Dr. Brien Benoit: Your comments are multi-pointed, I might say. I know you have an interest in the generics.

Ms. Judy Wasylycia-Leis: I have an interest in getting lower drug prices for Canadians, and we know patent protection has given drug companies a huge lucrative hold on the business, so we're trying to see what we can do to bring it down.

Dr. Brien Benoit: Well, you said the cost of drugs is skyrocketing.

Ms. Judy Wasylycia-Leis: Yes, we just had a study by the Canadian Institute for Health Information that was just reported in Parliament—a huge increase.

Dr. Brien Benoit: The amount spent on drugs in Canada—for you, as an individual Canadian citizen—is the second-highest in the world. The people in the United States spend I don't know how much. We spend roughly $900 per person in Canada on drugs of all kinds—not all prescription, not all patented.

Now, our mandate is to control the price of patented medicine during the 20 years that they are actually protected by patents. Once they go off patent, there's nothing that obliges the patented manufacturer to lower his price.

If he has generic competition, then he is going to lose market share. That's because in most provinces, in the provincial plans, there's mandatory substitution. It's not in all, but there's a lot of mandatory substitution. So if you're under one of the provincial drug plans and you go to your drugstore with your prescription and it says a brand name, the pharmacist is then authorized to give you the generic, which in most cases will cost less.

The only control we have, as the PMPRB, is over generics that have patents.

Ms. Judy Wasylycia-Leis: But you could allow new patented drugs to be priced in at the medium as opposed to the maximum, and that might help.

Dr. Brien Benoit: But if you have a breakthrough drug, I think the last time—

Ms. Judy Wasylycia-Leis: But you said there were very few, so—

Dr. Brien Benoit: They're very few, but the last time we talked in February, you referred to cancer drugs, for example. If you have a drug that's going to cure breast cancer and there's no competitor in Canada, there's nobody that does the same treatment, then we go to the median international—

Ms. Judy Wasylycia-Leis: I hear what you're saying, fine. But if the majority are not breakthrough, why aren't they coming in as a new patent at a medium price, as opposed to the maximum? Why aren't you doing something to offset that, so when the patent comes off there are some lower prices?

Dr. Brien Benoit: Madam, they will never get higher than the highest-priced competitor in the same therapeutic class. So if you have a new drug—

Ms. Judy Wasylycia-Leis: They'll never get lower.

Dr. Brien Benoit: Well, the thing is we don't have the mandate to do that because—

Ms. Judy Wasylycia-Leis: Okay. My time's running out. I've got your answer and I'm not satisfied. I think we should devote a whole session to receiving your latest report to Parliament on the PMPRB.

I would like to know why you're branching out so extensively into generic drugs. You said yourself you deal with patent medicines. You are now engaged in imposing excessive price guidelines on some generic products. You're using the argument that they may be associated with a patent. There are huge concerns in the community about what's going on.

The generic drugs association has written to the minister saying that you're now asserting that you have jurisdiction over any medicine with a patent, including generic medicines with patents that are sold in competitive multi-sourced environments. And then they say that while it's true that a small minority of generic products are associated with patents through process innovations or licence requirements, no price or market advantage can be obtained by a generic patent.

So I want to know why you're doing this, and why you're not trying to include their voices in the consultations. Is this where some of the money is going? Are you branching out, and do you have the authority under the act—under the Patented Medicines Prices Review Board—to actually do this? Has the minister given her consent to this?

● (1620)

Dr. Brien Benoit: First of all, we have not discussed this with the minister. We have a new minister. We've met her, and this has not been part of the original consultation between us.

We are driven and controlled and mandated by the Patent Act. So if a generic product doesn't have a patent, we have no jurisdiction.

Now, it is only recently—and if you were a consumer, Madam, you would be grateful that we're actually doing this—that we have found that many generic products actually do have patents. Some of them are licences from the brand companies; some of them are processing patents, manufacturing patents.

Now, you say that we're not doing our job. We're actually doing our job, we think, fairly well, because we've now undertaken this workload, as directed by the Patent Act, to look at medications that have patents.

The Chair: Thank you, Mr. Benoit.

We'll now to go Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

I will be focusing my comments and questions on Ms. Elinor Wilson and Assisted Human Reproduction Canada.

You had mentioned that it was 30 years ago, of course, when we had the first test-tube baby. I think there's probably not a month or two that doesn't go by without significant developments or stunning news stories. So what are you doing, actually, to keep up with the evolving science? Is that a mandate that you've taken on, and what are you doing in that direction, first of all?

Dr. Elinor Wilson: Thank you very much for the question.

You're absolutely correct. On a daily basis we receive a minimum of 15 newspaper clippings from around the world about new developments and new ways scientists have found to assist people with planning families. This continuously raises medical, moral, ethical, legal, and scientific issues for us.

Certainly one of the mandates under the act for Assisted Human Reproduction Canada is to keep abreast of the new and evolving science. As we move into our licensing responsibilities and as new technologies appear, the board of the Assisted Human Reproduction Agency will have to make some decisions. Is this particular technology ready for what we might call prime time, or is it still in the experimental stages and should perhaps be restricted to fewer places?

One of the ways we've done this is by establishing a science advisory panel comprised of internationally recognized experts in the field, with very broad backgrounds. We have reproductive health clinicians, obstetricians, and gynecologists. We have an embryologist, and people with backgrounds in reproductive biology, social sciences, epidemiology, family medicine, genetics, neonatology, and anthropology. So we've tried to cover the expertise areas that apply to assisted human reproduction.

This panel provides advice to the board, but one of its more important responsibilities is what we call a future scanning process. They've put in place a mechanism to constantly monitor scientific literature. When you see some new development in the literature, it generally takes several years before it actually gets into the hands of people who are doing and utilizing the technologies. So we hope in that time, if it requires new regulations, etc., we'll be able to keep abreast of that.

From a staff perspective, we've recruited a public servant with a strong background in scientific research as our chief science advisor.

Mrs. Cathy McLeod: Good. So that leads me to the next question.

You have a budget of $10 million, and 44 staff members—FTEs. In the absence of regulations, can you tell me a little more? In your brief you talked about what you were doing, but it would help provide clarity. Are there 44 people here, or are they across the country?

Dr. Elinor Wilson: Thank you for the question.

We have two offices. Vancouver is our head office, as determined by Governor in Council, and we have staff here in Ottawa as well. The staff in Ottawa are here because, as regulations are being developed by Health Canada, there is a need to work constantly with Health Canada to ensure that the regulations take into account any possible challenges around their implementation.

As regulations are being developed—for example, in the licensing of clinics area—we also have to develop the internal systems to be able to immediately start to receive applications from the field and issue licences as quickly as possible once the regulations are passed. One of the key activities in the last year and a half has been starting to build that system capacity, so the day the regulations are passed by the government we will have the application form for clinics to start to apply for their licences on our website

In the period leading up to the licensing activities, we have several other responsibilities in the area of outreach. In any regulatory program, the ability to reach out in the field to the parties that are going to be regulated is vital. You need their cooperation in order to regulate and ensure that people follow the rules and report as asked by the government.

So we have done considerable outreach with the medical and scientific community, as well as the patient community. The patient community needs to understand why the act was put in place and how it protects their health and safety. It's not there to get in the way of them being able to have families; it's there to protect their health and safety as they choose to use technologies to do so.

The third major area is producing information for the field. We've started on a major information exchange program. It is reaching patients and professionals, and hopefully it will soon start reaching younger people. We know that the age of pregnancy is increasing in this country, and obesity and STIs are continuing to increase, so there really is a need to educate younger people, prior to them even considering that they might wish to be parents, about some of the challenges in this area.

Those are some of the activities we've been doing.

● (1625)

The Chair: Thank you very much.

Now we'll go to our second round, with five minutes for questions and answers, starting with Dr. Bennett.

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

Although I would very much like to hear the horrible story from CIHR as to how you're having to deal with these cuts at a time when the Americans have put $25 billion into this, I think we just actually have to move on and hope we can be persuasive that this is a hugely important area of investment that needs to be rectified as soon as possible. So we'll just fight for more money for you, instead of hearing the horrible details of what you're having to do with less.

However, in the one area where the budget actually doubled, which is PMPRB, I just don't understand it, other than in terms of the conversation we had about the allegations of mandate creep and the idea that something happened in terms of a climate change or attitude about PMPRB, so that instead of just doing what the board was supposed to do—which was to allow for patent protection and ensure research and development and that the prices not be excessive—there seems to be a new approach, which is to ensure the prices are as low as possible, which then, I understand, creates great problems for our innovative companies to persuade their head offices to invest here.

I understand that the reason there are more hearings, which are the very expensive part of your work, is because not as many cases have been negotiated as in previous years, when there was viewed to be more flexibility, and that this explains the wild increase in your budget.

I also understand that instead of just regulating or trying to maintain a decent national average, you are now drilling down into the averages in hospitals, averages in communities, and you're actually doing a much more granular approach to your job than was intended in the original mandate of the board.

So even though you were able to obtain the money in the supplementary estimates last year, what it looks like on paper is that your budget is doubled. You said the compliance has changed by about 4%. I'm having trouble understanding why your budget is doubled when you're having trouble with compliance. Can you explain where you think the trouble with compliance is? Is it that the people aren't complying, or that your interpretation of compliance is different?

● (1630)

Dr. Brien Benoit: Dr. Bennett, we had a similar conversation three months ago, when I came the last time. You've obviously been well briefed by the innovative patent pharmaceutical industry in Canada, because the term "mandate creep" originates from a document that was provided to you last time we came.

Hon. Carolyn Bennett: The Institute on Governance document.

Dr. Brien Benoit: The Institute on Governance document was paid for by Rx&D, was never published on the Rx&D website, was never published on the Institute on Governance website, and reflects ideas that are at least two years old. The thing was published in April 2008. We were provided with a copy in September 2008, which was supposed to be confidential, but obviously was distributed to members of this committee. I'm not going to defend that document, because it reflects the environment of at least two years ago.

Now, we've been going through a major guidelines revision process, and one of the objectives of it was to address many of the things mentioned in that IOG report. The term "mandate creep" is a total misnomer. We are regulated by the Patent Act, which hasn't changed since 1987. We are regulated by our regulations, which haven't changed since 1994. So for 15 years we have had the same rules to operate under. We're not the ones who have changed—they have changed.

Hon. Carolyn Bennett: Who?

Dr. Brien Benoit: The industry, the pharmaceutical environment. The compliance rate in 2004 was something like 95%. It has now gradually drifted down, and you're going to see it in our annual report, to about 89%. You say it's only 5%, but that 5% may represent many companies, may represent many drugs, each one of which deserves its own investigation.

Now, the drugs in Canada—and you're going to hate to hear this—are the second or third most expensive in the world. Our industry is not suffering excessively. The highest prices in the world are in the United States, which has very few price controls. Recently we were second highest in the world. Now I'm told that we are probably the third highest in the world. We used to be right in the middle. We used to be at the median. We have seven comparator countries. I think you've heard about how this works. Now we are actually slightly higher than the median. We are slightly higher, so we are spending more on our drugs in Canada.

Hon. Carolyn Bennett: But you're spending twice the budget you had before.

The Chair: Thank you, Mr. Benoit.

Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): Thank you.

I have questions in regard to the PMPRB. We last had you here on February 2009. My concern at the time related to the 76% increase, and I had a few follow-up questions to ask. Your comments today lead to more questions.

You mentioned that there was 95% compliance in 2004. In 2007 the annual report said that 22 existing drug products were subject to a hearing, out of a total of 1,114 products. That compliance would be 98%, but you said it was going the other way. If compliance is going down, why was it 95% in 2004 and 98% in 2007? Am I reading those numbers wrong?

● (1635)

Dr. Brien Benoit: I have it before me here. In 2004, the compliance rate was 95.4%. In 2008 it's going to be down to 87.9%, so it's about 90% compliance. You're going to be getting the document soon.

Mr. Patrick Brown: So it's gone down 10% in the last year. The 2007 annual report said it was 98%. So the compliance got better between 2004 and 2007, and then had a huge drop-off in the last year and a half?

Dr. Brien Benoit: I don't know where you're getting those figures.

Mr. Patrick Brown: I'm getting them from your annual report, the 2007 PMPRB annual report, page 13.

Dr. Brien Benoit: In a hearing like this, I can't go looking at the papers every two minutes. Whatever the exact number is, the message I'm trying to convey is that there has been a gradual decline in compliance. This means that we're not the ones who are changing. A gradual decline in compliance means that we have to hire more staff to do the investigations. At the end of the investigations, we don't always find that the price is excessive, but we find that there's something that has triggered it. When we render decisions in our hearings, the pharmaceutical manufacturer is not always the loser.

The thing you have to take away from this is that there's a voluntary compliance. The industry has paid a lot of money back to the federal government, because they have realized that they were outside the guidelines. This amount of money, since the start of this board some 20 years ago, is more than $70 million.

Mr. Patrick Brown: I guess what I'd like to see at some point, then, if it could be provided to the committee, is something showing where there has been a gradual decline. I'm looking at numbers that suggest otherwise, based on what we've been provided. Maybe the 2008 report will shed some light on that for us.

Previously there was a concern raised about patented pharmaceutical products for human use and new active substances that are entering the marketplace. Because of the increased volume, the PMPRB required additional funding. The note I have is that the 2007 annual report actually reveals that the number of products and active substances fluctuates on a yearly basis, but the trend remains consistent. If the number of new substances is actually consistent with previous years, what would be the motivation for an increase?

Dr. Brien Benoit: The number of new drugs requires a full, in-depth investigation right from the outset. However, don't forget that if you have 75 new drugs, last year you had 1,100. So now you have 1,200. The number of drugs that we are mandated to control is steadily creeping up. Each one of these drugs has to get a price review every year.

Mr. Patrick Brown: I'm struggling to understand the 76% increase. Is compliance driving it? Are there other factors you can point to that would alleviate concerns about the size of the increase?

Dr. Brien Benoit: Compliance is one of the reasons our budget increase was necessary, but we are also, as I've said several times, just completing a very long and complicated guidelines review process, which has involved not only public hearings but the issuance of notices of hearings and the evaluation of comments.

We have had meetings with the Canadian generic drug association, BIOTECanada, and Rx&D. We have a committee. We have had five meetings with Rx&D, which is the main innovative organization. All of this is coming to an end in June, so that part of our excessive workload is hopefully going to stop.

● (1640)

The Chair: Thank you, Mr. Benoit.

We'll now go to Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Thank you, Madam Chair.

First of all, I would like to welcome the witnesses, thank them for being here today, and tell them that I sympathize with them because the government has, unfortunately, cut $160 million from the science sector. I realize that the cuts will probably affect them.

I would like to begin with Ms. Wilson. We began a conversation in February, and I would like to pick up where we left off. To my great surprise, not much has changed since February. We met during the committee's initial meetings. Assisted Human Reproduction Canada was still in court against the Government of Quebec, which was challenging the organization's constitutionality. The organization is still mired in that same legal process.

Ms. Wilson, I think it is strange that, during your opening statement, you said that you consulted stakeholder organizations and individuals. You also said that, when you took the job in February 2007, you made it a priority to meet with various individuals and organizations from across the country who represented the interests of parties governed by the Assisted Human Reproduction Act. You also said that you wanted to work with both Canadian and international organizations.

Unfortunately, Quebec has once again been forgotten. The proof is that the Province is challenging the federal government's decision and the constitutionality of your organization in court. You said that you consulted interested individuals and organizations, but did you consult Quebec before setting your priorities and getting started? It does cost $10 million per year, after all. Right now, you are setting priorities and you have 44 employees. I see here that you are thinking of setting the agency up in Vancouver, transferring the head office there, but you are still where you were in February. The case with the Government of Quebec is still before the court. You are still spending $10 million per year, and everything is going well, you have no problems, you have 44 employees. Yet, you have no idea whether the Supreme Court will rule in your favour or in favour of the Government of Quebec, which has a strong position. In my opinion, which is also the opinion of the Province of Quebec and its ministry of health, your organization's activities encroach on Quebec's jurisdiction.

We started talking about this last time, but we did not have time to finish our conversation. I would like to know how you see things working out given that the case with Quebec is not yet resolved. Do you have a plan B in case the Supreme Court does not rule in your favour? What will you do with the money that will have been spent? Have you come up with a way to compensate Quebec if the court does not rule in your favour?

[*English*]

The Chair: Dr. Wilson.

Dr. Elinor Wilson: Thank you, Madam Chair.

Thank you very much for the question. Perhaps I could start with some of the factual information.

We are not moving our office to Vancouver. It was situated in Vancouver by Governor in Council and that was done before the agency was brought into being and before the board was appointed. And yes, when fully staffed we have a complement of 45. At the moment we have 22 people; 15 are civil servants and the rest are consultants or part-time through temporary help services. We are staffing to correspond to the regulations coming into force.

The third factual piece that might be helpful is that, yes, our budget is $10.2 million, but since the beginning of the agency, last year, for example, we spent $5.7 million of that $10.2 million.

In terms of the federal government and the Supreme Court, I would ask, with all due respect, that this question be addressed to the department, because it is the Government of Canada's and the department's question in terms of the Supreme Court and its ruling. We are all awaiting with great interest the decision of the court. Once that decision comes, then the Government of Canada will take it under advisement and make decisions from there as to progress.

● (1645)

The Chair: Thank you, Ms. Wilson.

Ms. Davidson.

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

Thanks to our panel with us this afternoon.

I'm going to ask my first question to Ms. Watts, please.

In your presentation to us, you talked about 2007-2008 being a year of change and transition. And then you also talked about the claims processing backlog of approximately two years and the 95% non-compliance issue and all those issues. Then you talked about your determination to eliminate the backlog over the three-year period. You went on to say you had received the transfer of funds from Health Canada and you were pleased to say you were on target. And it's great that you are on target.

What are the key changes to the claim process that are going to allow you to keep this backlog at bay? What's going to allow you to keep things caught up?

Ms. Sharon Watts: Thank you for the question.

That's an excellent question, one that I can assure you our stakeholders have posed several times. Certainly one key factor in tackling this backlog situation has been the core, labour-intensive part of that work, which is the people. In terms of recruiting and retaining the calibre of people who can tackle this work and get it out the door quickly, that was our number one priority.

The number two priority was getting those people up to speed, because I'm sure everyone is aware that you can bring someone in on day one, and depending on the job, it can take up to a year to get that person up to speed and productive. We put our minds to making sure that wasn't going to happen. From our own staff, we produced a training and orientation program, from the grassroots, which ended up cutting our training time from about nine months down to two months. So when we get a scientific evaluator on staff now, as we did when we first received this funding, we have them up to speed and producing advice documents to our screening officers within two months. That's something that will grow with us. That's something that, as we experience turnover, as all agencies do—and certainly in small agencies it's far more disruptive—we can now live with and ensure that the turnover and the productivity we've seen will continue with us.

The other thing I'd like to mention in the context of the backlog—and I talked about compliance, I talked about risk—is that there are a couple of risk mitigation measures we've taken to make sure that.... Notwithstanding our great productivity rates, there are still claims coming in the door that may have highly hazardous substances in them that are incorrectly identified. So we have a prioritization scheme at the commission that weeds out those high-hazard claims immediately upon receipt and puts them to the front, even if there are other claims in the backlog that we've committed to eliminating. Those high-hazard claims are always done first and foremost, and that information is expedited back to the claimant and eventually back to the worker.

Another means by which we're trying to manage the backlog is in doing some voluntary compliance work. That's a term that's maybe overused. We're starting to see some actual results, where we've put together a checklist for our claimants that tells them those kinds of errors we often see and they can easily correct without having us go through and send out an order. So when their claim comes in, if they haven't already used the checklist, we'll send it right back with the checklist and say, “Have a quick look at this. Look at what you can do before we start to review this.” About 70% of the cases are using the checklist. It's coming back, so that should be diminishing the number of errors we see and therefore diminishing the amount of time it would take us to work on that backlog.

The last thing we're doing is something we're quite proud of: we're getting with the program in terms of electronic data management. One might think maybe we should have done that long ago, but we work with confidential information and we're very concerned about ensuring the confidentiality. So it was with reticence that we embarked on an electronic data management system. We have that, and we're just in the process of implementing it. This will allow our evaluators and our screening officers to have access to documents literally at the push of a button without poring through literature studies and CAS files and toxicity profile summaries that are piled up on people's desks. This is going to make their jobs go a lot faster.

Thank you.

● (1650)

The Chair: Thank you, Ms. Watts.

I will now go to Ms. Murray.

Ms. Joyce Murray: Mr. Roberge and Mr. Tibelius, I want to understand a bit more. You gave us some answers, and I just need to be able to picture what is happening with the CIHR. You mentioned a couple of projects that won't be funded any more: the open team grant program, and the intellectual property mobilization program. Can you describe the kind of research that we will not be funding because of the cuts, which, if I factor in inflation, are more like $22 million than $4 million? Clearly this is significant. What kinds of work that would have been done aren't being done?

Mr. Karl Tibelius (Director, Targeted Initiatives, Research Portfolio, Canadian Institutes of Health Research): The open team grants could cover almost any type of research. It's an open competition, so it could be in any area you can think of—cardiovascular or genetics or cancer or whatever. But those areas could still be covered by our strategic team grant program, so it doesn't mean that there won't be continued team grants in those areas.

Ms. Joyce Murray: So “team grant” means it's crossing disciplines, or there a few people who are applying?

Mr. Karl Tibelius: Yes, exactly. It's a group of researchers, often from different areas. It's interdisciplinary or multidisciplinary researchers coming together to work on a single project.

Ms. Joyce Murray: Okay, so the whole basket of team grants programs has shrunk, but the strategic ones are where the money is focused and the open ones are not.

Mr. Karl Tibelius: That's right. So now our institutes decide what the priorities should be for research, and they fund team grants in those areas.

Ms. Joyce Murray: Are you aware of research teams, like the one that was in the media a week or two ago, that are now eyeing that huge funding increase for research in the United States? Are we at risk of losing more of those teams?

Mr. Karl Tibelius: The teams that would have been funded under the open grants program could still apply for the strategic ones, if they're in the right areas.

Ms. Joyce Murray: Yes, but there are fewer altogether, so presumably compared with last year, some teams will get a no that last year would have gotten a yes.

Mr. Karl Tibelius: A few of these teams are rolling off their grants each year, so it's not as if it's one mass of 200 researchers all at once. There are just a few each year coming off their grants, and they will probably be able to find opportunities either in the strategic team grants or in what we call our main operating grant program, which is our biggest program and which can also fund teams of individuals.

Ms. Joyce Murray: So if the criteria as set in Treasury Board are whether something is relevant, efficient, effective, and meets the mandate of the organization, do the cuts you are applying affect research that, if you had more money, you would fund? Or do they involve research that was simply not effective or poorly done or whatever?

Mr. James Roberge: In terms of the IPM program, that was viewed as a program that was no longer effective. It was intended originally to be a catalyst program to encourage universities, particularly smaller universities, to establish tech-transfer offices.

● (1655)

Ms. Joyce Murray: I don't know what an IPM program is.

Mr. James Roberge: Sorry, it's the intellectual property mobilization program.

Ms. Joyce Murray: So can you just explain what that is?

Mr. James Roberge: It was a small program—$2 million—and it was designed several years ago with the other two granting councils to encourage particularly small universities to establish tech-transfer offices so they would manage IP at the location of the university. That was in an era when there were very few other supports available for universities. The indirect cost of the research program had yet to be established, and some of the other programs have been developed, both federally and provincially, since then.

So our view was that the tech-transfer offices had been largely put in place and that the ongoing requirement for the program was not nearly as strong as it had been when it was first envisioned.

In the case of the open team grant, we believe team grants are the way to go in terms of multidisciplinary research. For the open team grant, through evaluation, we found that in many cases the work environments that were already functioning extremely well were the most successful in that program. We were missing out in areas where we had weaknesses that we wanted to target. So the view was that a strategic team grant was a better instrument overall for CIHR.

Thank you.

The Chair: Thank you, Mr. Roberge.

We're now going to go to Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Thank you, Madam Chairperson.

This is for the CIHR. I would like to hear what you think the ripple effect of this cutback might be. It's not concerning you as a body per se; it's the effect on so many different researchers and organizations around this country. Have you estimated the ripple effect?

Secondly, can you tell me whether something like the Canadian Research Data Centre Network, which you have funded now or will fund till 2010, will be guaranteed funding from CIHR, given this current fiscal restriction?

Mr. James Roberge: I will answer your second question first, on the research data centres.

You are correct that our MOU or agreement with those centres and Statistics Canada will be expiring during the course of the year, and we are currently looking at a renewal of that grant. However, it has not been approved yet, so I can't speculate. All I can say is that it's not part of strategic review. It's not counted as part of that; it's just a regular business decision for CIHR.

As for the ripple effect, it's extremely difficult for us to really know whether there will be any ripple effect, in the sense that a lot of things depend on there being or not being future budget year increases. It's really difficult for us to know whether there will be significant effects.

This year's reduction, as I mentioned at the outset, is extremely modest. It is $1.5 million. That, in and of itself, is not likely to have an impact.

We mentioned before that the open teams are going to continue, probably until about 2012, but they will not be renewed under that program, as that program is terminated. So the impacts will be felt in that year; however, there may be offsetting budgetary increases—who knows?—that may allow us to mitigate them. We don't know; it's speculation, of course.

Ms. Judy Wasylycia-Leis: Thank you.

Dr. Benoit, when is your next annual report coming out? What's the date?

Dr. Brien Benoit: We pass it to the Minister of Health on May 31, and it goes to Parliament shortly thereafter, so there's not long to wait.

Ms. Judy Wasylycia-Leis: You haven't really accounted for a doubling of the budget on the basis, you say, of a lack of compliance. To double the budget, you must be facing a heck of a lot of misdemeanours from brand-name drug companies. Why are they doing this? What happened in 2006, that there was suddenly this huge jump? You say gradual, but I'm saying huge, because if your budget doubled, then something dramatic has to be happening in terms of compliance, because your major role is to deal with pricing of patented medicines.

Dr. Brien Benoit: Madam, you're right; 2006 was the year in which the environment changed. But don't forget that some of the increase in our budget relates to this guidelines review process, which is coming to an end.

Ms. Judy Wasylycia-Leis: Right, and part of that guideline review process is branching out into an area that seems to be somewhat extraneous to your mandate and has to do with generics.

I'd like to know why, if your main mandate is to deal with patented medicines, two of the eight hearings you've set up on guidelines on excessive pricing are devoted to generics.

● (1700)

Dr. Brien Benoit: Madam, obviously you've been lobbied by the Canadian Generic Pharmaceutical Association, but here's my answer.

Ms. Judy Wasylycia-Leis: Obviously I have concerns on behalf of Canadians about what you're doing, as a body that reports to the Government of Canada, about getting our patented medicine prices down. I don't see any evidence of that, and it's up to you to tell this committee how, where, and when they're coming down.

Dr. Brien Benoit: First of all, I'll say again, we do not have any control over most generic products.

Ms. Judy Wasylycia-Leis: Then why are you spending two hearings out of eight, if it's just a small amount?

Dr. Brien Benoit: Because if you were a consumer in Canada and knew the technical details related to those two hearings, both of these drugs—and I don't have the file before me—have patents. Our staff have reviewed those prices and found them to be outside the guidelines.

The result of the hearing cannot be predetermined, because the manufacturers will present their experts, and our staff will have their experts, which will help determine the real issues here.

You're correct; there are two—

Ms. Judy Wasylycia-Leis: Two of eight, so that's one quarter of your hearings on generics, when your main mandate is patented medicines.

Dr. Brien Benoit: Yes, ma'am. Our mandate is to protect the Canadian consumer.

Ms. Judy Wasylycia-Leis: And your compliance issue is with respect to brand-name drugs. So how do we understand this proportionality in terms of expenditure of resources? Are the brand-name drug companies coming to you and whining that the generics are getting too much control or too much influence? What is it?

The Chair: Our time is running out. Could you answer very briefly?

Dr. Brien Benoit: Obviously your last comment is probably correct.

Ms. Judy Wasylycia-Leis: They're whining. Thank you.

The Chair: Thank you, Mr. Benoit.

Dr. Carrie, please.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

I want to thank all the witnesses for being here today.

I apologize that I had to step out, if the question has been answered already. I have a couple of questions, but I think most of my questions have already been answered.

In the information given to committee, AHRC noted that $350,000 was spent on travel last year. Where did that travel number come from? We are doing the estimates. Do you consider it to be high, to be average? Is that $350,00 going to be ongoing?

Dr. Elinor Wilson: Thank you very much for the question.

First, let me say in terms of travel that there are several things. We have a national board of directors that is mandated to meet at minimum twice a year and we have a mandate for stakeholder outreach.

Over the course of the last year, travel costs were incurred obviously for the board meetings. Secondly, we facilitated the bringing together of patient groups and professional groups to share best practices, to identify issues of common concern, and in some cases to develop standards and guidelines that help to direct their practice.

The third area is staff having been invited to major meetings of the professionals in Canada, to do workshops on the act and on what will be expected of them under the act as the regulations come into place. We've also done outreach to many clinics that have invited us to come to speak to their staff.

The last part of that outreach is that I and the chairperson of the board have been invited to present at both national and international meetings about the work of the agency and to provide information on its future direction.

Mr. Colin Carrie: Thank you very much. I appreciate this.

AHRC is forecasting, in the main estimates, spending about $10.5 million. Have you ever spent that amount before? Where is that number going?

Dr. Elinor Wilson: Thank you very much again for the question.

The allocation we have in the main estimates is for $10.5 million ongoing. That was set by Parliament several years ago.

Obviously our intention is to be operational as quickly as possible. But you are quite correct; up to this point we have not spent our total budget, because, as I mentioned earlier, we are trying to gear up and staff up based on the regulations' being released and announced by the government. We are very hopeful that over the next year we will be able to start hiring the rest of our staff and have our full regulatory program in place, at which time we will need the full allocation. We monitor this on a quarterly basis. Obviously we'll know better, as we get into the year, what lies ahead.

● (1705)

Mr. Colin Carrie: Thank you very much. I like hearing cases in which a government agency doesn't spend its full budget. That's a good-news story—by my standards, anyway.

Madam Chair, those are all the questions I have. Thank you very much.

The Chair: I want to thank the witnesses for coming in.

Hon. Carolyn Bennett: Madam Chair, you said we'd keep going until 5:15.

The Chair: I know, but let me finish what I'm saying. Mr. Uppal has kindly given up some of his time, because we have some committee business that has to be done and a few issues we need to work through. I didn't want to keep the committee for extra time.

Hon. Carolyn Bennett: I think this would be the choice of the committee, Madam Chair.

The Chair: I'm about to do that, Dr. Bennett, if you would give me two minutes.

Hon. Carolyn Bennett: No, we wanted to keep asking questions until 5:15. That was the consensus.

The Chair: I want to hear what the committee has to say.

Hon. Carolyn Bennett: Well, you've just heard from me.

The Chair: I know I did.

I want to say quite categorically that we have business to do that has to do with our witnesses and with our trip. At this time I'll ask for the will of the committee. We have ten minutes in which we could still ask questions, and I will be very tight on the time.

At the will of the committee, who would like to continue with questions? Three.

And who would like to go on with committee business? Four.

Can we try that again? I didn't see the hands. Who, as the will of the committee, would like to continue asking questions? Five.

Okay, we'll continue with questions, but I'm going to stop right on the dot at 5:15.

We will start with the same list of people.

Mr. Patrick Brown: Madam Chair, on a point of order, if we're continuing with questions, shouldn't it be the Conservative spot next?

The Chair: It is going to be, yes. We need to have—

Hon. Carolyn Bennett: You did the last question.

The Chair: We have one more from the Conservative side. Who would like to go first?

Ms. McLeod.

Mrs. Cathy McLeod: Thank you, Madam Chair.

I'll direct this question to the PMPRB. You appeared before the health committee in the winter of 2009 regarding the supplementary estimates and indicated that similar to the additional funds awarded in the main estimates, a significant increase in the workload had produced a need for more funds. However, the main estimates for 2007-08 awarded the PMPRB almost $11.5 million, while the main estimates for 2006-07 only awarded $6.5 million, and you were then given an additional $4.5 million in the supplementary estimates.

So could you clarify this for me? The way I'm reading this is that perhaps rather than having a dramatic budget increase between the main and supplementary estimates, you have actually been relatively stable over time.

Dr. Brien Benoit: Yes, that's correct. We have been relatively stable.

The two reasons for our recent increase are the increased workload relating to compliance, and also the increased workload relating to this revision of our guidelines, which we hope is going to correct some of the compliance issues.

Mrs. Cathy McLeod: So, indeed, in order for you to do your job appropriately according to the mandate of the PMPRB, you've required funding in the $10 million to $11 million range each year for the last few years then?

Dr. Brien Benoit: That's correct.

Mrs. Cathy McLeod: Okay, thank you. For some reason, it's something that really stood out.

I guess my next question will be for Sharon Watts. I remember the old days when WHMIS came out and everyone went for training, and you had your MSDS sheets and your product labelling. Can you tell us how things have dramatically changed since those days in terms of who's doing what and in terms of training? What's happened over these last 10 to 15 years in terms of what the process is?

Ms. Sharon Watts: Thank you for the question.

In fact, it's been 20 years. It was in 1988—on October 31—that WHMIS first came into being, and that's when we were created as the commission to look at trade secrets.

I would say to you that not much has changed in terms of the fundamental system, which I think is a wonderful thing. The fundamental right of workers to know about the hazards they're working with and industry's right to protect their trade secrets have remained fundamental cornerstones of the WHMIS system.

What has changed is global harmonization—multinational companies and the need for Canada to keep up with what the other countries are doing. So in the last ten years we've been working with other countries—and domestically—in looking at the global harmonization of hazard classification, and have been inching forward towards bringing that to fruition and being able to incorporate those new harmonized standards into the new WHMIS standard. So of course, by extension, our commission will then adopt those WHMIS standards to apply to our claimants.

But other than that, I think technology, as with all things, has made everyone's job in compliance a little more challenging.

● (1710)

The Chair: Ms. McLeod, do you want to continue—or Mr. Uppal, as you're back now after giving up your time?

Okay, go ahead, Ms. McLeod.

Mrs. Cathy McLeod: Then of course you have probably computerized your process for the whole....

Ms. Sharon Watts: Yes, we have. Certainly the advent of technology has very much helped our own ability to receive claims for exemption. It used to be only a paper process. I doubt if the committee will remember every detail of the regulations that we brought before you, but one of those provisions was to allow for the interactivity of claims for exemption to come forward in a computerized fashion, as long as we had security measures to back that up.

I guess the other wonderful thing that's happened is that we can reach out and touch our claimants, literally in seconds, because of our new website and the technology. It's challenging for us, because as soon as we've made a change or as soon as something happens on someone's claim, they're back to us in a second.

The Chair: Thank you, Ms. Watts. I'm sorry to interrupt, but I'm trying to keep to the time.

Dr. Bennett.

Hon. Carolyn Bennett: Thank you very much.

Ms. Wilson, this committee has only seen one group of the regulations. I think it's chapter 8. By some people's analysis, there are a number of chapters that would not be subject to the present Supreme Court challenge.

Are you aware of regulations we could be receiving that in your analysis wouldn't be subject to the Supreme Court? Could you list the areas you think wouldn't be subject to the Supreme Court challenge, and could we see them? Are you already preparing for those you've seen? And if not, if you haven't seen them, is that the reason for the reduction in your funding?

Dr. Elinor Wilson: Thank you very much for the question.

As was mentioned earlier, we do not develop the policy or the regulations. However, our staff works very closely with the staff at Health Canada who are developing the regulations to ensure that any considerations around implementation are taken into account as those regulations are developed.

In terms of what is currently on their plate and what they're doing, with respect, I would ask that you might refer that question to the departmental officials when they appear, because it's not our piece to speak about.

Hon. Carolyn Bennett: Okay.

Dr. Elinor Wilson: Thank you.

The Chair: We're pretty well out of time. It's 5:15 right now.

We're going to go in camera now for our committee business.

I want to thank you so much for coming to our committee. This is a very good committee and we're happy to have all your input. Thank you.

[*Proceedings continue in camera*]

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