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Monday, November 30, 2009

Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Welcome, everybody, to the Standing Committee on Health. We are delighted to have our witnesses here today, pursuant to Standing Order 108(2), a study of chapter 4 of the Auditor General's 2009 fall report on electronic health records. We have with us Sheila Fraser, Auditor General of Canada. Welcome. Everybody knows your face and your reports.

Some hon. members: Oh, oh!

The Chair: So we have a celebrity with us today.

Neil Maxwell, assistant auditor general, we welcome you. Louise Dubé is the principal, and we welcome you as well. From Canada Health Infoway, we have Richard Alvarez, president and chief executive officer. Welcome, Mr. Alvarez. We also have Mike Sheridan, chief operating officer of Canada Health Infoway.

So we will begin. We'll start with Mrs. Sheila Fraser.

Ms. Sheila Fraser (Auditor General of Canada, Office of the Auditor General of Canada): Thank you, Madam Chair. We thank you for this opportunity to present the results of our audit on Canada Health Infoway Inc., which were included in our November 2009 report. As you mentioned, I'm accompanied today by Neil Maxwell, assistant auditor general, and Louise Dubé, principal, who were responsible for this audit.

Infoway was created in 2001 as a not-for-profit corporation at arm's length from the government. It describes its role as that of a strategic investor that works with the provinces and territories to foster and accelerate the development and adoption of electronic health records, EHRs, across Canada.

[*Translation*]

Electronic health records are intended to offer solutions to a number of persistent problems in Canada's health system, some of which can be attributed to the use of paper-based health records. With EHRs, it is expected that health care professionals would be better able to share patient information.

It is anticipated that this could result in reduced costs, improved quality of care, and lives saved. As of 31 March 2009, Infoway had spent close to $615 million and had committed another $615 million on electronic health records, for a total of $1.2 billion.

But it is still in its early days. Some experts have estimated the total cost of implementing EHRs Canada-wide at over $10 billion. We examined how Infoway manages the funds from the federal government to achieve its goal of making compatible electronic health records available across Canada.

Concurrent with our audit, six provincial audit offices audited how electronic health records funded by Infoway and/or provincial governments are being implemented in their respective provinces. The provincial audit offices are each reporting separately and we will table a summary of the federal and provincial audits next spring.

[*English*]

Overall, we found that Infoway has accomplished a lot since its inception and that it manages well the $1.2 billion in funds granted by the federal government to achieve its goal. There is good oversight of the corporation by the board of directors and Health Canada, the sponsoring department. Infoway has set the national direction for the implementation of electronic health records by developing an approach, as well as the key requirements and components of an electronic health record. It developed a blueprint, or architecture, for the design of the systems, and it developed strategic plans and a risk management strategy. Infoway worked collaboratively with, and obtained buy-in from, its partners and stakeholders, which is critical to the success of the initiative.

We also found that Infoway approves projects, which it cost shares with the provinces and territories, that are designed to comply with standards and align with the blueprint. We noted that Infoway adequately monitors the implementation of projects by provinces and territories.

We reported that Infoway needs to improve in certain areas. Infoway's 2010 goal is for 50% of Canadians to have electronic health records available to their health care professionals. We found that Infoway needs to report more information on results, in particular information on progress achieved toward its 2010 goal. To date, it only reports if systems are completed, not whether the systems are actually being used by health care professionals or whether completed systems meet the requirements for compatibility. This information on systems usage and compatibility would help Parliament and Canadians better understand progress to date.

● (1535)

[*Translation*]

We also found that Infoway approves projects, which it cost shares with the provinces and territories, that are designed to comply with standards and align with the Blueprint. We noted that Infoway adequately monitors the implementation of projects by provinces and territories. We noted that Infoway's controls over executive pay, travel, and hospitality are basically sound, although it could improve its contracting policy. Infoway has made a significant contribution to the development and implementation of EHRs, but important challenges remain. Reaching the goal of 50% of Canadians having an EHR available to their health care professionals by 2010 will be very challenging because they are only at 17% now.

Other challenges include upgrading legacy systems to ensure compatibility, ensuring that electronic medical records are used by primary care doctors, ensuring the compatibility of systems designed to allow patients direct access and control over their personal health information, and ensuring the privacy and security of personal health information. These challenges also need to be addressed by the provinces and territories.

[*English*]

Madam Chair, we are pleased that Infoway agreed with our recommendations and that it is developing an action plan. It has committed to clarifying its goal, to reporting additional information on progress achieved, and to revising its contracting policy. Because significant funds are spent on this initiative to implement electronic health records across Canada, and because the potential benefits offered by electronic health records are important to Canadians, this committee may wish to devote continued attention to the initiative by following up on progress achieved against the goal and against Infoway's action plan.

Madam Chair, this concludes my opening statement. My colleagues and I would be pleased to answer any questions that committee members may have.

The Chair: Thank you, Mrs. Fraser.

We'll now go to Richard Alvarez from Canada Health Infoway.

Please go ahead, sir.

Mr. Richard Alvarez (President and Chief Executive Officer, Canada Health Infoway): Madam Chair, thank you for this opportunity to be invited here today for the presentation of the results of our recent audit by the Auditor General of Canada. With me today is Mr. Mike Sheridan, our chief operating officer.

I want to start by complimenting the Auditor General and her staff for what we believe is a thorough, balanced, and transparent audit conducted on Canada Health Infoway. Being an organization that strives for continuous improvement, we believe the implementation of the auditor's recommendations will strengthen Infoway.

The Auditor General pointed out in her November 3 news release that Canada Health Infoway has accomplished a lot since its creation. Needless to say, as its CEO I'm quick to agree with that, but I'm also quick to state that a lot more needs to be done.

Across Canada today, every province and territory and the populations they serve are benefiting from a share of the federal government's investments through Infoway in new information systems that will help transform health care. For example, our investments have helped eliminate three-quarters of X-ray films and replaced them with digitized images. The images are cheaper to produce, easier to store, and can be accessed by health professionals in various locations. Most importantly, they can be used to diagnose and help patients thousands of miles away in the remote and rural communities of our country. Today, as many as 40% of radiologists are now reporting on providing services in new or remote sites, eliminating anywhere between 10,000 and 17,000 patient transfers each year.

Leveraging Infoway's investments, drug information systems are now in place in B.C., Alberta, P.E.I., and Saskatchewan. Today, PharmaNet in B.C. captures every prescription dispensed in pharmacies and provides alerts to pharmacists and some physicians. For example, in 2008 more than 55 million prescriptions were processed via PharmaNet in British Columbia. Of those, 2.5 million significant drug interactions were identified. When you project that across Canada, this suggests that drug information systems could reduce about 55 million inappropriate prescriptions and identify more than 20 million significant drug interactions each year. In terms of lives saved and injuries prevented, that is hugely significant.

In Alberta, 20,000 authorized health care providers are active users of the electronic health record. Having the EHR in place has enabled Alberta to begin essential chronic disease management systems, like the management of diabetes.

The investment Infoway is making in the area of telemedicine is making a substantial impact in Canada, especially in the north, where all communities north of 60 are telehealth-enabled or are getting there. We're also on track to get 40% of first nations communities telehealth-enabled, with a focus on mental health and drug addiction services.

The Auditor General has quite correctly defined some of the challenges in making electronic health records available for 50% of Canadians by December 2010, and of course their subsequent use by health care professionals. I want to be clear that without the availability of these systems, use cannot and will not happen. It really is a two-stage process. Our jurisdictional partners are building and implementing the core system solutions for the electronic health records.

Developing such health information systems is very similar to constructing a home or a building. The building has to be available before tenants can actually move into the space, occupy it, and use it as it was designed and intended. In this joint initiative, as the Auditor General has so astutely noted, Infoway can move only as quickly as our jurisdictional partners are able. The jurisdictional deputy ministers of health have told me they are committed to making their best efforts to meet the December 2010 target of 50%. Again, I need to be clear: I believe it will be a challenge.

Infoway has accepted the Auditor General' s eight recommendations. We have completed an action plan for each of the recommendations, have shared the plan with the Auditor General's office, and have received extremely useful comments. It's our intention to file the action plan with this committee and with the public accounts committee by mid December, following a review of that action plan by my board this week. We intend to have the Auditor General's recommendations fully implemented during the next year.

In closing, I would like to say that while we remain committed to our ambitious call to action target of 50%, I do believe that we have a bigger challenge emerging, especially if we need to start equipping our community clinicians with electronic medical records to increase the use of the investment to date.

● (1540)

The time, Madam Chair, doesn't allow me to explain the difference between electronic medical records and electronic health records. However, the auditor's office has done a wonderful job in chapter 4, paragraph 4.4, which explains the difference.

Let me say that in a recent Commonwealth study of primary care in 11 countries, Canada had a deplorably poor showing. In an example from the study, Canada is last of 11 countries on doctors in communities using EMRs. We're second to last of 11 countries on routinely sending patients reminders for preventative or follow-up care. And we're second to last of countries where the practice routinely receives and reviews data on patient clinical outcomes.

These basically add up to one conclusion, as the Auditor General has said in her report:

> Unless the percentage of primary care doctors using electronic medical records (EMRs) increases significantly, the potential benefits offered by electronic health records (EHRs) will not be fully realized.

As a country, we really do need to take the next logical step and focus on the implementation and broad adoption of the use of EMRs.

Madam Chair, that concludes my remarks.

Both myself and Mr. Sheridan would be delighted to take questions.

The Chair: Thank you, Mr. Alvarez. I appreciate that.

Before we go into questions, I want to introduce a new analyst, Marie Chia. She will be joining our health committee, and we do welcome her here today and look forward to having her work with us.

We'll now go into our first round of seven minutes, questions and answers, beginning with Dr. Bennett.

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

Can you let me know the dates of the audit, the period of time you were in the field for this?

Ms. Sheila Fraser: Madam Chair, our audit focused on the 2006-07 and 2007-08 fiscal years, and the audit work was substantially completed on April 30 of this year, 2009.

Hon. Carolyn Bennett: In this last budget, Infoway was given $500 million. It is noted in paragraph 4.105 in your report that there is no funding agreement yet for this amount. Is that the case as we sit here today?

Ms. Sheila Fraser: I'm not aware of that, but Mr. Alvarez would probably be able to answer.

Mr. Richard Alvarez: Yes, that is the case. At this stage, the money hasn't flowed.

Hon. Carolyn Bennett: Maybe from the Auditor General's point of view, do you think that is normal, that from a January budget, 10 or 11 months later there would be no funding arrangement put in place for something that clearly saves lives?

● (1545)

Ms. Sheila Fraser: I really don't know the reasons why that has not flowed out to Infoway. Perhaps Mr. Alvarez knows. But no, it would not be unusual to see very long delays between a budget announcement and the actual issuance of funding. This has occurred in other situations.

Hon. Carolyn Bennett: But within a government department to an arm's-length agency, surely that.... This money didn't have any particular designation. It was a free $500 million to Infoway. What kind of trouble could one have in negotiating that?

Ms. Sheila Fraser: I could only say there was a budget announcement, but after that, of course, it has to go through all the process of funding submissions, of approvals by the Treasury Board, and on and on. And it depends, obviously, on the speed with which departments move this through.

Mr. Alvarez may know some of the reasons that—

Hon. Carolyn Bennett: The trouble for those of us on the committee is that everything we've said is accelerate, accelerate, accelerate. And certainly, from the Conference Board study that showed we would save $6 billion in the health care system in Canada, to the people who had wanted to testify today from the medical association, to the health care associations, pharmacists, nurses.... Even on H1N1, the Canadian Nurses Association cited the lack of the transfer of the $500 million as being problematic in terms of moving the system.

I guess I am concerned as to what could be the hold-up when that's as important as it seems to be to everybody we talk to.

The Chair: Who would like to comment on that?

Mr. Alvarez.

Mr. Richard Alvarez: Madam Chair, I should say that the specific reasons are still unclear. Having said that, in the government's third report on the economy to Canadians, the $500 million was marked with an asterisk, which basically indicated “due diligence”.

To be perfectly honest, given some of the scrutiny that has been placed on eHealth Ontario, it's hardly surprising that any government would want to do further due diligence on an organization like Canada Health Infoway, although we're not in the same business as eHealth Ontario. That said, the auditor's report basically speaks for itself. It came out early this month, and I hope the government will take that into great consideration as part of their due diligence.

Hon. Carolyn Bennett: What does the asterisk usually mean in terms of due diligence?

Just to make it clear to everybody, did Infoway give any money to eHealth Ontario?

Mr. Richard Alvarez: Let me answer your last question first. The answer is no. We didn't give any money to eHealth Ontario. We don't even have a contract with them. We have a contract with the ministry.

The funding model that Infoway employs is a funding model that basically pays for results. If you don't get results, you don't get the federal funds.

We've had some terrific results in Ontario, such as the diagnostic imaging systems I've talked about, and certainly such things as having the drug systems for seniors available in emergency centres, as well as many good telehealth systems. We did fund those systems and we did get results.

In terms of the asterisk, we read the report, which said due diligence was being conducted. I would hope that part of that due diligence is what the Auditor General of Canada was doing, and I hope the government will take that into consideration.

Hon. Carolyn Bennett: So to get the clean bill of health to say that you've accepted the recommendations of the Auditor General and will put in place an action plan, what are you now in negotiations with to get that asterisk removed and the money to flow?

Mr. Richard Alvarez: We're really not in any negotiations, so to speak. The government did allocate this money in their budget. Based on some of the goings on, certainly in Ontario, we suspect we were put under due diligence. For the last 18 months, the Auditor General has been conducting a major report. As I've said before, we certainly hope the government takes the findings into consideration, and the fact that—

● (1550)

Hon. Carolyn Bennett: Can you maybe go even further to explain what kind of stimulus an investment in eHealth can be in terms of an economy? I think you gave a very impressive presentation in the pre-budget consultations, as substantiated by the Conference Board. Can you explain?

Mr. Richard Alvarez: As part of our submission, we brought forward a report that was done by the Conference Board of Canada, which says for every $100 million, 1,500 knowledge worker jobs are created in this country; that for every dollar spent, the GDP is increased by $1.34. These are knowledge worker jobs that are dedicated to the digital economy, which Canada hopes to become. And there are many other economic numbers in that report that are exceedingly positive.

The Chair: Thank you, Mr. Alvarez.

We'll now go to Monsieur Dufour.

[*Translation*]

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

I want to thank the witnesses for being here today. I mainly want to thank Ms. Fraser because I know her time is extremely important.

Thank you very much.

In your statement, you talked about Infoway's goals. I'm going to read a quotation:

> By 2010, every province and territory and the populations they serve will benefit from new health information systems that will help transform their health care system.
>
> By 2010, 50% of Canadians and, by 2016, 100% will have their electronic health records available to their authorized health care professionals.

This leads me to ask you the following question. In your opinion, have the provinces received enough money to date to achieve the goals set out for Infoway by 2010?

Ms. Sheila Fraser: Madam Chair, that's perhaps a question that Mr. Alvarez could answer. We don't audit the provinces. I don't believe our auditor colleagues in the provinces look at that issue in their audits. We can simply look at management of the funds that have been allocated to Infoway.

[*English*]

The Chair: Again, we'll go to Mr. Alvarez.

Mr. Richard Alvarez: *Bonjour.*

Let me give my response in two parts.

I said this is very similar to building a house. You have to have the house built and available and then you can sell it and it can be used. So in terms of having the house available and the systems for 50% available, the answer is yes. The provinces have enough money.

Do they have enough money for the use? The answer is no. To incent use, which involves a lot of training and change management, we are going to need more money. And that was part of the $500 million.

One of the incentives for provinces is not just building it but making sure that people come and use it. So use goes hand in hand with construction.

[*Translation*]

Mr. Nicolas Dufour: Thank you very much.

The following passage in the Auditor General's report is interesting. It reads as follows: Some experts have estimated the total cost of implementing EHRs Canada-wide at over $10 billion, and Infoway concurs.

To date, the federal government has invested $1.2 billion in Health Infoway. If it didn't invest the amount the experts have estimated by 2016, would the project risk being compromised?

[*English*]

The Chair: Go ahead, Mr. Alvarez.

Mr. Richard Alvarez: The answer to that would be no. In the federal government, part of the model of Infoway is that for every dollar the federal government invests, we leverage that dollar with a provincial dollar; if $1.2 billion is invested by the federal government, then rest assured that about $2.4 billion is being spent, because that's been leveraged.

Part of the use of these systems is the electronic medical records in physicians' offices in primary care, and that's a big part that is missing. Part of the use would be Canadians having access to their own information, their own medical data, as well. That's very much part of the $10 billion that we're talking about.

● (1555)

[*Translation*]

Mr. Nicolas Dufour: According to Health Infoway, as of March 31, 2009, only 17% of Canadians lived in a province or territory where a complete electronic health records system was accessible.

Health Infoway intends to achieve its goal of covering 50% of the population by December 31, 2010 at the latest. We noted that, based on Health Infoway's own assessment, the risk of not achieving that was high.

What do you at Health Infoway intend to do to achieve that goal?

[*English*]

Mr. Richard Alvarez: Thank you.

The goals, first, are a call to action. They are premised on the goals put forward by the provinces and the territories. As Madam Fraser has said, at Infoway we can only move as quickly as the provinces and territories move, so based on the plans put forward, we felt that by the end of 2010 we should be able to get to 50%.

These are complex projects. Today we're at 17%. Remember that the larger the province you are—meaning Ontario, Quebec, and British Columbia in particular—the more you will contribute to that 50% goal. With the best evidence we have today, we're still fairly confident that we're going to get close to the 50%, on the understanding that the provinces keep their commitments and keep driving the projects forward.

[*Translation*]

Mr. Nicolas Dufour: Do you believe you have the necessary resources at your disposal to achieve your goals, both financial and administrative?

[*English*]

Mr. Richard Alvarez: Certainly from an administrative perspective we do, and at this stage also from a financial perspective. Again, if the provinces saw that we would incent use with the building of electronic medical records, etc., it would incent the provinces to move faster, because they'll be pushed along by the clinicians in the field as well. That would really help.

I believe that if they stick to their plans, they should be able to get close. If you take the 2016 goal, that is a goal, a call to action, but we certainly don't have the dollars to get there.

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

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

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you very much.

And thanks to all of you. This is an issue of particular urgency for our committee, as we grapple with health human resources and the renewal of our health care system. Electronic health records have been seen as key to this whole area of renewal. The government made a commitment in the last budget to advance the agenda for that reason and other reasons. But this issue goes back to 2001, and progress, by all accounts, has been very, very slow.

Madam Auditor General, I know people are interpreting your report as a clean bill of health for Health Infoway, and on that basis they are urging us to urge the government to flow the $500 million. I'm not sure we're ready to do that yet. Beyond the straight accounting practices, I'm not sure whether this program has met its mandate. I'm wondering if you can help us figure out what questions to ask and where to take it.

For example, if they've already spent $1.6 billion and only covered 17% of the population, is that getting the job done? Is that a clean bill of health? Reports that go back to May, June, July, August, and September all show there are big concerns with the whole Infoway program. We had the health council before us in May, and they had big concerns.

There have been news reports suggesting that Health Infoway could be headed toward the same problems that eHealth in Ontario faced...without accountability, according to news reports—and I'm asking whether this is true or not—without oversight by federal watchdogs, without accountability with respect to contracts, with the use of outside consultants but no requirement to proactively disclose contracts, whether sole-source or otherwise.

I think we need some of those questions answered. Maybe it's not in the context of this report, but I would certainly like to hear your advice, Madam Fraser, so we'll know what advice to give to government.

● (1600)

Ms. Sheila Fraser: I think it's important to note at the very beginning that the role of Infoway is very different from eHealth or provincial organizations that are putting electronic health records in place. Infoway is a funder, so it is about how well they assess the projects being brought to them. Are they in line with the strategies that have been developed—the blueprint? The actual development of the electronic health records is a responsibility of the provinces and the territories. Our audit looked at how well Infoway was managing in that role of strategic investor.

To compare the 17% to the $1.2 billion that has been spent is a false comparison, because much of the money—and Mr. Alvarez may have the numbers—has gone to provinces that have not completed an electronic health record. The 17% is for two provinces at this point, but much funding has gone to other provinces to help them develop the electronic health record. Getting to that goal of 50% is very dependent upon the provinces putting in the necessary funding and having the necessary management in place to be able to deliver on electronic health records.

As I mentioned, there are six auditors general looking at doing audits of electronic health records within their jurisdictions. I'm hopeful that when we come in the spring we can give the committee a better idea of the actual state of affairs. To date the reports have not been particularly positive on the management within the provinces.

I think we have to separate the roles and responsibilities of the various players. While Infoway has a very important role to play, the success of these projects is not its alone.

Ms. Judy Wasylycia-Leis: I appreciate that. But I'm wondering if this agency, which is arm's length from the federal government, has played the appropriate role in terms of coordination and encouragement at the provincial level. If we see that kind of slow progress, shouldn't we question whether we wouldn't see more progress and it being a higher priority if this were taken seriously at the federal level?

Even if what you're saying is true—and I believe what you're saying—when Infoway says we'll achieve 50% by the end of 2010 and we're only at 17%, it seems a bit hard to accept. There might be a bit of smoke and mirrors happening on a critical issue.

Ms. Sheila Fraser: I can't really respond to that. Perhaps Mr. Alvarez can. We don't know. Where the provinces are and what stage they're at is not something we looked at in our audit. We certainly note that Infoway played a very important role in starting that strategic direction, developing the blueprint, and trying to ensure that there was compatibility of systems across the provinces and territories. These are very complex. Just to have done that would require....

Ms. Judy Wasylycia-Leis: Isn't there a problem when you have promises made at the federal level, as we have also had with the national pharmaceutical strategy, and people hold out great hope, and then nothing is really done at the federal level to push the envelope and make it happen? How do we, in fact, recommend that the government flow another $500 million when we haven't really seen this made a high priority at the federal level?

Just before I go to Mr. Alvarez, could I just ask you, Madam Fraser—

● (1605)

The Chair: Your time is running out, Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: —if there's any truth to the fact that it is an agency that hires outside consultants, and they're not required to—

The Chair: Your time is running out.

Ms. Sheila Fraser: We looked at the contracting practices, and we found that there were some modifications needed to contracting policies, in particular as regards amendments to policies that were made. We did not see, I would say, any significant problems with sole sourcing of undue numbers of consultants, quite frankly. It was certainly nothing that was comparable to what was in eHealth.

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

Now we'll go to Dr. Carrie and Ms. McLeod, who will share their time, I believe.

Mr. Colin Carrie (Oshawa, CPC): It will actually be Madam Davidson. We switched around. I'm sorry about that.

The Chair: Okay, that's fine. You're playing games behind me here.

Some hon. members: Oh, oh!

Mr. Colin Carrie: I certainly am.

The Chair: We'll have Dr. Carrie and Ms. Davidson, and we'll start with Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Madam Chair.

I want to take this opportunity to thank our witnesses I think on behalf of all Canadians for your good work. Let's just say that I don't envy you working with all the provinces. I know there are certain challenges working among different jurisdictions. I like the results of the audit. Overall we are getting the job done, but it is very challenging. I can tell you from being on the ground that having these X-rays digitized is a wonderful communication tool. My background is that I'm a chiropractor, and it's just wonderful to have that.

Mr. Alvarez, you mentioned provincial-territorial collaboration, and the audit noted that Infoway's ability to achieve key outcomes in its funding agreements depends on the collaboration between the provinces and territories. I was wondering what Infoway is doing, or what it can do, to foster better collaboration with the jurisdictions.

Mr. Richard Alvarez: Madam Chair, thank you for that question.

I've been working at the national level now, having come from a province, for the last 15 to 20 years. I've never seen the kind of collaboration that is taking place between the federal government and the jurisdictions as I've seen around this particular project. Make no mistake about it, the jurisdictions are very keen to modernize the health care system. There are problems in sustaining our health care system and funding it. This is clearly an area where it could not only save lives but could actually save money. So they really want to get on with the job.

It is a complex job. If it were an easy job, incidentally, it would have been taken care of a long time ago. And it hasn't been taken care of in most parts of the world.

There is a high level of collaboration. Never before has the country agreed to a blueprint, an architectural diagram, of how these systems should work. Never before have they agreed to a set of standards, with federal leadership coming into play, so that every single province is not developing its own standards. After all, we have portability as part of our Canada Health Act. They've agreed to a set of standards. Now implementing the standards is always a challenge, depending on what they're starting with.

Never before have they agreed to a role wherein Canada Health Infoway does not fund provinces on a per capita basis. We fund them on the basis of results, and we fund them as a strategic investor in terms of take-up rates. As Madam Fraser has talked about, the use is going to be really important. We hold back 50% of those funds. The provinces have played by those rules. They realize that to leverage federal dollars, they need to get their own money as well. They need to get commitment from the highest level.

The level of collaboration from the provinces, I have to tell you, has been quite outstanding. For the last three or four years, I can tell you, the health ministers have made this the number one priority in health care, as they've written to the federal health minister and to others. We enjoy a very high level of collaboration in what is typically a fractious environment.

Mr. Colin Carrie: I appreciate hearing that, because often in various government initiatives you hear about what things are going wrong, but I think it's important to point out what is going right as well.

Am I about halfway?

The Chair: You're halfway now. Perhaps Ms. Davidson should continue.

Thank you, Dr. Carrie.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thanks, Madam Chair, and thanks very much to each of you for being here with us this afternoon.

I think Infoway is an issue that is perhaps a little misunderstood by the general public. Perhaps it's difficult for the general public to get a handle on it, when we're talking about electronic health records and also talking about electronic medical records. I think people become confused by the two.

Do you have a simple explanation, Mr. Alvarez?

● (1610)

Mr. Richard Alvarez: An electronic medical record is typically a record that is at a provider's location. Given that we all go to see our GPs, we want to build electronic medical records whereby a vast majority of your records will be there. Having said that, as individuals we seek services at times in emergency rooms, at clinics, in private labs, etc. At times, those records are locked away and don't actually make it back to the GP.

An electronic health record is ubiquitous around the patient. No matter where the patient moves, all of their records, all of their medication histories, lab results, and diagnostic imaging will be available. If the GP can download other points of care where care has been given into their medical record, it really becomes an electronic health record.

So one is ubiquitous around the patient—the health record—and the other is more location-specific.

Mrs. Patricia Davidson: Thank you.

Do I have more time?

The Chair: You have one more minute.

Mrs. Patricia Davidson: Mr. Alvarez, what do you see as the biggest challenges and successes so far?

Mr. Richard Alvarez: I tried to point out some of the successes. I pointed out one success in British Columbia where, with a project like PharmaNet, pharmacists will have access to all dispensed prescriptions. They're picking up something like 2.5 million adverse events that could occur and are changing the prescription, typically in collaboration with the prescriber.

That was some seven years ago. Had this initiative not been started by the federal government and the provinces, I can tell you that today those systems would not be available in Alberta, Saskatchewan, P.E.I., or certainly in Ontario with all the emergency rooms.

There was a system that was producing great stuff, but there was no stimulus and no incentive to move it along. That has happened. Since we've been around, three-quarters of X-rays are now gone. We have the entire provinces of Newfoundland, Nova Scotia, and Alberta in which you won't handle an X-ray. No matter where you move, they can pull up your digitized images. Very important results have been produced.

I have to tell you that our 2010 goal really is a two-part goal. Part one says that by 2010 every single province and territory will benefit from some aspect of what we're funding. That, I can tell you, is happening. The other part says—the call to action—that 50% will have all of their meds, labs, and diagnostic imaging available through their practitioner. That's the one that is tough.

The Chair: Thank you, Mr. Alvarez.

We'll now go into our second round. There are five minutes for the question and the answer, so we're going to have to be sharp on it.

Ms. Murray.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thanks for being here and helping us understand this. My questions are really about how this works.

When you say that two provinces are substantially there, Ms. Fraser, and that this is where most of the 17% comes from, which two provinces are they?

Ms. Sheila Fraser: Chair, they are Prince Edward Island and Alberta.

Ms. Joyce Murray: Does that mean that P.E.I. and Alberta would have had more than their per capita share of the funds and that this is what helped them get there, or were they already ahead of the pack, so will get less because they don't need as much help?

Mr. Richard Alvarez: I wouldn't say that they got a lot more than their per capita share; they've just completed their project.

I'll take one second to explain what we mean by this, because there's some confusion.

There are six fundamental elements that make up an electronic health record. There is one uniquely identifying Canadians, which we call a client registry. There is one uniquely identifying providers; we call it a provider registry. There's medication history, there's a drug database, there are lab results, and there is the diagnostic imaging. Those are the six components.

We're saying that Alberta and P.E.I. have switched on all six components, and they're working. The rest of the provinces are switching them on gradually, but they haven't switched all six on.

● (1615)

Ms. Joyce Murray: How much of a barrier to your goals is a province that doesn't have broadband piped to its remote communities?

Mr. Richard Alvarez: The one part of the country we're struggling with is Nunavut. There certainly have been commitments that the broadband will be extended up to Nunavut by the time we're ready to roll out the systems. In Iqaluit, it's fine; we can get the systems there. But to get them down into the communities is going to take some work, I believe through Industry Canada.

In the rest of the country, we're pretty well served. In fact, we're very fortunate to be able to get what we need out there.

Ms. Joyce Murray: Last, we heard from a number of people recently in our health human resources study that multidisciplinary collaborative teams are the primary care of the future.

Do your standards and the direction you're setting include some of the other team members who should be part of a collaborative team, not necessarily just the doctors, but it may be naturopathic physicians or other complementary medicine primary care providers? How are you helping towards that goal of collaborative teams being able to work with electronic records?

Mr. Richard Alvarez: As I've said before, when you look at the six elements that we're talking about, it's building out those six elements. Once we've done that, it is a matter of access and authority to access those files.

Frankly, at the end of the day we want Canadians to have access to their own medication history, to their own lab results, and we want Canadians to allow whoever they want—a chiropractor, whoever they want—to have access to those files as well. There shouldn't be any reason that they shouldn't, once those files are available.

The Chair: You have some more time, Ms. Murray, if you want it.

Ms. Joyce Murray: I do have another question.

Are provinces sharing best practices with other provinces, or are they each married to their own approach? I know that British Columbia changed from 53 to 6 health regions, with the goal of being able to integrate information technology in that province. Obviously, there may be similar challenges that other provinces can learn from.

How much are you helping them to share best practices and beg, borrow, and steal each other's successes?

Mr. Richard Alvarez: I have to tell you that one of the great successes, I believe, of an Infoway, which is no more than an instrument from a national perspective to bring the provinces together, has been aspects of commonality. Whether it is the architectural design adopted by the provinces, which is the standards, or whether it's entire applications, like the PharmaNet system, which we pick up from B.C. and implement and replicate in Alberta and in other provinces, or whether it's bringing three provinces together, as we did, and going out to tender for diagnostic imaging, saving something like $60 million because we had critical mass and putting it back into the system, there is a huge amount of collaboration.

Nobody wants to reinvent the wheel, which is a good thing, and we're a conduit, if you like, to best practice. We basically create toolkits and make them available to the country, not only to learn from lessons where there have been successes, but to learn from lessons where there have been failures as well.

The Chair: Thank you, Mr. Alvarez.

We'll now go to Ms. McLeod.

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

I appreciate the review of this very important issue and the enthusiasm that Mr. Alvarez brings to the work he's doing.

This is near and dear to my heart, and within our region we've just made incredible progress, from the X-rays, by which you can clear people in a rural emergency and they don't have to transfer to larger communities, to chronic disease toolkits.

In Williams Lake right now, they have a nurse. The thoracic surgeon in Kelowna is reviewing.... Through telemedicine, the thoracic surgeons are seeing them, doing consultations. In another community, again funded by Health Infoway, the congestive heart failure patients are being sent home and are being monitored through some home devices. They're having a huge impact upon stays.

I have a few questions, and my first one is this. I understand that public health is looking at a Canadian-wide system—Panorama, is it? What is Health Infoway's role in that? How, with this current H1N1, would it have made a difference—how, and what difference?

Mr. Alvarez, could you respond?

● (1620)

Mr. Richard Alvarez: Panorama is a system that is being built for the country. It's a system where B.C. took the leadership role on behalf of the country. It's the only system I know of where every single public health officer and chief information officer came to the table over several months, probably 18 months, with a common specification and design. It is a system that will cover alert management, outbreak management, case management, immunization, etc. Unfortunately, it wasn't ready to roll out in time for the H1N1. It will make a huge difference, as further pandemics—unfortunately—come to our shores, in terms of an alert perspective, an outbreak perspective, an inventory control perspective, just controlling how many vaccines we have and who's getting what vaccines.

In this country, for example, public health physicians have never had access to lab results, and that's going to happen. With the Panorama system and the EHR as we're building it, with the lab results, they will have access to those.

There is no system of its nature anywhere in the world that is being rolled out like that, including in the U.S. Unfortunately, I say, really, we didn't have enough time to roll it out for H1N1, but it will make a substantial difference. It's being rolled out in B.C., Ontario, and Quebec at this stage.

Mrs. Cathy McLeod: So right now it's designed. Is it being cost-shared? Is it money you've committed out of the $1.6 billion?

Mr. Richard Alvarez: We received $100 million from the federal government. When we went to market to look at the specifications, the bill was something like $300 million. We obviously couldn't afford the $300 million, so we had to sit the country down and say we have to make some concessions somewhere in terms of the specifications, and we cut it back I believe to $130 million, $150 million. A lot of those costs are actually in the implementation of the system, so we have spent a part of that, but as we roll it out we'd be spending time in terms of training and the testing of these systems across the country.

Mrs. Cathy McLeod: You talked about the difference between an electronic health record and an electronic medical record, and I'll again use British Columbia as an example, where I know they've finally gone through the process of creating five that meet the standards for the electronic medical record. We now have large groups of physicians implementing that in their practices.

I understand that's part of your future phases. Has the work that's going on in terms of the electronic medical record within British Columbia been picked up by the provinces solely, or again, is there some support from Health Infoway?

Mr. Richard Alvarez: Madam Chair, this was part of the $500 million, where we needed to accelerate the medical record at the community level. So far the heavy lifting has been done by the provinces, but it's moving up too slowly. We are really at the back of the bus when it comes to the rest of the world. We were there, and were probably quite content to be there because our southern cousins, in the U.S., were sitting in the seat next to us. That's all changing, with the $20 billion Obama has put into accelerating their electronic medical record. I can tell you there are going to be huge advances in the next two years in the U.S., and we're working very closely with Washington on that.

The Chair: Thank you, Mr. Alvarez.

We'll now go to Monsieur Malo.

[*Translation*]

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

Good afternoon to everyone.

Ms. Fraser, I can't help but ask you a question since you are here before us. If you can't answer it, I'll understand. Please feel comfortable. This is not a trap. I simply want to know what the situation is.

Health Canada has had difficulty planning the human and financial resources and the necessary time to approve natural health products.

I simply wonder whether your office was asked to look into this matter to determine in greater detail why all that had happened. If not, would it be possible for you to do that?

● (1625)

Ms. Sheila Fraser: To date, we haven't examined that issue, and I don't believe that's planned for the next two or three years.

Perhaps Ms. Dubé could give us more details on that subject. I believe that drugs are the next issue we will try to address.

Ms. Louise Dubé (Principal, Office of the Auditor General of Canada): We're conducting a follow-up on medical instruments. That's scheduled for spring 2011. We're currently developing a long-term plan for future audits. We should be finalizing it in the next few months.

Ms. Sheila Fraser: That will have to be consolidated.

Mr. Luc Malo: Very good. Thank you very much.

Thank you, Madam Chair.

[*English*]

The Chair: Thank you very much, Monsieur Malo.

I want to say a special thank you to our guests today. I know we have about three more minutes. Would anyone else like to ask questions?

You're completely finished, Monsieur Malo? Okay?

Now we go to the Conservative side. Would anybody there like to ask a question?

Ms. McLeod, I know you were right in the middle of something when I had to go to Monsieur Malo.

Mrs. Cathy McLeod: No, other than congratulations. I know my colleague from the NDP was concerned, but it's been identified that this is a huge task and it's huge change management. I think we're making some good progress on some really important work. Again, I appreciate the enthusiasm and the passion. And I am really appreciative of an audit report that reflects the good management.

The Chair: We do have a couple more minutes.

Ms. Wasylycia-Leis, did you have a quick question?

Ms. Judy Wasylycia-Leis: Back to eHealth Ontario compared to Infoway—and I know there is a big difference—eHealth Ontario got started when people didn't practise proper oversight and contracts were untendered and there were single-source contracts. You've said there are some, in the case of Infoway. Do we not need to be cognizant of where that can lead and how we can watch for that and make sure we're not going down that path, leading toward a similar scandal at the federal level?

Ms. Sheila Fraser: I think, Madam Chair, that organizations always have to be vigilant and always require good governance and oversight. And we did see that the board of directors, in the case of Infoway, was providing that governance and oversight and was being rigorous in the kinds of information.

The issues we raised in contracting out say there were only five out of over 500 contracts that we saw that had been sole-sourced. The issue we had with contracting related to Infoway's own policy about how they reported amendments to contracts, and this is something they had indicated. So we certainly saw nothing at all similar to what was happening at eHealth.

The Chair: Thank you very much, Ms. Fraser and all our witnesses today. It was very insightful and very useful having you come. We appreciate the time you have taken.

Now I will suspend the meeting for two minutes, and we'll ask our other guests to please take their chairs.

● (1625)

(Pause)

● (1630)

The Chair: Good afternoon.

Welcome to the committee. We're very pleased to have you here today.

We have before us, pursuant to Standing Orders 110 and 111, the order in council appointment of Bernard Michel Prigent to the position of member of the governing council of the Canadian Institutes of Health Research, referred to the committee on October 21, 2009.

Welcome, Dr. Prigent.

We also have here today, from the Canadian Institutes of Health Research, Dr. Alain Beaudet. We're very pleased to have you here.

We ask that you make your presentations, but prior to that, Ms. Wasylycia-Leis has asked for a point of order to be addressed.

Ms. Judy Wasylycia-Leis: Thank you, Madam Chair. I won't take too much time.

I originally brought this motion to the committee, so I have a real concern with making sure it is followed through appropriately.

I want you to know, Madam Chair, that I did speak to Dr. Beaudet and indicated to him that I would have no trouble with his appearance here today. I thought it was only appropriate. However, I certainly didn't assume it would mean no other witnesses would be permitted, so I want to do a couple of things right now.

First I want to table my letter to you, Madam Chairperson, as of this past Friday, indicating my concern for the refusal on your part to entertain any other witnesses who were willing and able to come. They include Dr. Patricia Baird, Dr. Noralou Roos, Dr. Joel Lexchin, Dr. Abby Lippman, Dr. Steve Morgan, and Dr. Trudo Lemmens.

In the letter I'm tabling, Madam Chair, I indicated that I certainly didn't expect all of these witnesses to come. I knew we were limited in time. I suggested that one voice bringing an alternative perspective to this debate would have been very useful. I'm disappointed that you disregarded the recommendation and did not bring it to either the steering committee or this committee as a whole before you made that decision. I will table the letter and seek the advice of other committee members as to appropriate action.

Let me also table a petition of some 2,085 names of concerned citizens around the appointment of Dr. Prigent to CIHR.

Finally, let me reference the considerable correspondence that we've all received from numerous scientists, researchers, and health care specialists around the country. If it is appropriate, I would be happy to table all of those as well.

I don't want to take up the time of the committee. We have two courses of action. One is to schedule another meeting to hear from other witnesses, which would be my preference. However, it would have to be done, and a report sent back to Parliament, before December 9. It would mean we would have to make this decision rather quickly and have it happen by no later than next week.

The other option for us would be to just swallow what has happened, to grin and bear it, and to bring a motion later on for how we as a committee will deal with this kind of situation in the future. I'm certainly prepared to do that.

● (1635)

The Chair: I'll just speak to that for a moment, and I thank you for your presentation.

Your motion is there, and the cut-off is December 9. This is November 30.

A lot of witnesses were brought forward. The decision was made in the best interests of the committee, because when we calculated the time, Ms. Wasylycia-Leis, we discovered that it came to 48 minutes, plus another question. We would have run out of time. I thought the committee was very clear that it wanted to be able to hear from Mr. Prigent and Mr. Beaudet, and one of your witnesses—Mr. Beaudet—is a request you had, so we brought Mr. Beaudet forward. That request came from your office, so you did get your one witness.

Go ahead, Dr. Bennett.

Hon. Carolyn Bennett: Madam Chair, with due respect, my understanding of the people who are objecting to this appointment... they are very well known to one another, and I'm sure they would have been able to select somebody to speak on their behalf in terms of being able to have one witness who was opposed to this appointment and who would speak. Certainly, in the e-mails that I have received, from some of the most prominent health ethicists, professors, and health law professors, it has been quite a tsunami of objections. I will go along with my colleague as to whether or not we would table the e-mails we've received to date, as well as the petitions, in that these are very eloquent and persuasive arguments that they've brought to us.

As we unfortunately know, this committee can only express our concerns to the House. I think you will find that there are concerns. Because we are up against the time limit of the parliamentary break, I would take from my colleagues as to whether we need to hear these people in person or whether by the end of today's hearings we'd be able to make a decision based on what they've written to us already.

The Chair: Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: First of all, it is true that we had submitted the name of Dr. Beaudet. I certainly wanted him before the committee, but under no circumstances did I suspect that would be the limit. In fact, the list of the names I gave you were checked out, and we knew there was at least one person who would have been able to make it today, if not two. Certainly, Dr. Noralou Roos, who is in Ottawa for an important award, was prepared to come, and so was Dr. Trudo Lemmens, from Toronto. I think that would have ended this matter today and we would have been able to deal with it. But since we did not get a chance to hear another side, I think we should actually meet on Monday, December 7, have one more hour of discussion, and put our report in before the deadline of the 9th.

I also move that.

● (1640)

The Chair: This has to be agreed to by the committee. We certainly can do that, because your motion says until December 9. We also have the HHR panel on the 9th, where we could do it as well.

They tell me that the report can be done within an hour, so we could have the first hour with witnesses and the second hour the report.

Hon. Carolyn Bennett: The clerk is saying before the 9th.

The Chair: Sorry, Dr. Bennett.

Ms. Wasylycia-Leis, you have the floor.

Ms. Judy Wasylycia-Leis: My motion mentions the 9th because that's the standing order requirement, that this committee must report to the House before December 9, so it has to be on the 7th.

The Chair: That's perfectly okay. So you're bringing before the committee...who else is there?

Dr. Carrie.

Mr. Colin Carrie: I was going to say, Madam Chair, after today, if they would like to bring some more witnesses for an hour, we don't have a problem with that.

The Chair: Yes, no problem.

Mr. Colin Carrie: But I would like move on, as I do have some important questions for the witnesses. If we only have 45 minutes now, it would be good if we—

The Chair: Is it agreed then, first of all, that on the 7th we have an hour bringing witnesses in on this topic that we're dealing with now?

Some hon. members: Agreed.

The Chair: Thank you.

We will now proceed.

I would like to go, first of all, to Mr. Bernard Prigent of the Canadian Institutes of Health Research governing council.

You have 10 minutes for a presentation, sir, on whatever you like.

Dr. Bernard Prigent (Member, Canadian Institutes of Health Research Governing Council, As an Individual): Thank you, Madam Chair.

I wish to thank you and your colleagues for providing me with the opportunity to outline my role and contribution as a member of the governing council of the Canadian Institutes of Health Research.

Let me begin by sharing with you my experience and credentials, which are relevant and consistent with CIHR's overall objectives and mandate.

[*Translation*]

I received my general medical training in France. At the start of my career, I had to deal with the major clinical and public health problems experienced by immigrants settling in the suburbs of Paris.

My interest in global health issues stems from my involvement in a medical mission to Cambodia, in a war zone where, among other threats, civilians suffered from the ravages of multi-resistant malaria. That experience led me to write my thesis on tropical medicine and public health.

I also worked for five years in various demanding clinical and hospital environments in France, Asia and Australasia. The diverse nature of those clinical experiences led me to discover emergency medicine, obstetrics, but especially, for nearly two years, the role of district physician. That was in a tropical environment, in Samoa. There, as the only practitioner, I had to provide care and promote public heath to a rural population of 20,000 inhabitants.

All those experiences formed me and made me always keep in mind the viewpoint and interest of the patient, even when my career strayed from clinical medicine to medicine in a pharmaceutical environment.

[*English*]

I joined the pharmaceutical industry in 1984, working for the international medical and clinical research operations of three major European pharmaceutical companies before joining Pfizer in Canada in 1995. I have worked on the clinical development and commercialization of new medicines in a variety of therapeutic areas, including cardiology, respiratory medicine, infectious diseases, rheumatology, urology, neurology, and oncology. I was able to pioneer the conduct of pivotal studies more than 20 years ago in countries like Poland, Hungary, and Russia, and developed medical and clinical capabilities in Africa and in the Middle East.

My interest in the management of research and development led me to complete an MBA in the United Kingdom at the Henley Management College, where my main research was on the management of global research and development organization.

In Canada I'm actively involved in the building of research and development capabilities that foster the collaboration between the public and the private sectors. Such activities have enabled me to become chair of the scientific committee of the research foundation of Canada's Research-Based Pharmaceutical Companies; a member of the strategic advisory committee of the Centre of Excellence in Personalized Medicine; a board member of the Centre of Excellence in the Prevention of Organ Failure; chairman of the strategic orientation committee of the Québec Consortium for Drug Discovery; a member of the national advisory board of the Canadian Dementia Knowledge Translation Network; and co-president of the research working group of Montréal InVivo.

● (1645)

[*Translation*]

I believe that my international clinical experience and my contribution to developing new drugs and to their accessibility for patients will be useful on the governing council of the Canadian Institutes of Health Research. The CIHR recently launched its five-year strategic plan. In particular, that plan emphasizes the importance of cooperation between the industry and the research community so that research work leads to improved health products, technologies, tools and services.

More specifically, the plan sets out a commitment to launch a new flagship initiative in patient-based research that will enable Canada's health system to more effectively use research results to improve care and health.

[*English*]

In recent years we've seen some measure of success in patient-oriented research, most notably in cardiovascular care, critical care, stroke, and HIV. However, Canada is rapidly falling behind other industrial countries in terms of the capacity to carry out high-level, patient-oriented research. In Canada we have some of the best health researchers in the world. Where we are less successful is in moving health research results out of the laboratory and into hospitals and clinics where they can improve health outcomes.

I believe my significant experience in clinical research and multilateral research collaborations across the world involving industry and academic-based research can assist CIHR in developing solutions to remedy these shortcomings.

[*Translation*]

As a member of the CIHR governing council, I undertake to strictly observe the Conflict of Interest Act, the Ethical Guidelines for Public Office Holders, the Guidelines for the Political Activities of Public Office Holders and the CIHR's Policy on Conflict of Interest and Confidentiality in the Context of Merit, Relevance and Peer Review. As a new member of the governing council, I have received orientation from CIHR management personnel and have carefully read all documents.

In closing, I repeat to the committee my dedication and commitment to meeting the highest ethical standards in this position, as I have in all those I have held in the past.

[*English*]

I now welcome the opportunity to answer any questions you may have. Thank you.

The Chair: Thank you very much.

Now we'll go to Mr. Beaudet.

[*Translation*]

Dr. Alain Beaudet (President, Canadian Institutes of Health Research): Thank you, Madam Chair. I'm pleased to appear before you as part of the review of Dr. Prigent's recent appointment to the CIHR governing council.

[*English*]

Let me tell you right at the outset how much CIHR's governing council and I personally welcome and support this superb addition to our board. Dr. Prigent was appointed by Governor in Council because of his vast knowledge, his unique experience, and his keen understanding of the Canadian international health research landscape. Like all other council members, Dr. Prigent was appointed as an individual and not as a representative of his employer.

[*Translation*]

The mandate of the CIHR's governing council is to oversee the agency's orientation and management. It defines its strategic orientations, objectives and policies, and assesses its overall performance. It is important to emphasize that it is not the council's responsibility to examine or approve funding applications. There is no doubt in my mind that Dr. Prigent's appointment meets the criteria for the appointment of members to the governing council as set out in the Canadian Institutes of Health Research Act.

That act states that council members must meet the highest standards of scientific excellence and represent a range of relevant disciplines and communities. No one will doubt Dr. Prigent's exceptional qualifications and experience in this regard.

[*English*]

Dr. Prigent is a distinguished international researcher and vice-president of Pfizer Canada Inc. He is a member of the Canadian Society of Clinical Pharmacology and the Canadian Arthritis Network. He sits on the board and chairs the Scientific Advisory Council of Rx&D's Health Research Foundation, and he co-chairs the research committee of Montréal InVivo, a non-profit group of over 600 public and private organizations in Montreal that promotes scientific partnership and innovation.

Dr. Prigent brings to the council an unparalleled background in matters ranging from global health to research management, particularly a vast experience in innovation and commercialization, thereby filling what the governing council had identified as a major expertise gap in its midst. His unique knowledge in this field will enable us to better fulfill our responsibilities with respect to the achievement of CIHR's objectives, as stated in section 4 of the CIHR Act:

> to excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products, and a strengthened Canadian health care system, by
>
> (i) encouraging innovation, facilitating the commercialization of health research in Canada and promoting economic development through health research in Canada;

● (1650)

[*Translation*]

Innovation and commercialization are key elements in the CIHR's mandate for improving the health of Canadians and the effectiveness of our health system.

As you are aware, Canada ranks poorly in private sector research and development investment. In fact, in its last report card on innovation, the Conference Board of Canada gave the country a D for its innovation performance in the past three decades.

This unfulfilled need has been underscored in the Government of Canada's National Science and Technology Strategy which, on this point, specifically recommends:

> As the government fills vacancies on the councils' governing bodies, it will seek out more business and community representation to ensure that the composition of granting council governing bodies reflects Canada's broad economic and national interests.

[*English*]

Up until now, this call had been heard by virtually every single federal research agency except CIHR. Indeed, members from the biopharmaceutical sector sit on the boards of Genome Canada, the National Research Council, the Natural Sciences and Engineering Research Council, and the Canadian Foundation for Innovation.

Several provincial health research organizations, including the Manitoba Health Research Council and the Fonds de la recherche en santé du Québec, also have members from the biopharmaceutical industry sitting on their boards. Likewise, sister councils in other countries—for instance, the Medical Research Council in the U.K.—have board members from this sector.

In all cases, these individuals have been appointed not as representatives of their employers but as unique individuals willing to share their knowledge and able to help build bridges between the private and public sectors for the common good.

In closing, I would like to remind the committee that all governing council members must observe the Conflict of Interest Act, the ethical guidelines for public office holders, and the guidelines for the political activities of public office holders, as a condition of appointment.

In addition, disclosure of conflict of interest is a standing item on governing council meeting agendas.

[*Translation*]

I am deeply convinced that Dr. Prigent's appointment will have no negative impact on the CIHR's integrity. Quite the contrary, his presence will be of great assistance in carrying out our mission. Dr. Prigent shares CIHR's vision and brings unique expertise to its implementation.

Thank you.

[*English*]

The Chair: Thank you.

We'll now go to our seven-minute round of questions and answers, beginning with Dr. Bennett.

Hon. Carolyn Bennett: Madam Chair, if you'd rather take five-minute rounds to allow more members to participate, I would be happy with that.

The Chair: Is that agreed by the committee, a five-minute round?

Some hon. members: Agreed.

The Chair: Okay, we'll have five-minute rounds.

Thank you, Dr. Bennett.

Hon. Carolyn Bennett: I have to admit, Madam Chair, that I've been quite taken aback by the objections to this appointment that have been flooding into my office. I think we all know that part of the mandate of CIHR is the commercialization. I think there was, from a lot of the community, a well-articulated need to have someone on the board that had some experience in getting research into practice and into the market.

Dr. Beaudet, you have stated the ethical declaration, the conflict of interest. What's also being expressed is that a present employee of a company that has its prime responsibility to its shareholders.... The concern would be in terms of the conflict of interest declaration. There has obviously been articulated a great deal of concern about recusing oneself at multiple policy-setting positions of the governing council, which could provide a huge gap if there were another appointment, like somebody from an incubator side, or somebody from the MaRS side, or a retired professor emeritus who doesn't actually see that. I don't think any of us wants to see CIHR reduced in the estimation of the public by the fact that any policy decision could be perceived to be questioned because of the interest of the pharmaceutical industry.

I want to know how you would deal with the perception, but also the actual practice of declaring a conflict of interest on so many issues that would come to the governing council, and how often it would be seen as inappropriate. I think you actually have to deal with the fact that the advisor, unfortunately, has a history of transgressions against the integrity of science, and since 2002 has paid substantial—

● (1655)

The Chair: Dr. Bennett, this is out of the scope. You know the purpose here is to see the person who has been appointed. You're way off scope here, and I don't want to have to cut you off.

Hon. Carolyn Bennett: I'm afraid the company he represents has paid $2.3 billion in fines for off-label use of medication—

The Chair: Dr. Bennett, I want to remind members that in looking at the order in council appointments, committees can ask someone to come and present themselves after they've been appointed. I'll read right from the order in council documentation, just to make sure that you all know how your questions should be directed. It says:

> Among the areas usually considered to be outside the scope of the committee's study are the political affiliation of the appointee or nominee, his or her contributions to political parties, and the nature of the nomination process itself. Any question may be permitted if it can be shown that it relates directly to the appointee's or nominee's ability to perform the duties of the office.

You know the resumé. Just be careful.

Carry on, Dr. Bennett. We stopped the clock.

Hon. Carolyn Bennett: The ability and perception of being able to make the ethical declaration and the conflict of interest declaration is the concern that I think needs to be addressed, if you wouldn't mind.

Dr. Bernard Prigent: As I said in my presentation, there is a very strong framework that's put in place to manage conflict of interest. But before we talk about the tools, I want to refer to the fact that you don't leave integrity and standards of integrity when you move from a sector to another. The responsibility of individuals serving the governing council is to, first of all, be driven by standards of integrity, and I think that throughout my career I've demonstrated the highest integrity in everything I've done.

Now, in terms of managing what is available in terms of managing the conflict of interest, there is clearly the Conflict of Interest Act, there are the ethical guidelines for public office holders and the guidelines for political activities. In addition, conflict of interest declarations have to be made in a preamble of any agenda of the governing council. Every member of the governing council may be in a position of conflict of interest. Conflict of interest does not belong just to one sector. Every one of us, as individuals...we're all representing different institutions and we all have potential conflicts of interest. So the best way to manage it is to have a strong framework, as defined by the act, and to have procedures, which are indeed put in place by CIHR.

The number of activities that I've mentioned to you follow exactly the same guidelines, where you have around the table very often people representing private interests, public interests, government interests, and we all have to declare any conflict of interest before any decision is made.

In addition, there is something that is very important to realize: the governing council does not make decisions on investment towards any institution or any projects. So the review of funding is not a mandate of the governing council. I think it's very important for this committee to understand.

● (1700)

The Chair: Thank you, Mr. Prigent.

We now go to Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you very much, Madam Chair. Dr. Beaudet and Dr. Prigent, thank you for being with us this afternoon.

We understand very clearly that the government wants to invest more in business-related research. However, from our viewpoint, that must not be done to the detriment of basic research. In our opinion, short-term public health research must not be sacrificed for the benefit of long-term research.

What do you think of that view?

Dr. Bernard Prigent: You are absolutely right. We are currently dealing with complex research and development issues, which are issues being faced by the scientific community, both private and public, and which require closer cooperation. In fact, this calls for an enhanced quality of research in public institutions that do not serve private ends, but simply innovation.

We need to increase the rate of investment in public research. This is a very clear mandate of the institutes. I'll give you with some perspective: the investment that Canada makes in the institutes represents $700 million. The overall budget available to the pharmaceutical and biotechnology industry is $100 billion for the 20 largest companies. It is much more important for the institutes to find partnerships enabling it to align with the private sector on clearly defined objectives where the two can complement each other. We're not talking at all about seizing power over the private sector, quite the contrary.

Quebec is the best illustration of the power of these cooperative arrangements. The launch of the Quebec Consortium for Drug Discovery is an obvious example of what the three sectors—if you include the government—can do together. This is an initiative that helps build on the strengths of all three partners. This kind of initiative is the envy of the other Canadian provinces and has an extraordinarily high profile outside Canada. It could only have happened because the players sat down around the table, determined the research policy and matched the competencies of the two communities.

Mr. Luc Malo: Dr. Beaudet, I'd like to ask you my next question in the wake of Dr. Prigent's answer to my Liberal Party colleague.

Dr. Prigent said that everyone around the governing council table has a certain interest since they all belong to various organizations. You said in your presentation that the members of the governing council do not approve grant applications.

Have certain members of previous governing councils recused themselves at times when the council sat? If so, in what context? Can you elaborate a little on that subject?

Dr. Alain Beaudet: I can definitely do that.

First of all, I would like to go back to the question from your colleague Ms. Bennett.

In fact, they are all potentially in conflict of interest. There is a vice-president for research. Is he speaking for his university? Should we have former vice-presidents of research? There's also a dean of faculty of medicine. Is he speaking on behalf of his faculty of medicine? Should we have former deans of faculties of medicine?

We want people who are in the thick of the subject because health research changes extremely quickly. We want the country's leaders, people who absolutely and completely know all research aspects, both basic research aspects, which you referred to, and more applied research aspects, commercialization aspects such as aspects of research on health services.

The important thing is to be able to have expertise around the table. We are clearly looking for varied expertise that enables us to respond more effectively to our mission as a whole.

More specifically, it is quite rare for members of the governing council to have to recuse themselves because we do not make financial decisions. Active researchers nevertheless do sit on the governing council, and they may at times feel uncomfortable in certain discussions.

For example, one council member is an active stem cell researcher. When we discussed ethical issues related to stem cell research, that member recused himself. This is a question not only of conflict of interest, but of apparent conflict of interest as well, to which we are very sensitive. We do not want to give the impression that we favour one player over another. We are very sensitive to that.

● (1705)

[*English*]

The Chair: Thank you, Mr. Beaudet.

Now we'll go to Ms. Wasylycia-Leis.

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

And thank you, Dr. Prigent and Dr. Beaudet, for being here.

I want to begin by saying, Dr. Prigent, that I have no doubts about your professional expertise, your integrity, or your significant experience. This is really about whether it makes sense to have someone who is currently a vice-president, or in any position with a major drug company, sitting on the governing council of the CIHR. I know you said the governing council doesn't actually give out money. The governing council governs the CIHR, whose mandate is to make decisions about where to target money, what priority areas should be focused on, how we can increase the research capacity in this country, and how we can support a new generation of health researchers. So it is rather important.

My question to you and to Dr. Beaudet, who I believe submitted your name in the first place—

Dr. Alain Beaudet: Correct.

Ms. Judy Wasylycia-Leis: —is how do we explain your position to all these scientists—and you've heard their names—who have brought forward big concerns when you would have to recuse yourself much of the time and would put a particular slant on a body that's supposed to be absolutely independent in terms of health research?

Dr. Bernard Prigent: The nomination of someone representing any sector does not touch on the mandate of independence. The independence is there. I find it hard to believe that the presence of one person from one sector could derail the mandate of the governing council.

Once again, I have been asked to sit on the governing council as a citizen and as someone who brings experience. And that experience can be brought to the service of the public good.

I tend to take my cues from the international environment. As I said, when you look at the Medical Research Council, the United Kingdom is paying a lot of attention to issues similar to those here. And they have this as a standard practice. If you look at the similar body in Australia, it's the same. If you're looking at a similar organization in France, it's the same.

So the principle, if you like.... And I fully share your concerns. But we cannot have a situation where, when it comes to thinking strategically about the health of Canadians, we're creating some kind of intellectual apartheid, with some people not being asked to the table.

I find it extremely surprising. If there's one thing I pay attention to, it's the conflict of interest. I think it's important.

If you go into a private research institution and a public research institution, there is no difference. These people come from the same background. They have the same goals. They want to do good and they want to bring innovation to the service of patients. It's important to take that into consideration when you're looking at the appointment.

I understand the sensitivity, but it's really important for Canada and for CIHR to move forward and tackle—

Ms. Judy Wasylycia-Leis: I think what folks are saying is that there are other ways for CIHR to in fact tap into the private sector expertise, and there are advisory bodies, and there are other ways in which we can benefit from your expertise based in the commercial sector. But I think an appointment of this nature on the governing council tells folks that in fact we're prepared to undermine the independence of the body and open up a possible trend in terms of commercialization on what should be absolutely neutral, independent bodies, particularly when it comes to drug companies—

● (1710)

The Chair: Ms. Wasylycia-Leis, I just have to say you're so on the edge right now. I'm trying not to interrupt you, but just be reminded of what I just told the committee. As it's set out here, you're verging on the nomination process itself. What you're supposed to be focusing on is Mr. Prigent's ability to do the job and what his qualifications are, not his outside interest—

Ms. Judy Wasylycia-Leis: And according to the parameters of the committee's purview, it is to also examine the ability of the individual to talk about that position in terms of the requirements of the office. So I'm asking about the requirements of the office. In fact, I would specifically ask the question of the conflict of interest and what that means for the body, and what it means for the entire field, especially in terms of the context of Pfizer. Whether or not all of the mistakes that Pfizer made were in your time or not, your name is there in some of the most difficult cases. In fact, I think it's probably fair to say that your name is associated and it's tied to papers where there's been a significant history of transgressions against the integrity of science. I think that has to be understood and therefore taken into account in terms of assessment.

The Chair: You are way over time, Ms. Wasylycia-Leis. I'm sorry.

Perhaps you'd like to make a comment on that.

Dr. Alain Beaudet: First of all, I'd like to reiterate that Dr. Prigent is not representing Pfizer. Actually, if he was representing Pfizer, the outcry wouldn't be from the community; it would be from all the pharmaceutical companies that would also want to have a representative.

Dr. Prigent is representing himself. He is bringing his unique expertise to the table. It's an expertise, quite frankly, that I cannot believe was not there at CIHR previously. We're talking about the sector that is the third largest investor in R and D in this country. We're talking about a major player in health research, and we wouldn't talk to them? We wouldn't ensure that we align a vision?

I think we have to start doing things differently. I think we really have to first listen to each other and understand how Canada can do better on the world stage in terms of being truly competitive in health research. That's what we're talking about here. If we want to align our agendas, if we want to do that and as a country be competitive, we have to look at ways to work together with the private sector. I think we need to learn how to do that. Who better qualified than someone like Dr. Prigent to help us do that better?

The Chair: Thank you, Mr. Beaudet.

We'll now go to Dr. Carrie.

Mr. Colin Carrie: Thank you Madam Chair.

To follow up, Dr. Beaudet, you mentioned expertise. As you know, before I was the PS to health, I was the PS to industry, and one of the biggest complaints I got was that there's not enough real-world experience. Government makes these programs and regulations without enough input from the private sector. You mentioned that this sector is huge in Canada. Occasionally, government, though well meaning, is sometimes not very practical in promoting things like innovation, commercialization, and applied research.

That's what we want to do as a country. We want to create good quality jobs; we want to stimulate the economy. You mentioned we were given a D. So there are some things that we need to do better. Internationally and in Canada, these types of appointments are nothing new. We talked about the health research board in Ireland and what they've done. If we look at the amount of research and development that Ireland has seen over the last 20 years.... Dr. Prigent, you mentioned that Australia, the United States, and the U.K. all have private representation. In Canada, even four provinces have the private sector involved.

So my question to you, Dr. Beaudet, is what has been the experience in these countries around the world? Are these countries prisoner to the private sector agenda? How are they finding this type of expertise to have on their agencies?

Dr. Alain Beaudet: First of all, I can only state what I know. I know for a fact that there's a heavy presence in the U.K. on the board of MRC of the biopharmaceutical sector, and I must say that they are fairly successful at curbing the trend and doing things differently in terms of innovation and public-private partnership. I think it has certainly been a major plus in that country.

I am also familiar with the CNRS in France, where there have also been, as you know, members on the board from the biopharmaceutical sector. There again, I can see only positive aspects. It's obvious that I would not have recommended Dr. Prigent to Minister Aglukkaq if I didn't feel it was an area where I thought we needed to do better.

As you know very well, we are in the midst of an economic downturn. I happen to believe that the way we're going to get out of it for good is through research and innovation, and it's not the public sector alone that's going to do it. It's the public sector and the private sector, and we have to work together. We have to understand what the needs of the private sector are. The private sector must understand where the public sector is going. We have to join our efforts. As Dr. Prigent mentioned, when I was head of the FRSQ in Quebec, we did that in a variety of initiatives.

I can tell you that we're not talking here about the protection of the intellectual property of a specific company. We're talking about areas at the pre-competitive level, where research benefits everyone. It benefits the public sector. It benefits Canadians, and of course it also benefits the private sector. That's what we want, isn't it? We want the private sector to invest more. We don't want to see them investing outside Canada. On the contrary, we want them to come back and invest in Canada so that we can actually gain economically from R and D investments.

I think we have a role to play in helping them do their job and doing our job better. It's our mandate. It's in the act.

● (1715)

Mr. Colin Carrie: Dr. Prigent, your résumé speaks for itself, and I don't think anybody at the table would dispute your immense body of experience. We do want to encourage more people in the private sector to become involved and help better communicate and work with governments, because at the end of the day, as we were saying, we want greater commercialization, innovation, research jobs, those spinoffs to our economy.

I was wondering if you could explain for the committee how you think your experiences qualify you for the role, and give us some thoughts on where you think the CIHR needs to go to position Canada globally, given the context Dr. Beaudet was discussing.

Dr. Bernard Prigent: I think one of the specific things that I will bring to CIHR is the experience that I've acquired working in various provinces, where that research for the right interface between public and private has been set in motion.

If you look at Quebec, if you look at British Columbia, if you look at Ontario, there is a series of initiatives at the provincial level that has encouraged and fostered innovative partnerships. We've talked about the creation of a consortium, which is at the pre-competitive level. In British Columbia, there has been the launch of not only the CDRD, the Centre for Drug Research and Development, but your government has launched centres of excellence for commercialization and research. Many companies have embraced those initiatives, and I think these are lessons, these are early days. But I think as an individual who is working and immersed in some of those initiatives, there is some experience that I can bring back to CIHR. CIHR is trying to develop an agenda to force the relationship with the private sector.

The other areas where clearly I'll be able to provide insight is around the reinforcement of the clinical research capability, or, even more so, as was mentioned, the patient-centred outcome initiative, which is much broader than the clinical development of drugs, if you like. There are many elements where I think my expertise can enrich the thought process and the thinking among the members and the leaders of that initiative.

Those are just short examples. Another interest that goes beyond my current appointment is my background in global health. I know that CIHR is looking strategically at partnering around the world with global charities and other governments to address global health. I'm extremely convinced that a closer collaboration with the private sector can bring solutions to the health of many people in need, in Canada and beyond.

The Chair: Thank you, Mr. Prigent.

Ms. Murray.

Ms. Joyce Murray: Thanks for being here to speak with us today. Like other intervenors, I wouldn't question Dr. Prigent's integrity or his understanding of conflict of interest. I acknowledge that pharmaceutical products have an important role in health care, as does commercialization. But here's my concern: we're struggling with our health care system across the country. We have a demographic that's going to put more pressure on the system, and we know we need a new paradigm. We also know that pharmaceuticals contribute to one out of nine emergency visits to Vancouver General Hospital, and that those visits are more likely to result in admissions and longer hospital stays. So the new paradigm —

● (1720)

The Chair: Ms. Murray, can I just interrupt you?

Ms. Joyce Murray: No, I'm actually getting to the point, Madam Chair.

The Chair: No, you are going outside the scope of questioning and you have to go back to where you're supposed to be.

Ms. Joyce Murray: What we're looking for is more in the way of a whole-person approach, social factors, and collaborative approaches to disease prevention.

When I look at the doctor's résumé, I see that in 1981 he completed GP training; from 1981 to 1983, he worked on a small island in western Samoa and then in New Zealand; and then for the next 25 years he was in the employ of the pharmaceutical industry. I guess you could say if you only have a hammer, every problem looks like a nail. Dr. Prigent brings a strong pharmaceutical bias to what should be a strategic direction in this council.

The Chair: All right, I'm going to have to stop this line of questioning.

Who's next?

Ms. Joyce Murray: I'd like Dr. Prigent to be able to respond to that bias.

The Chair: Okay, go ahead. Be careful.

Ms. Joyce Murray: I think it would be natural in the context of a career that has been fully and almost solely in the pharmaceutical sector.

Dr. Bernard Prigent: The work in the pharmaceuticals touches on global health issues. I've worked in pharma in sub-Saharan Africa, and I'm still involved with my former Pfizer colleagues in some malaria programs. The work with pharma doesn't mean that the global health perspective that I had in the initial stages of my career has disappeared. I was involved in setting up a chronic disease management in respiratory medicine in Africa. I collaborated with U. K. physicians and with African physicians. I believe I have maintained my original perspective. It has been strongly enriched by methodological learnings that I've acquired through the years. They are fundamental to the development of new technologies. You cannot develop technologies without looking at methodologies, and these methodologies will inform the work that we mean to establish with the academic communities.

I take your point, but I believe that I have been able to maintain, through my activities and across therapeutic areas, a strong focus on health.

Ms. Joyce Murray: But that was always within a certain context. Your employers were large pharmaceutical companies and the solutions were pharmaceutical solutions.

Dr. Bernard Prigent: Indeed, but you mentioned prevention, and there are a lot of prevention activities that reside in pharma. I have contributed to the study of preventive measures in a whole range of settings, with a pharma perspective. The fact that you're looking at something from a pharma perspective doesn't stop you from looking at issues in a holistic way and extracting lessons that could benefit CIHR.

The Chair: You still have a bit more time, Ms. Murray.

Ms. Joyce Murray: I'd like to ask the same question to Monsieur Beaudet. The governing council is talking about direction and strategy. We have one support letter for this appointment and a number of others against. Doesn't a whole career in the pharmaceutical industry bring a pharmaceutical bias to what should be a neutral approach?

Dr. Alain Beaudet: The letter of support you have is a letter of support by the governing council, signed by all members.

Ms. Joyce Murray: It's the research-based pharmaceutical companies that are supporting it.

Dr. Alain Beaudet: Perhaps the other letter was not distributed. There was a letter written to this committee, I think, sent to you on behalf of all members of the governing council.

The Chair: They should all have a copy of it. If not, we'll make sure they do.

Dr. Alain Beaudet: Thank you.

Clearly what they say is that, after a careful gap analysis, what was glaringly missing in terms of expertise on the council—because we do have experts in public health, experts in global health, experts in basic research, experts in applied research, and experts in health policy—were experts in commercialization, innovation, and development of pharmacology. So I think we are filling a gap that was identified by council members, and I must say that, unanimously, members of council have approved of the nomination and thanked the government for listening to their request to provide someone who could fill that gap.

● (1725)

The Chair: Thank you, Mr. Beaudet.

Now we'll go to Dr. Carrie—or I'm sorry, Mrs. Davidson, instead.

Mrs. Patricia Davidson: Thanks, Madam Chair.

And thanks very much to both of you for being here with us this afternoon.

We're hearing different, conflicting stories here. We're talking about all these letters of displeasure, and so on. I received four letters of displeasure and one of support, and now you're telling me there is another one that hasn't been circulated. So in my mind, it really isn't heavily weighted here.

Then there's something else you just said, Dr. Beaudet, that it was a unanimous decision by the council.

Dr. Alain Beaudet: If I may, council unanimously approved the nomination of Mr. Prigent. It was welcomed unanimously by council as fulfilling a need.

Mrs. Patricia Davidson: Thank you very much. I am glad we've made that point clear. There has been some suggestion that perhaps it wasn't unanimous, so I'm glad to hear you clarify that position.

I think one of the other things we've talked about on and off over many years is the fact that there needs to be better rapport and a better working relationship between the public and the private sector. We all know that health research in science and technology is an extremely important area. But it's not only important for the private sector; it's important for the public sector too. To see both sides represented, I think there needs to be that collaboration and the input.

Can you tell me, what are CIHR's current priority areas, and how will the appointment of Dr. Prigent help you work towards that?

Dr. Alain Beaudet: Certainly. Actually, I can even recommend excellent reading, which is the strategic plan of CIHR that was just launched a few weeks ago, where our priorities are very clearly outlined.

Without going into a large presentation of our strategic plan, I'll just insist on impartiality and excellence in what we fund, based on excellence, and focusing on excellence and competitiveness internationally, a few select but very important health research priorities based on the needs of Canadians, which includes better support for patient-oriented research, including clinical research; better support for research on our health care system and improving the sustainability of our health care system; better support of research on aboriginal health issues and other vulnerable populations; support for chronic diseases and mental health, which, as you know, are major issues in our society and are only growing with the aging of the population; and further support of research into emerging threats. As you know, some of these emerging threats are infectious in nature—we are living it right now—but we can foresee more of these threats that are, for instance, brought in by climate change.

Those are the five major priorities of CIHR for the next five years. Quite clearly, I can see how critical Dr. Prigent's expertise in clinical research will be in helping us to implement our priority on patient-oriented research strategy, how his superb expertise in research management will help us with our strategy on improving our health care system and the translation of the results of health research into better health care and health outcomes for Canadians. I can see how his expertise with global health will help us respond to the priorities on vulnerable populations, on aboriginal health issues, which, as you know, are very similar to the ones in developing countries, but also on emerging threats, particularly infection. And finally, Dr. Prigent has, as you saw, a wealth of expertise on a number of chronic diseases, which is the last focus in our strategic plan.

So I feel, actually, that he's exceptionally qualified to help us implement these different priorities during the next five years.

● (1730)

Mrs. Patricia Davidson: Thank you.

The Chair: We're pretty well finished now, Ms. Davidson. I'm sorry about that.

I want to thank both of you very much, Mr. Prigent and Mr. Beaudet, for coming today. You've been very helpful and very gracious. Clearly, the expertise before us is something that we do value so much here in Canada. We welcome your input, Mr. Prigent, into the many very vital parts you will be serving in your appointment. Thank you for coming today.

The meeting is adjourned.

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