House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 003 • 3rd SESSION • 40th PARLIAMENT

EVIDENCE

Thursday, March 18, 2010

Chair

Mrs. Joy Smith

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● (0900)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning, ladies and gentlemen. Welcome once again to the health committee. I'm glad to see everybody here this morning.

Pursuant to Standing Order 81(5), we are here for supplementary estimates (C) 2009-10, votes 1c, 5c, 10c, 25c, 40c, 45c, and 50c under Health, referred to the committee on Wednesday, March 3, 2010, and, pursuant to Standing Order 81(4), main estimates 2010-11, votes 1, 5, 10, 15, 20, 25, 30, 35, 40, 45, and 50 under Health, referred to the committee on Wednesday, March 3, 2010. We will be engaging in the estimates once again this morning.

I want to say a special welcome to our witnesses this morning.

From the Department of Health, we have Morris Rosenberg, Deputy Minister. Welcome once again, deputy.

We have Glenda Yeates, associate deputy minister. Welcome.

We have Mr. Alfred Tsang, chief financial officer. Welcome again, Mr. Tsang.

From the Public Health Agency of Canada, we have Dr. Butler-Jones, Chief Public Health Officer. Again welcome, Dr. Butler-Jones.

We have James Libbey, the chief financial officer, at our table once again, and we have Mary Chaput, associate deputy minister. Welcome to our committee.

This morning we will not have opening comments. We had them yesterday. We're going right into the question and answer period to give you ample time to cover all the questions you have on committee.

We will start with our seven-minute round, beginning with Dr. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Good morning, Madam Chair.

Good morning to all the witnesses. Thank you so much for coming.

Before I begin today, I would just like to once again raise the unacceptable TB rate among our Inuit, which is 186 times that among Canadian non-aboriginals, and among first nations, which is 31.4 times higher.

This risk is similar to some countries in the developing world. It's unacceptable.

I'm wondering if we would like to consider bringing Dr. Gully back to look at this.

Mr. Morris Rosenberg (Deputy Minister, Department of Health): Maybe I can just start, Madam Chair.

I would be happy to bring Dr. Gully back. Dr. Gully is with us not just for H1N1 but is providing public health advice generally to first nations and Inuit health branch. Obviously we'd be happy to find an appropriate time to explore that issue.

If you would like, we can address the issue a little bit further this morning. I'd ask my associate deputy minister, Glenda Yeates, to perhaps speak to this.

Ms. Kirsty Duncan: I think I'll leave that. Thank you.

Mr. Morris Rosenberg: Okay.

Ms. Kirsty Duncan: Knowing that he is going to be there gives us great faith that this will be addressed.

I'm going to come back to CHVI. What was the initial driving reason for CHVI?

Dr. David Butler-Jones (Chief Public Health Officer, Public Health Agency of Canada): Canada was very much interested in being part of global efforts to develop a vaccine. At the time that started, one of the deficiencies, or one of the challenges, was having trial-lot production facilities for clinical trials. That's why, as part of Canada's CHVI strategy, that was one of the areas of focus. In the subsequent time, that has now been addressed, so those resources are better used elsewhere.

Ms. Kirsty Duncan: Was the driving rationale the fact that a number of clinical trials failed for reasons related to clinical lots manufactured under inadequate conditions, rather than because of the actual design of the vaccine?

● (0905)

Dr. David Butler-Jones: No. As you can appreciate, there are tremendous challenges in the development of a vaccine against a retrovirus. One of the key concerns is that you don't want to actually stimulate... Since the action of the retrovirus is to create a challenge for the immune system, you don't want to actually recreate a challenge to the immune system in otherwise healthy people.

With the complexity of the vaccine, as we've seen in multiple clinical trials, they've been very challenged, and even the one that has some promise still had very marginal benefit. The issue now is finding good models for vaccines that might have the prospect of working. There have been multiple trials that have not worked well, and it has not been about manufacturing; it has been about the basic vaccine itself.

Ms. Kirsty Duncan: I'm still struggling with the fact that a due diligence study was undertaken in 2009 after the government announced the partnership with Gates in 2006.

We know the scientific committee met in May 2009, and you kindly offered to provide dates of subsequent meetings. What it looks like is that the international committee was invited in May, and at the same time this parallel process was going on. I think you have made capacity in the world the focus. Shouldn't it have been the quality of manufacturing?

Dr. David Butler-Jones: We were proceeding on with the process. As it turned out, none of the applicants crossed the bar. At the same time, given the time elapsed and given the recognition that things had changed in the world, Gates commissioned the study to look at capacity to make sure that we were on the right track. That turned out to illustrate that in fact capacity had increased and that the needs and circumstances had changed, so since we did not have a successful applicant and the capacity issue was now addressed, it seemed much better to use that money elsewhere.

Whenever that takes place, it's a bit like arguing that we could have done something different about H1N1 because H1N1 arrived in April and surely we should have known that it was going to be H1N1 a year before that. You only know what you know as you know it, and there were in fact reviews that identified, when we started the process, that there was this need. By the time we got to that point last year, there was no longer that need. The world changes no matter what we do.

Ms. Kirsty Duncan: With reference to the Oliver Wyman report, do you think there are any problems with the study?

Dr. David Butler-Jones: In the report itself they identify the limitations, but there is clearly sufficient evidence there about the change in circumstances that convinced people that we now need to redirect those resources to other areas of HIV vaccine work.

Ms. Kirsty Duncan: The document does begin with a disclaimer. Do you think it's acceptable that the document is in part based on secondary information that was not independently verified?

Dr. David Butler-Jones: For this purpose, yes. You can't do everything and you can't follow everything, but certainly for this purpose, yes.

Ms. Kirsty Duncan: The project objectives were as follows: the primary emphasis was on assessing physical capacity, not quality of the capacity, and, where possible, to capture data on prior GMP experience as proxy. The study was to assess the physical capacity, not the quality of the capacity, for manufacturing clinical trial materials for HIV vaccines.

It's my understanding that it was the lack of manufacturing facilities meeting stringent regulatory requirements for vaccine manufacturing that initiated the CHVI program. These vaccines are tested on living people, and we have to ensure the safety of all vaccines. Do you think that study should have included the quality aspects of manufacturing—yes or no?

Dr. David Butler-Jones: These production facilities are all subject, where they are, to the usual kinds of regulatory controls, as would be a facility were we to build it here. If we built it here, there's no guarantee that it would be any better than one built anywhere else. That's just a practical reality.

The point is that for the clinical trials, for ethics reviews, for all of these purposes, they have to meet those standards. It's in the scientific world; you're not going to be able to cover 99.9999% of every issue or every question. The point is that the capacity is there and it's with reputable organizations, and the feeling is that there is sufficient capacity now to address what we need going forward.

● (0910)

The Chair: Thank you, Dr. Butler-Jones.

Go ahead, Monsieur Malo.

[*Translation*]

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

Unfortunately, this morning I am going to have to revisit the comments made on Tuesday by Michelle Boudreau, the director general of the Natural Health Products Directorate. As I pointed out on Tuesday, the figures she provided did not seem to correspond to the figures we were given by the Library of Parliament Research Service. I am going to quote Ms. Boudreau, who said: "Within this backlog, there are only 193 product applications left to be completed."

That means that when we look at the backlog, the pile of what is left to be completed, we see that all the rest have been completed. There are still 193 applications left to be completed in the pile. The rest have been completed, with a yes or a no. That is what "completed" means.

Here is another quotation from what Ms. Boudreau said: "So, we are very confident that we will reach the stated objective by the end of March and within the timelines we had set. We expect to have completed everything that is outstanding, in other words 3,000 licensing requests by the end of December 2010."

We look at the two piles, the pile that is backlogged and the pile of applications after April 2008, that is all that's left. For the rest, Ms. Boudreau told us it was 3,000, while according to the Library of Parliament Research Service, what is left is 10,705 applications. I am asking Mr. Rosenberg to tell me what the real figure is, is it 3,000 or 10,705?

Mr. Morris Rosenberg: Thank you for the question.

I am going to ask Ms. Boudreau. I am going to ask her whether she can explain the difference between the figures from the Library of Parliament researchers and hers.

Ms. Michelle Boudreau (Director General, Natural Health Products Directorate, Department of Health): Thank you.

I am certainly going to try to explain the figures and I admit they can sometimes cause confusion.

In part, it is because we are using two terms. I am going to use the English term because I think it expresses it better. In French, we would say it is the same term. In English, we say "addressed", while in French, we say "*traité*". When we talk about the term "addressed" in English, we mean that either the licence has been issued for the product or we are in the process of processing the application, that is, we have reviewed the application, we are in the process of evaluating it and we have at least sent a request for further information in order to complete the application. We are talking about these three things when we use the term "addressed", which is not easy to express in French. In that language, we say "*traité*". So it is that number, 193 applications, that are left to be addressed, as I said the other day.

Mr. Luc Malo: So you are no longer using the word "complete"?

Ms. Michelle Boudreau: No, because for the term "complete", I'm going to come back to that.

Mr. Luc Malo: That is the word you used on Tuesday, "complete".

Ms. Michelle Boudreau: Right, I apologize if I said that, but the distinction is that 193 applications are left to be addressed, and in the total exact figure, which is 3,098, the rest, that is, the 3,098 less the 193, all the applications can be completed with a final decision by the end of December. However, between now and then, I can't tell you that we will have completed the 9,764 remaining applications. So it isn't just the backlog, it is the normal workload. That is the distinction to be made, because I know the two different terms can cause confusion.

Mr. Luc Malo: I asked the minister the question on Tuesday and I asked her whether, as she had told us on February 10, 2009, she was going to eliminate the backlog. When I say "eliminate", when we are talking about a deficit, that means there is none left, it is zero. That is the term she used here, in the committee, in February 2009. She talked about eliminating the backlog before March 31 and I was told yes. So are you still confirming that the backlog will be eliminated by March 31?

● (0915)

Ms. Michelle Boudreau: No, I am simply going to go back to what I said earlier. The backlog will be "addressed", in English, because I think that expresses it better, before the end of March, and the backlog will be eliminated, if you want to use the term "eliminated", before the end of December of this year.

Mr. Luc Malo: What is the complete deadline? Because the deadlines are getting pushed back. There was talk of December 2009. You gave yourselves a number of internal rules. You were talking about March, but ultimately, it's December, and it ends up being a little later. But I think people are entitled to know what the real deadline and the real budget you have given yourselves are. Those are legitimate questions and we are looking at contradictions and also fluctuating information. Are you able to tell us? There are jobs and revenue at stake.

[*English*]

The Chair: Monsieur Malo, your time is running out, and we need her to answer the question.

Mr. Luc Malo: *Merci.*

The Chair: Thank you. Calm yourself.

[*Translation*]

Ms. Michelle Boudreau: For the year and a half I have been the director general, we have always been talking about the same deadlines. The first deadline you mentioned, in 2009, is the only one we see in the present regulations and it applies only to products with a DIN, Drug Identification Number. These are products that were in fact regulated under the former regulations that are now transferred to the new regulations. That is the only deadline in the regulations. You will not see another. So as a department, we adopted a deadline that we announced several times to the industry and consumers, to tell them: "This is the deadline we have given ourselves, it is an internal deadline."

As I said earlier, we are in fact on the right track to address the backlog before the end of March. That is the deadline we have been announcing in several of our documents for at least a year. For the December deadline announced to people a few months ago, we are in fact on the right tract to complete the backlog, 3,098 applications before the end of December 2010.

[*English*]

The Chair: Thank you, Madam Boudreau.

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

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Madam Chairperson.

Thanks to all of you for coming back today.

I want to go back to Dr. Butler-Jones—as he would expect me to—on the Canadian HIV vaccine initiative, and refer specifically to the process pertaining to the four bids for the actual vaccine production facility.

On February 21, in a very long conversation I had with Dr. Rainer Engelhardt and Mr. Steven Sternthal, who is the director of the Canadian HIV initiative, it was indicated to me that all four consortiums who had placed bids in this process had received full explanations for why their bids were not accepted in a spirit of complete transparency.

To the best of my knowledge, those full explanations have not been forthcoming. Can you table for us today the detailed explanations that were given to each of these four bidders, or at least tell us if that request has been met, or if that promise has been fulfilled?

Dr. David Butler-Jones: As with other bids or with research bids, it would not be appropriate to table what it is. Should they wish to share it with you, that's up to them. But we would keep that in confidence. We don't share that with... We share that with the individual who placed the submission.

Ms. Judy Wasylycia-Leis: Fair enough.

Dr. David Butler-Jones: Those discussions have taken place, and further discussions will be taking place.

Ms. Judy Wasylycia-Leis: It's hard for them to share anything with us if they haven't been given anything. And the promise for full, detailed explanations does not appear to have been fulfilled. When will it be fulfilled? When will each of the four bidders get a detailed explanation of why their bids did not meet the requirements?

Dr. David Butler-Jones: They've all had detailed discussions. Whether their perception of it is the same as...that's a different question. But the discussions have taken place with all of them, and they are continuing.

● (0920)

Ms. Judy Wasylycia-Leis: So you haven't given a detailed written explanation to any of these four bidders, who put in upwards of $2 million in total to meet the process as set out in 2007.

Dr. David Butler-Jones: Our responsibility is to make sure they understand where there were deficiencies for them, and those conversations have taken place. I'm not sure about what was put in writing to them or not, but those discussions have taken place. And as I say, they will continue, as they wish.

Ms. Judy Wasylycia-Leis: You don't find it strange that they wouldn't receive detailed written explanations, after such a long and costly process, about why they didn't meet the requirements of the program? You don't find that strange?

Dr. David Butler-Jones: They've been told what their deficiencies were.

Ms. Judy Wasylycia-Leis: Okay. We'll leave it at that, then.

Dr. David Butler-Jones: There's no reason to...because there is no successful bid, and we are not proceeding. It's not like a new bid will make a difference. If there were to be a new bid, the detail would be more, but the detailed discussions are ongoing. They've had high-level discussions, they've had various levels of detail.

Information has been shared with them—

Ms. Judy Wasylycia-Leis: Let's leave it at that, because in fact—

Dr. David Butler-Jones: —and we'll continue to do so. And that's between the bidder and ourselves.

Ms. Judy Wasylycia-Leis: —that is not in the spirit of any kind of transparency and full disclosure that anyone would expect in the field or that was promised and indicated to me was a commitment that was fulfilled by the head of this program and leading scientists at the laboratory in Winnipeg.

Let me go on further to Kirsty Duncan's questioning around the study that has been used as one of the excuses for the termination of these bids. Are you aware of a study that has been done to critique the Gates study? I want to refer specifically to a study done by Don Gerson, who is a leading expert in this field. He has his Ph.D. from McGill, he is a professor of biophysics and biochemical engineering at the University of Western Ontario, he is president and CEO of PnuVax, Inc., and he did, on March 8, a complete analysis of the Gates study, indicating in fact that "this study is fatally flawed by its failure to place priority on the quality aspects of clinical materials manufacturing".

Are you aware of the importance of good manufacturing practices and what that means in this context?

Dr. David Butler-Jones: I am aware, and that is obviously a criterion. Both the Gates Foundation and we are very conscious of the need for quality science, and the assessment was that this was sufficient information. The issue of quality is one that is always there in terms of good manufacturing processes, quality manufacturing processes. That's always going to be there. It's not going to happen without that. The deficiencies in the Canadian proposals relate to that.

It really is something which...for the Gates Foundation and for us, the information is sufficient, given the standard of laboratory practices, given the standards that all the laboratories are expected to provide and to do in terms of good manufacturing processes, that it was not an issue. There will always be an exceptional view, but the general view was clearly that this was sufficient.

Ms. Judy Wasylycia-Leis: Given the scientific questions, the questions based on good scientific merits that have been raised about the Gates study, and given the fact that the Gates part of this whole proposal was only $22 million out of the $139 million in total—so only a portion of that against the $88 million for the facility—we're talking about a fairly small contribution in the face of a promise by the Canadian government three years ago to provide a leading-edge production facility in this area.

Given your role as the chief health officer of Canada, are you not questioning at all how this study suddenly emerged under the auspices of the Gates Foundation in July 2009, and are you now not, based on this strong representation by scientists like Dr. Gerson, questioning the process and the study, and in fact sounding the alarms about the entire process? Is it not your obligation—

The Chair: Your time is just about up, Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: —as chief public health officer to do that?

Dr. David Butler-Jones: My obligation is to provide the best advice possible, both scientific and in matters of public health, and as the deputy responsible for the Public Health Agency to manage its affairs both in policy and finance. Those are my responsibilities.

I have seen this. I have seen this evidence and been part of the discussions with the Gates Foundation and with the scientists. It is my assessment, along with the Gates Foundation, that in fact this resource could be better spent elsewhere at this time, given the capacity that's developed in the world.

I have to take evidence as it arises. For example, throughout the H1N1 that we've been having, we saw things that arose on a certain date. It wasn't three weeks earlier, it wasn't three weeks later. You deal with it when it comes. This was part of additional due diligence beyond the original. Given the space of time, it was appropriate to assess what the capacity was in the world and how it had changed. The assessment was that the capacity had changed. Therefore, re-examination, given that none of the applicants passed the bar—they all had deficiencies and would require some major work in order to change that, whether in a new process or a revised process—and that capacity is now out there, it was my clear assessment and that of those who advised me, as well as the Gates Foundation, that in this case it is time to move on and use those resources for something else to move the agenda around an HIV vaccine.

● (0925)

The Chair: Thank you, Dr. Butler-Jones.

Ms. McLeod.

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

I would like to start by building on my colleague's comment around tuberculosis. Not only is tuberculosis an issue, but we know there are significant health disparities within our native and Inuit communities. We obviously know that improving housing conditions, poverty, water, and safe drinking supplies are part of the solution, but certainly first nations and Inuit health have a critical role to play.

I notice there are some changes in terms of where you're going. You're talking about $237.3 million to stabilize primary health care services and non-insured health benefits, and I'd like to hear a bit more about what that will involve. How much of it is primary health care, and how much is related to drugs, eyeglasses, dental care? That's my first focus.

The Chair: Who would like to take that question?

Ms. Yeates.

Ms. Glenda Yeates (Associate Deputy Minister, Department of Health): Thank you very much, and thank you for the question.

It is the case that we have significant challenges in terms of supporting and improving health services and health status on first nations reserves. I think reducing the inequalities that we see is a very significant priority for the first nations and Inuit health branch. To that end, we have a number of programs. You mentioned the non-insured health benefits program, by which we provide a range of drugs, dental services, and other services to people living on and off reserve. You mentioned the estimates; the incremental amount there is $305 million that was put in budget 2009, over the two years, to help stabilize that program.

In addition, of those stabilization funds for the $440 million over the two years that was announced as part of the economic action plan, there is $135 million for infrastructure. We have a significant number of communities, around 200 communities, that are very isolated, where we have nursing stations and often we have nursing residences to support the staff who stay there. We have some significant ability with those funds to move forward on our capital program to construct and renovate and modernize some of those capital facilities as well.

In budget 2010 there is also $285 million, over two years, for aboriginal health programs in some of the prevention and treatment areas, such as diabetes, suicide prevention, maternal and child health.

These are investments that we think will be very important as we move forward to try to reduce the inequalities in health status that we see.

Mrs. Cathy McLeod: The additional money is providing additional capital infrastructure, but is it changing what's available in each community, for example, in terms of non-insured health benefits or primary care services? Or is it more focused on ensuring some reasonable accommodation?

Ms. Glenda Yeates: In terms of the non-insured health benefits, it is a program that has rising costs every year. Typically that's because we're always adding new drugs, for example, so there would be an expanded range of drugs. But it's not a major policy expansion. It's simply that as new drugs come on the market and they are assessed, they are added to the formulary, for example.

In addition, we have increased population. We are covering more people because this is a growing population, so that leads to increased costs as well.

Where we have been able to have some new programming in recent years—and we are able to continue that with the $285 million in this coming budget—is in the area of youth suicide prevention and maternal and child health. These are programs that have been started in more recent years, and this money will allow us to continue those, to refine them, and to make sure that in addition to the very important treatment services we have some services on the prevention side as well.

● (0930)

Mrs. Cathy McLeod: Thank you.

I'd like to shift directions. I think I like to explore Canada Health Infoway frequently because many people believe it is absolutely critical to creating success across Canada in terms of our electronic health records. Technology is supporting our communities, our physicians, our hospitals, and most importantly, of course, our patients and how we provide care.

I know that the audit federally was very positive. People's perception of what is happening is due to some unfortunate circumstances within some of the provinces, where perhaps people are not as aware of the good work. I would like to hear more about Infoway, where we're going, and how it's moving forward.

Mr. Morris Rosenberg: Thank you.

As was mentioned, the federal Auditor General did an audit of Infoway. While no audit is ever perfect, I think the Auditor General found that Infoway was largely on the right track. A few recommendations were made with respect to some of its management practices. Infoway did issue a management response and action plan to move forward on those recommendations. On that basis, in budget 2010 the government freed up the $500 million that was part of the economic action plan for Infoway.

A lot has been accomplished. I can give you a sense of some of the initiatives with respect to moving toward the benefits of electronic health records. Three-quarters of X-ray films—this applies to anybody who's ever had to go to a hospital and wait for X-rays, even though X-rays may have been taken before—have been replaced by digitized images in the public health system. So the accessibility of those X-rays, the reduction of needless duplication, I think is a very important part of this.

The development of drug information systems, which are a key building block of electronic health records, are in place in B.C., Alberta, P.E.I., and Saskatchewan, and that's really important. I think one of the main benefits of the electronic health record is getting information that will avoid error. If you can get a sense of what has been prescribed and what contraindications are, and avoid some of the written script where there are errors in terms of interpreting it by pharmacists, I think that's an important benefit of an electronic health record.

All communities north of 60 degrees are telehealth-enabled, or are in the process of implementing telehealth capabilities. Again, given the nature of Canada and the remoteness of a lot of our communities, the importance of having access to telehealth is huge.

In Alberta, 20,000 authorized health care providers are actively using the electronic health record, and this has helped Alberta start to implement a chronic disease management system.

Those are just some of the examples. Infoway continues to work with the provinces and territories. The Auditor General found a very prudential funding arrangement. It needs to see real proof of sound implementation plans before money will flow to the provinces and territories.

The Chair: Thank you, Mr. Rosenberg.

Now we'll go into our second round. It's five minutes for the question and answer.

We'll start with Dr. Bennett.

● (0935)

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

I want to focus a little bit on maternal and child health, and the Prime Minister's commitment. Is that a priority for the G8?

I want you to explain how, with that commitment, in the main estimates on page 13-7, $900,000 has been cut from non-profit international organizations in support of their projects or programs on health. Can you tell us which projects those were, or table them, or let us know that none of those are to do with maternal child health?

Mr. Morris Rosenberg: I can't give you the list today. I think you're referring to some of the reallocations made as a result of the strategic review last year. Is that...?

Hon. Carolyn Bennett: On page 13-7 in the main estimates.

Mr. Morris Rosenberg: If you'll just give us a second, we'll have a look at that.

Hon. Carolyn Bennett: It's in the grants and it's for next year.

Mr. Morris Rosenberg: Thank you.

I'm informed—and we will provide you with more details—that none of those cuts deal with maternal health issues.

Hon. Carolyn Bennett: Okay.

In our domestic record on this, in terms of setting it as a priority, obviously there is some concern that the Centres of Excellence for Children's Well-Being have been cut and that the Centres of Excellence for Women's Health have received informal cuts and a much narrower mandate.

It's mainly in our domestic record on infant and maternal mortality in our first nations and Inuit that I'm concerned. We are seeing $70 million transferred from the community care programs for first nations and $50 million transferred from Inuit primary care. I would like to know how that is justified.

We are still having trouble having the data on infant mortality in terms of first nations and Inuit. We know it's higher. We know that when you average it in, it puts Canada worse than Cuba in infant mortality rates. I would like to know when you're anticipating having the data. What would be the strategy in terms of what, by when, and how we will reduce the infant mortality rate in our first nations and Inuit as well as among all Canadians in remote rural areas?

Ms. Glenda Yeates: Thank you for the question. There are two parts. I'll address the data part first and then speak to the programming section.

I think we all share the concern and the challenge about getting better data, because it does enable us as a country, whether be it at the local, regional, provincial, or national level, to actually understand where the fine points are, where the interventions are, where the challenges are, and where the interventions should be targeted.

As you mentioned, unlike some countries, we have not gone with first nations identifiers or ethnicity identifiers. The U.S. has taken a much different approach in their data collection than we have in Canada. At this point, the strategy is to work nationally with first nations national aboriginal organizations, and to work locally with bands and regions to understand their willingness to have data collected and to work with them, so that there is some understanding of the importance of having data that will give us better information on a first nations basis.

Having said that, working with organizations such as Statistics Canada or the Canadian Institute for Health Information, there are some ways of, writ large, trying to estimate some of the gaps in, for example, infant mortality. We do know that there are some higher rates. We are working with those organizations and with national aboriginal organizations to continue to improve the data.

Having said that, we do know this is an area of priority and of urgency, and we do have a maternal and child health program. The estimates reveal the reductions that you mention, because they don't reflect the $285 million over the next two years that was announced in budget 2010 for five programs, one of which is the maternal and child health program. In fact, there will be no reduction in funding to that program. Although, as you say, that's announced in the budget, it's not reflected in the estimates before you.

With that money, we have... You asked about the strategy. There is a multi-faceted strategy. I think we always understand the complexity of working with communities and individuals on maternal and child health. Some of the program elements that have been in place are things like home visitation, having community workers doing screening, for example, in terms of high-risk moms, and trying to both prenatally and postnatally support those particular families and individuals. There has been an effort to integrate culture into care, so it's working, again, to adapt, through elders and through translation into local languages, for example, some of those documents, supports, and guides that we have.

There is case management to help families who might be high-risk, who have specific needs, to try to help those targeted families access the services they need.

● (0940)

The Chair: Thank you, Ms. Yeates. Time is up.

We'll now go to Mr. Brown.

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

I'd like to follow up on some of the questions that Ms. McLeod asked. I too am interested in the Canada Health Infoway.

I appreciate the benefits. I'm just a little curious about how we monitor where it's going in the partnerships with the provinces, because every year we see these budget allocations, and in past budgets we had more money going towards the Canada Health Infoway.

I was curious, so I asked the CEO of our hospital in Barrie, Janice Skot, what investment she has seen in e-health come down from the province. She told me they haven't seen any e-health funding at our local hospital.

When we go back to our communities, what evidence should we be seeing of the federal investments in Canada Health Infoway? You mentioned to Ms. McLeod the digital copies of X-rays. Are there other examples like that, and would I be seeing that at my regional hospital? Would that be the result of federal investments into Canada Health Infoway?

Mr. Morris Rosenberg: Thank you for the question.

I think one of the realities of Infoway, and it really does go to the funding model, is that funding isn't flowing across the country on an equal basis. That is because Infoway, as part of its prudence in how it manages its money, will only flow money where it feels that provinces have met a threshold of readiness to implement projects. So you have some provinces—I think Alberta and P.E.I. are examples—that are further ahead than others. You have others—Ontario would be an example right now—that for a variety of reasons are less far ahead. So not everybody will see all of the benefits I talked about in an equal way.

The idea, though, in Infoway is that the country will be very close by the end of this year to having 50% implementation of electronic health records. Again, that will not be 50% across the board, but it will be 50% looking at various jurisdictions.

Obviously the idea is to get the entire country on a basis of electronic health records to establish standards in a way that, when people move across the country, there will be portability of those records even though the systems are going to be built on a provincial basis. That, by the way, is very similar to the way other electronic systems in other industries have evolved.

Mr. Patrick Brown: I love the goal, but I'm curious to know where we are. You mentioned P.E.I. and Alberta being ahead. Where are we in Ontario? As an MP who resides in Ontario, what progress could I point to in Ontario where we've seen federal investments have success?

Mr. Morris Rosenberg: Ontario has been a little bit more problematic, as you're aware, because of some of the difficulties that occurred initially with Smart Systems for Health, and then more recently with eHealth Ontario.

One thing I will say is that there is one very good example, and that is the Ontario Telemedicine Network, which has over 2,000 health care professionals now delivering care to over 660 rural and remote sites throughout the province. In terms of the progress that I mentioned generally with respect to telehealth, I would say that Ontario is, in respect of that aspect, among the leaders.

I would also say that, in Ontario, following the much-publicized concerns and the provincial Auditor General's report around eHealth Ontario, I know that new management has been brought in. I know that a former federal deputy and former head of the board of The Ottawa Hospital, Ray Hession, who has an excellent reputation as someone who can come in and essentially put big informatics systems on the right track, has been working with eHealth Ontario, and I'm hopeful that within a reasonably short time you'll see real progress in Ontario.

● (0945)

Mr. Patrick Brown: You had mentioned the 50% implementation rate. Is that unrealistic to hope for by the end of the year in Ontario?

Mr. Morris Rosenberg: I think it may be. That's a national rate. I'd have to get back to you on where we would be with Ontario. I don't think Ontario will be at 50%. I think we're actually quite close to 50%, even though in the Auditor General's report the actual metric was somewhere just below 20%. The reason for that is in the way the 50% is calculated. Every element of an electronic health record has to be in place. Even if you have 10 elements, and nine are in place and the tenth isn't, it's not there yet. But in fact, in our discussions with Infoway, they were quite confident that we will actually see very significant progress in getting to that 50%.

Mr. Patrick Brown: And—

The Chair: I'm sorry, Mr. Brown, your time is up.

Thank you, Mr. Rosenberg.

We'll go to Mr. Malo.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

The commitment made by the minister, Ms. Aglukkaq, concerning the backlog regulations on February 10, 2009, is as follows, and I am going to read it in English because it was made in that language:

[*English*]

"Our government is committed to eliminating the backlog by March 2010."

[*Translation*]

So the minister told us that her objective, her political commitment, is to eliminate the backlog by March 2010. From what Ms. Boudreau said, her directorate's objective at the Department of Health was more specifically to start to address all files in the backlog by March 2010, to give them a file number, that is. Mr. Rosenberg, how is it that the minister's political commitment was not the message conveyed or understood by the directorate? Is it common practice for there to be dissonance between a directorate's objective and a minister's political commitment?

Mr. Morris Rosenberg: I began by saying, as Ms. Boudreau explained yesterday, that in part, it is the meaning of the words that is in issue. There is no intention to give you incorrect information. It is a complex question. I have to say that the department and the Natural Health Products Directorate are clear and transparent. On our website, there is information that had been there for some time and that advises natural product suppliers and consumers about the deadlines. If the committee wants, we can submit that information, which is public anyway. We are trying to deal with a challenging situation with as much transparency as possible. I can't give any reply other than that.

Mr. Luc Malo: You say the deadline is on the website. In her reply a little earlier, Ms. Boudreau told us about the deadline for the backlog. In her mind, it will all be eliminated by December 2010, but for the rest, 6,666, if my calculation is correct, what is the deadline and what financial resources have you given yourselves to deal with the normal workload?

● (0950)

Ms. Michelle Boudreau: To come back to the question Mr. Rosenberg answered, yes, we certainly have details on our website. There are information sheets created for consumers, pharmacists and the industry that have been posted for several months showing the three dates, 2009, March 2010 and December 2010.

In terms of the deadlines, for the rest, about 6,000 applications, we have no deadline as such, but we are in the process of addressing applications made by monograph. The other day I mentioned that we have monographs. Those applications, we complete them, with a final decision that is, within 60 days. That is a fairly respectable performance standard. For the others, somewhat complex applications, products that have several ingredients, for example, or more sophisticated health claims, we are working with our advisory committee, the one I referred to the other day, to develop performance standards. We are in the process of developing something that would still be respectable and reasonable, a performance standard between 90 and 180 days, which is still very respectable, as I said. In fact, the 180 day standard is a figure suggested to us by the industry for this type of more complex application. I admit that we are not there yet at this point. As Mr. Rosenberg said, this is a very complex field. We had a number of applications to deal with, as you undoubtedly know. There had been nearly 47,000 applications received since the regulations came into force and we have completed almost 37,000. So we have really progressed a lot, by completing 78 to 80% of the applications. As I told you, regarding performance standards, we are getting there and we think we can put those standards in place in a few months, with the help of the advisory committee.

[*English*]

The Chair: Thank you, Madame Boudreau.

We'll now go to Mrs. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thanks very much, Madam Chair.

Thanks very much to our presenters for being here with us again this morning.

I want to change pace a little and ask some questions about seniors. We know that we are certainly coming up to having a large percentage of seniors in this country, and I think we have evidence that shows us that falls are the most frequent injury among seniors. We also know that many of these falls result in institutional placement and loss of independence, and all these things give rise to a far lower quality of life for our seniors.

The number of older persons in Canada is projected to increase greatly between 2005 and 2036, from 4.2 million to 9.8 million, and it is also estimated that the number of older persons who will fall at least once in 2036 will increase to 3.3 million. These figures are staggering.

We have also seen evidence that falls can be prevented through a combination of interventions, including education on their risks, how to prevent them, exercise, and those types of things.

Can you tell me what the Public Health Agency of Canada is doing to address the issue of falls in seniors?

Dr. David Butler-Jones: Thanks very much for the question.

All of us are aging. That is a good thing. The alternative is not preferred.

As we age, in many ways the challenges do increase. In terms of falls or aging, a number of things can be done. In some ways it's actually quite simple. A lot of the falls are based on declining vision, throw rugs, tripping in the home, etc. It can be from not clearing sidewalks, or from not having smooth transitions on stairs; suddenly you can't see the edges of stairs. Simply having strips on stairs can tell you where the edge is.

There are a lot of things that are fairly simple, so education is part of the answer. Partly it's also the municipalities and others, in terms of creating age-friendly communities—not just for the aged, but for all ages—that provide access and movement and exercise and all of these things that make for a healthy outcome.

In Vancouver on March 22 and March 23 there will be the first-ever conference on seniors' falls prevention. It is being sponsored by us. As well, we have been involved in the development of the award-winning Canadian falls prevention curriculum initiative. There are also e-learning issues. In 2005 we had our report on seniors' falls, and we plan to update it next year.

There is also my report this year on the state of public health. Each year has a theme, and this year's theme will be seniors. Clearly falls prevention is one very important aspect, and it is something that we've demonstrated we can do something about. It takes a little thought and effort. It's not expensive, though, and it can make a huge difference to quality of life.

● (0955)

Mrs. Patricia Davidson: Thank you. I think it's commendable that we are definitely looking into these areas. It is definitely much needed as we look after the health and well-being of our seniors.

I have one more question. It's regarding the Patented Medicine Prices Review Board. When I looked at the main estimates, on page 13-13 I believe, I saw that you were requiring about $7.75 million for compliance and enforcement of non-excessive prices for patented drug products. This is an increase of about $704,000 for this particular program activity over the last year's estimates.

How many public hearings does the PMPRB expect to conduct in 2010-11 in support of its mandate, and how does this number compare with the number of hearings held in the previous year? Are we increasing the number greatly? Is this keeping up with the backlogs, and so on?

Mr. Morris Rosenberg: Thank you for the question.

Just to be clear, the regulatory mandate of the Patented Medicine Prices Review Board is to ensure that prices charged by patentees for their patented medicines sold in Canada are not excessive. The role of the board and its staff is to investigate prices of patented medicines that appear to be excessive. This may result in a report to the chairman for a possible hearing, once board staff and the patentee have determined that the matter can't be resolved by a voluntary compliance undertaking from the patentee.

Currently there are several patented drug products that appear to be priced excessively. Board staff will submit a report to the chairman for the issuance of a notice of hearing on one or all matters, if it's not possible to resolve these voluntarily.

As I mentioned the other day in response to a question from Mr. Malo, there has been a change over the last while with respect to the way the practice of that board is carried out. Traditionally, going back to the mid-1980s, when it was set up, most matters were resolved voluntarily. There has been a tendency lately for more matters to go to a contested hearing.

In 2009-10, the board completed four hearings and has issued to date two notices of hearing. At this time there are currently nine ongoing hearings, three of which are at the decision stage.

Mrs. Patricia Davidson: Thank you.

The Chair: Thank you, Ms. Davidson.

We're now going to go to Mr. Bagnell.

Hon. Larry Bagnell (Yukon, Lib.): Thank you, Chair.

Thank you, everyone, for being here.

I want to ask a bit about the services you provide to residential school survivors. Budget 2010 commits $199 million to higher expected funding needs to support the settlement agreement. I know that some of that goes just to the fact that we owe individuals money, but the minister said some of it is going to services that you provide for mental health.

I'm wondering what the breakdown of that money might be. Of the $199 million, how much is going to survivors and how much is going to your department to provide counselling services, etc.?

● (1000)

Ms. Glenda Yeates: Thank you very much for the question.

The $199 million that is referenced in budget 2010 includes $65.9 million that is the Health Canada portion of it. That's for the Health Canada resolution health support program, to be able to respond to the growing demands that we anticipate as a result of the Indian residential school process.

Hon. Larry Bagnell: Is that just for one year?

Ms. Glenda Yeates: No, it's for two years. The $199 million is a two-year figure, and $65.9 million of that is for Health Canada.

Hon. Larry Bagnell: That's over two years? Okay.

How much did those services cost this year, the year before this $65 million came in?

Ms. Glenda Yeates: I don't have the precise figures. Some of the demands for services depend upon the uptake, and the truth and reconciliation process has been a bit slower than originally anticipated. It really is demand-driven, in terms of when people come forward to seek the services.

I have a note here that it was approximately $39 million last year.

Hon. Larry Bagnell: Over the next two years it's almost the same, slightly less per year.

Ms. Glenda Yeates: Yes, and because it's a court-ordered amount, if it turns out that there are more people who come forward, this is something we would have to respond to in a supplementary estimates way. But this is our estimate, which would reflect the demand we expect in the next two years.

Hon. Larry Bagnell: This is just for counselling, and health services, and things for these individuals, is it?

Ms. Glenda Yeates: Yes. There are a number of services here for mental health and emotional health support, including counselling. There's some traditional...using elders and others. There's a combination of services offered.

Hon. Larry Bagnell: Okay.

In a similar vein, but in a different area, there's the $285 million over two years in budget 2010 that renews funding for a number of programs. You've mentioned a couple of times already the five programs: diabetes, suicide, maternal health... It's $140 million for this year. How much was it last year? These are just extended programs. I want to know how much we spent or allocated this year.

Ms. Glenda Yeates: In terms of the $142 million, it was a little bit higher this year. It is broken down for a number of programs. The community programs—we talked about maternal child health or youth suicide prevention—are all at the same level as last year. There are two programs that over this period have less money, particularly in the aboriginal health human resources and some of the transition funds. This current year's spending, I think, will be slightly higher than the $142 million. But the community programs, all of the treatment programs, are at the same level. We've done a very good job, we think, in terms of increasing the number of aboriginal students in various program. Those are areas where we are needing money.

Hon. Larry Bagnell: I'm sorry; 2010 is going to be $140 million. So you're saying that this year, 2009-10, went slightly over $140 million?

Ms. Glenda Yeates: Yes, that's right.

Hon. Larry Bagnell: It was just slightly over—about the same?

Ms. Glenda Yeates: No, it was higher. The community programs—maternal child health, youth suicide, some of the mental health programs—are all at the same level as they were this year. We're still finalizing some of the details, but that certainly—

Hon. Larry Bagnell: But some other ones were higher this year?

Ms. Glenda Yeates: Yes, that's right.

Hon. Larry Bagnell: So there's actually a cut to those programs.

Ms. Glenda Yeates: There were five years of funding, and in some cases we felt, regarding some of the transition programs, that we've moved on and have priorities elsewhere. So there are some areas where we have moved money.

Hon. Larry Bagnell: Could you get us the exact figure later of what was spent this year?

Ms. Glenda Yeates: Yes. We're still in the process of finalizing it, but when it's available we can certainly make it available.

Hon. Larry Bagnell: Thank you.

The Chair: We'll now go to Dr. Carrie.

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

I want to thank the witnesses for being here today. I always find your presence to be very informative.

I want to follow up on my colleague's questions on the Infoway. I want to commend the government for taking a leadership role for electronic records. I think everybody sees the goal, and it's getting closer and closer.

I know there are challenges with the patchwork system we have in Canada. I had the opportunity to read an article about some software being developed at McGill; how it would even work both ways, whereby the software could remind patients, for example, to take their shots of insulin on time.

But it brings up privacy issues. I come from Oshawa, where there was a situation in which electronic records were misplaced. What is the role of the federal government regarding privacy issues in development of these records? Is it something that's a jurisdictional thing with us, or do the provinces look after it, or is it a combination between the two?

And how is that situation being worked upon? When that situation happened in Oshawa, in which these records... Electronically, you can now condense so much information on even a little stick—it's portable, and you can put it on the Internet—that there are some concerns about this. What kind of progress have we had with that?

● (1005)

Mr. Morris Rosenberg: Thank you for the question. I will start, but I may turn to Glenda, only because in her previous job as the president of the Canadian Institute for Health Information she was very involved in some ongoing work that I'll mention.

Privacy is an issue, obviously, with respect to any electronic system, especially a system dealing with the nature of the personal information you'd find on the electronic health record. It's important to manage the evolution of this in a way that will achieve a number of goals in equilibrium. Obviously we want to have the most efficient health record possible. We want to do it in a way that's going to be respectful of privacy. We also want to do it in a way—and it's in this area that the work is really important—that gives us access to aggregate information. There is huge value in having that aggregate information so that the management of the health system can understand outcomes on a regional or population basis.

I'll give you one example of how aggregate information might have been helpful had we had an electronic health record. You'll remember the situation around COX-2 inhibitors and Vioxx back a few years ago. What I've heard in the United States... Vioxx killed thousands and thousands of people. It killed a lot of middle-aged men with strokes and heart attacks. It took lengthy detective work to associate those conditions, because, frankly, a lot of middle-aged or elderly people might come into hospital with those kinds of conditions. If you could have linked the drug interaction—in other words, what they were taking—with the fact that they were presenting with these symptoms and you did a search that determined there was a pattern, it might have been possible for regulators in the world to have moved much more expeditiously with respect to dealing with that situation. To have that capability, you're going to need individual patient information. You don't necessarily need everybody's specific identifiers right down to the name, etc., but you need to have enough information to enable you to draw those conclusions.

That's one illustration, one example, of the kinds of issues we're dealing with. On the one hand, we don't want to have rules that would just expose everybody's information; obviously that has huge implications with respect to insurability, and there is no question that there are issues about that. On the other hand, you don't want to do it in such a way that it's going to prevent us from having better interventions through the power of that aggregate data.

That work is going on now. There is a working group that involves the provinces and territories, the federal government, and the Canadian Institute for Health Information, because as the premier national health information organization, CIHI obviously has an interest in making sure that we're not going to have the perverse effect of electronic health records causing less information to be available to them. Obviously Infoway itself is also involved, and discussions would take place with privacy commissioners across the country as well.

● (1010)

The Chair: Is there any other comment?

Thank you, Mr. Rosenberg.

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

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

I want to go back to Dr. Butler-Jones, because the more I ask about the HIV vaccine facility, the more questions there are, based on Dr. Butler-Jones' answers.

Last May you brought in a considerable number of experts from around the world to review the four bids that were part of this proposal your government announced in 2007.

So in late May you bring in a large number of experts from around the world—it must be fairly costly to do so—to create a review panel to look at the four bids. Why would you do a due diligence study after the fact, after the whole process was in place? None of this makes sense. You have to explain to us.

You bring in a review panel. You say there's a due diligence study going on that is at the end of the process. Either the whole process was done on a incompetent basis or there's some cover-up going on. It just doesn't make sense. I think you have to explain to us why you would bring in these expert reviewers to review four bids, all the while knowing there's a due diligence study going on at the end of the process.

Dr. David Butler-Jones: You've presented two assumptions, both of which are wrong.

In terms of the process itself, at the outset of the process, as I've said, casting about, not just with the Gates Foundation... Again, the Gates Foundation is probably the largest funder of these kinds of activities around the world in terms of dealing with HIV and a range of health conditions and research—the Grand Challenges, of which we actually have one, based in the lab in Winnipeg—and so on. They have tremendous expertise and access to expertise.

The need for a facility to produce trial lots of vaccine was something that was, at the outset of this process, a gap. That was something that both the Government of Canada and the Gates Foundation were interested in. So we went through that process. It was a transparent process and people had the right to apply. Four people came forward at the end of the day...were invited because of what they had potentially to offer, and we continued on that process.

In May, we brought together the panels and they identified deficiencies with all of them. None of them crossed the bar. There was some potential there, but still a lot of inadequacies to be addressed.

At the same time, Gates had recognized—again, they're involved internationally far more than we are—that the scope and the sea had changed. The world had changed. So they commissioned this report that we saw in July—so it was after that part of the process—that indicated we had a situation where capacity in the world had changed, and this would not be added value, and we would essentially spend a lot of money for a facility that would not be well used; I'm not sure that's the best use of the resource, given all the other things that we need to do.

It's nothing more complicated than that. Evidence came forward. We take evidence as it comes. At the outset of the process, two years ago, the need was there. In that time, the world has changed. A reassessment of that indicates that, yes, the world has changed. Therefore, given where we're at, we have to reassess it.

It's as complicated as that. As the chief public health officer, I am not interested in spending money on something that will not be well used, given all the other needs.

Ms. Judy Wasylycia-Leis: But new evidence has come forward, and so now it's important that we ask the questions about whether or not you're prepared to review that evidence and then reconsider the process.

First of all, I do want to say that the Oliver Wyman study said at the outset, as Kirsty mentioned earlier, that it was not a complete study, that in fact—quoting from it—based on the scope of choices agreed upon at the beginning of the project, there are "limitations" to this study that would require additional research.

It's a very important statement in the scheme of things, especially now that we have very clear research, scientific evidence, from Dr. Gerson. This is an expert in the field from whom your government has sought advice in the past. Dr. Gerson is seen as someone very important in the field, who has now confirmed what the Wyman study said at the outset, that it was not complete and there are serious problems with it—

● (1015)

The Chair: Ms. Wasylycia-Leis, your time is up.

Dr. Butler-Jones, do you want to—

Ms. Judy Wasylycia-Leis: My question is will you therefore now begin the process again and ensure that the four bids are given serious consideration?

Dr. David Butler-Jones: There are always exceptional views for whatever issue it is. We saw that through SARS. There were experts out there who had very contrary views to my own in terms of SARS and in terms of the H1. I go with not the one out of 10, I go with the nine out of 10.

We've reviewed this and the point is that you make decisions. If you wait for the 100% answer you can wait forever. The point is whether we have sufficient information to make a decision based on what we have. And our view is that was sufficient information.

The Gates Foundation does not feel they need to revisit. We do not feel we need to revisit.

Ms. Judy Wasylycia-Leis: [*Inaudible—Editor*]

Dr. David Butler-Jones: That is an individual's view. Around the panel—

Ms. Judy Wasylycia-Leis: One out of 10, or half of one out of 10.

The Chair: Ms. Wasylycia-Leis, I'm calling you to order.

Ms. Judy Wasylycia-Leis: You're going on one out of 10.

The Chair: Order, Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: All the other studies are suggesting there are—

Dr. David Butler-Jones: No, Madam.

Madam, that is not true. Others have reviewed this. We have—

The Chair: Excuse me. Order.

This is done now.

Ms. Judy Wasylycia-Leis: Would you table the others, then? Would you table the others?

The Chair: All right, Ms. Wasylycia-Leis.

Mr. Brown, proceed.

Mr. Patrick Brown: Thank you, Madam Chair.

I just want to follow up with some more questions on the Canada Health Infoway. I've got a few questions.

In terms of the X-rays you mentioned that are digitalized, was that only in Alberta or P.E.I., or do we actually have digitalized X-rays in Ontario?

Second, we talked about digitalizing prescriptions for pharmaceutical products or drugs. Is that taking place in Ontario as of yet? And if not, when can we expect that to take place?

How much do we invest into Ontario for the Canada Health Infoway?

Lastly, given the concerns we've had in the past few years with how the Ontario government has managed the Health Infoway funds, what monitoring tools do we have to make sure that in the future, federal dollars are used as efficiently as possible?

Mr. Morris Rosenberg: Thank you.

Let me say at the outset that I don't think I have with me all the specific information you want, but we will endeavour to get it and to provide it.

I can give you a little bit more information. To give you an example of things that have been done, drug information systems are in place in the following provinces: Alberta, British Columbia, Saskatchewan, and Prince Edward Island. A system is not yet in place in Ontario. That I can tell you.

I know that digitization of X-ray film is under way, as I said, across the country, but I wouldn't say that it's absolutely completed across the country. Again, we will come back to you with specifics on Ontario.

I'm sorry; what was the last part of your question?

Mr. Patrick Brown: How much do we invest in our partnership with Ontario?

Mr. Morris Rosenberg: We have provided money to Infoway; Infoway then provides money to the provinces. The cost-sharing ratio, I believe, is 75% to Infoway and 25% to the provinces. It is not done, as I mentioned earlier, on an across-the-board basis. Infoway isn't just providing money to everybody; Infoway insists—and this is part of the strength of Infoway—that they have to have a partner actually ready in the provincial electronic health records system with a plan that demonstrably can put the system into place before Infoway will flow the money. It is a very strict gated-funding approach.

Mr. Patrick Brown: Do we have any ballpark figures on how much that's resulted in Ontario projects?

Mr. Morris Rosenberg: I don't have that information. That information is available; I don't happen to have it here, but I would be happy to provide it to you as soon as we can.

Mr. Patrick Brown: The most important question is the last one. What monitoring mechanisms do we have, given the challenges that we have seen in Ontario?

Ms. Glenda Yeates: We've had a number of monitoring mechanisms. The most significant is the one that the deputy raised in terms of making sure only projects that actually meet the criteria get funded. It's not a per-capita approach that gives every province its share; it's actually project-specific, and they have to meet the criteria. Only when the system is in place, working, and actually being used does the remaining funding flow. A significant portion of the funding is held back. We use the term "gated".

In addition, following the Auditor General's reports and some of the concerns that have been raised by provincial auditors, in the most recent funding that we are flowing to Canada Health Infoway, we have put in some additional conditions. For example, there are things such as maximum daily rates for consultants by jurisdiction, and those kinds of things. There are a number of accountability measures in place now with Canada Health Infoway that they, in a sense, pass on to their individual projects. For example, there is the architecture of the national standards; we want to be able to have information that is consistent and comparable across the country.

● (1020)

Mr. Patrick Brown: If we wanted to find out which projects have been approved in each province, do we have a list of projects that have met those criteria you speak of?

Mr. Morris Rosenberg: Yes. Infoway would have that, and we could provide it.

The other thing I should say is that this is a multi-year program. If you look at the way both the previous Liberal government and the present government have provided funding, you see that it has been provided in tranches. To date, there has been $2.1 billion provided, but not in one big chunk. It comes in chunks of $400 million or $500 million. As well, there is a funding agreement between Infoway and Health Canada; Infoway has to demonstrate that it is actually making progress.

There will be more money needed to implement the electronic health record; there is no question about that, given some of the estimates that we've seen put together. I think it's fair to say that every time, we want to see results. We have seen results to date, and we need to keep seeing results from Infoway and from the provinces in order to keep flowing that money.

In terms of what's happened over the past year with the series of audits, the audits are intended to be helpful in addressing any deficiencies in management practices. As I said, I thought the Infoway audit federally was basically a good-news audit. Some small things were addressed; there were a number of other things in the provincial audits, and that will help to move forward to make sure that this is all being done on a prudential basis.

The Chair: Thank you, Mr. Rosenberg.

We have time now to go to yet another round, so we're going to do that. I am going to suspend at a quarter to 11 because we will need to vote on the estimates.

We'll go now to the second round. It's a seven-minute round.

We will begin with Dr. Duncan.

Ms. Kirsty Duncan: Thank you, Madam Chair.

I really am struggling with this, with regard to CHVI. We put four applicants through an expensive process, doing due diligence at the end of the process and not at the beginning. I find it highly unusual.

I am going to pick up on what my colleague Ms. Wasylycia-Leis said, which is that Dr. Gerson has been used in the past. I am wondering if he was involved in this process.

Dr. David Butler-Jones: I am not aware; certainly we used a range of international expertise.

Again, this is a critique of a study. This is not another study. This is not another assessment. We and the Gates Foundation are satisfied that we have enough information to make the decision.

In terms of the applicants themselves, none of them met the bar. There were deficiencies in all of them. I obviously can't go into details for matters of confidentiality, but the point is that we had a transparent process. We used outside expertise, we used expertise in the government, and we used the Gates Foundation and others.

That's the nature of scientific application. I have had proposals that I've worked on extensively that were very costly and they were not funded. That's the nature of the business.

Ms. Kirsty Duncan: I think we both understand scientific process and how proposals get funded. The question I have—and if it can't be answered today, I would like to know—is if Dr. Gerson was part of this process.

One of the reasons this facility was called for was to have a facility accessible to researchers. The Canadian Association of HIV Research has spoken loudly that the need is still there. Why have you cancelled this facility?

● (1025)

Dr. David Butler-Jones: It is our view that there is capacity out there. It's not specifically in this particular facility, but there is capacity. As you note, in the study itself, researchers have tended to use certain preferred suppliers or vaccine-manufacturing facilities. There are others available, so part of it will be matching the researchers to the facilities that are available so they can get it done.

Ms. Kirsty Duncan: Well, I think it's really key to know whether Dr. Gerson was part of this review process. And I appreciate that it is one study, but I think that really needs to be looked at.

Can you confirm that there was a scientific expert review, a steering committee, and a department decision?

Dr. David Butler-Jones: I'm not sure what you mean by the question.

Ms. Kirsty Duncan: Was there a scientific review for this project, was there a steering committee, and was there a departmental decision?

Dr. David Butler-Jones: There was the review committee, as Ms. Wasylycia-Leis identified, that had reviewed it, and all the reviews were discussed in May. There was a steering committee for the whole process. And at the end of the day there were recommendations that came forward from the total process that identified that none of them met it, and following the information from the Gates Foundation, there was not a need to proceed.

Ms. Kirsty Duncan: There was a ranking from the scientific committee. Did any of them make it past the steering committee?

Dr. David Butler-Jones: All of them had deficiencies. None of them were able to... The way they were presented—and all we can do is work from their proposals—none of them met all the criteria.

Ms. Kirsty Duncan: Did anyone make it past the steering committee?

Dr. David Butler-Jones: The steering committee is the facilitative committee. That's in terms of the whole process. The external review and the internal review come together. None of them were without deficiencies that would allow it to go forward.

Ms. Kirsty Duncan: Dr. Butler-Jones, with respect, did anyone make it past the steering committee?

Dr. David Butler-Jones: That's not a point; I'm not sure...because nobody makes it by until all of that comes together and the decision is made.

There was one proposal that was felt to maybe have potential, but it had serious deficiencies. So that means it does not make the bar.

At any point, none crossed the bar in terms of being adequate as a presentation to be ready for funding.

Ms. Kirsty Duncan: Okay.

What, if any, political support was there for ICID, which was bidding for CHVI?

Dr. David Butler-Jones: I'm not sure what you mean by that.

Ms. Kirsty Duncan: Was there any political support for—

Dr. David Butler-Jones: This was a non-political process in terms of the agency's role, the other departments' role, and the review process. It was a non-political process. It was an independent process. What other comments politicians might have is totally separate from the process.

Ms. Kirsty Duncan: Thank you.

What, if any, political support there is for L5L?

Dr. David Butler-Jones: L5L is the concept for—I think the committee is aware of it—a different way of doing high-level containment in clinical studies and so on. We're exploring what might be involved in that, the value of it, and so on. We're still in the development of what might be a proposal.

Ms. Kirsty Duncan: Before I hand it over to Dr. Bennett, I just want to point out that this is Brain Awareness Week. Over the next 20 years, brain issues will become the leading cause of death and disability, and I'd like to mention the need for a national brain strategy in this country.

Now I'll hand this over to Dr. Bennett.

Hon. Carolyn Bennett: I guess there's some controversy, particularly in the public health community this week, in terms of the statements of the government ministers. I guess as Canada's doctor, I wondered if you would set the record straight as to whether you believe that contraception saves lives.

Dr. David Butler-Jones: Clearly, as it relates to maternal and child health, appropriate programs across the spectrum, including contraception, are an important part of public health. Which aspects governments choose to focus on and provide any investment in that make a difference is helpful to the public's health. Public health planning will involve a comprehensive approach, and governments, agencies, organizations, and independent individuals focus on different aspects of that. It is all welcome.

● (1030)

The Chair: Thank you.

We'll go to Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

The National Association of Pharmacy Regulatory Authorities has advised pharmacists since January 1 to stop selling natural health products for which the Health Canada approval process has not been completed. So it is clear that if the approval process had been completed on December 31, 2009, that advice would not have been given by the National Association of Pharmacy Regulatory Authorities.

I would like to know, since the Ordre des pharmaciens does not advise its pharmacists based on frivolous considerations, what Health Canada's reaction is to this advice. Those people certainly based their recommendations on something concrete. What was Health Canada's reaction to the advice given to pharmacists? Did it state an intention of finding a way to eliminate the ambiguities in relation to what Ms. Boudreau earlier called the change from the DIN to the NPN as the sole factor in the regulations? Did Health Canada not evaluate incremental or interim measures so that from now until the entire approval process is completed, we can be sure that products on the shelves are safe, which I think is what everyone wants, but that producers and retailers are not unduly punished?

Ms. Michelle Boudreau: Thank you, Mr. Malo.

Yes, of course, we are fully aware of the NAPRA decision, which is fairly recent. For products that formerly had a DIN and now have an NPN, so are now natural health products, they were dealt with very efficiently by us. First, under the regulations, we gave them six years, which is a fairly long time. Then, the applications that had to be sent to us to transfer these products were quite simple. They were processed within 15 to 20 days. There were never backlogs in that category of applications. We completed all the applications we received within the time allowed in the regulations, that is, by the end of December 2009.

Regarding the NAPRA decision, it is clear to us that the NAPRA and Health Canada have the same objective. As you mentioned, we have to make sure that products are accessible, but also safe and effective. So we continue to work with the people at NAPRA. They are members of our external committee, which I referred to a few minutes ago. We continue to work with them to find potential solutions and internal administrative solutions. People have to be able to prioritize their applications and we have to be able to process the applications more efficiently. The improvements we have made in the last 12 to 18 months have helped a lot. If you look at our figures, you will see that most applications have been processed and finalized within that period, covering about the last two years. That is the kind of work we are continuing to do. As well, we work quite closely with consumers, who are also members of our external committee.

Mr. Luc Malo: Could transitional measures be considered?

Ms. Michelle Boudreau: For the moment we are not planning any transitional measures. I assume you are talking about transitional regulations.

Mr. Luc Malo: That's right.

Ms. Michelle Boudreau: No. At this point we are more considering administrative solutions. We have already implemented solutions relating to the way the work is done in the directorate. That being said, we will see how things go. Certainly we are working very closely with NAPRA to find a solution and recognize, as you said earlier, that there can in fact be an impact on the industry.

● (1035)

Mr. Luc Malo: Mr. Rosenberg, I wasn't satisfied with the answer you gave me earlier. So I am going to ask you again, simply to give you an opportunity to clarify.

The Minister said, right here in committee, that her objective was to eliminate the backlog by March 31. The Natural Health Products Directorate itself has an internal objective that it will simply have all of the backlog in the process. There is a very big difference between the political will expressed and what the administrative directorate is saying. Is this a common phenomenon?

Mr. Morris Rosenberg: I am going to do my best to provide a more satisfactory answer, but it may be that it will not satisfy you, in spite of everything.

As Mr. Butler-Jones said, this area, and I am not talking here only about natural products, but health policy in general, is very complicated. The data change frequently. Objectives are stated, but after some time we recognize that a fundamental change has taken place and we have to proceed differently. It happens. That does not mean that there is a lack of communication between the political level and the public service, but everyone has to be aware that we are working in a context where change happens quickly and the data change every day. That is the only explanation I can give. That will probably apply to a number of other cases where there has been a statement and changes as a result of the need to adapt to changing situations.

[*English*]

The Chair: Thank you, Mr. Rosenberg.

Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Thank you.

I'd like to ask another question on the HIV vaccine facility. Why did the criteria change? When the original applications were requested, it was based on the production of...on a not-for-profit basis. As the government itself said at the time, it was to provide capacity to produce HIV vaccine and to be conducted mostly in and for the benefit of low- and middle-income countries.

Clearly something happened from the initial application process to February of this year, when suddenly it became acceptable for this vaccine to be produced on a private sector basis, since that's the only capacity identified in the Oliver Wyman study.

Dr. David Butler-Jones: Thanks very much for the question.

Let's be clear, these are really important issues to be discussed. I'm quite transparent. I'm telling you everything I know. There is nothing about this that is hidden. In fact, the criteria at the outset were financial self-sustainability, governance and management, technical in terms of manufacturing and human resources, and global access. As I said before, all of the bids had limitations.

In terms of when the Government of Canada, with the Gates Foundation, decided a couple of years ago to move ahead with this as one of the aspects of the CHVI, the decision was that if we were to fund this, we would fund it as a not-for-profit thing. It was not that the whole issue can only be addressed by not-for-profit.

Since that time, as I've said—and there was not capacity, there was a challenge of capacity in the world—there is now capacity. The Gates Foundation, as you know, is very much concerned with the least-developed countries and access for low- and middle-income countries. They are confident in this and they have expertise in the international scene that we don't have, and others, and so we look to them, not just to ourselves, in terms of what is necessary.

● (1040)

Ms. Judy Wasylycia-Leis: Thank you.

I do want to refer to the Oliver Wyman study itself, where it says, “An open and transparent process to identify a not-for-profit corporation with the expertise to build and operate the proposed facility was launched in 2007 and is still ongoing.” So it's clear that there was a change from the original criteria given to the bidders, from that point to the present, and I think that's a most unfortunate revelation. Because, in fact, it means that people went to a lot of work to abide by certain criteria and then were told it was over through no fault of their own. I think they need to have full explanations for why their bids weren't accepted.

I want to ask, though, how you will in fact meet the... We now have this report from Dr. Gerson, who says the capacity isn't there, and we have concerns from the Canadian HIV association, which says that you can't test a vaccine without a production facility and this new direction isn't going to provide it.

We now have comments from the International AIDS Vaccine Initiative, which has said that we've had unprecedented advances: the discovery of two new broadly neutralizing antibodies by a research consortium led by International AIDS Vaccine Initiative, and the results of a clinical trial in Thailand by the Thai ministry of health.

So we have clear developments in the world, and this was all supposed to come together in terms of this not-for-profit facility in Canada, and it is now gone. So Canada has a black mark and we've lost an important leadership role. On top of it all, the world-renowned facility in Winnipeg, which was told by numerous sources that it had won the competition, is now left trying to explain to the world why, with world-class researchers on HIV and AIDS, with a level 4 laboratory, and with a world-class institution, they're suddenly not able to win the bid, for reasons unknown to them.

For the sake of the reputations of scientists, of people have struggled so hard to put together a world-class facility, I think an explanation is owed.

I think, in fact, that you know as well as I do, Dr. Butler-Jones, that Winnipeg won the bid and suddenly new criteria came into play. For reasons that are unknown to any of us, something changed. It was global drug politics, or regional politics, or local petty politics. Something happened, and you've been asked to carry the can on this. You've been asked to try to explain something that is inexplicable.

In fact, I just want to quote from one of the news items on this. It is by Dan Lett, who, as you know, has done enormous in-depth research on this issue. In fact, he has said:

> It is also known that the evaluation committee met for three days last May to make its final recommendations. And that following that meeting, several sources told ICID it had been chosen to host the facility.

ICID is the International Centre for Infectious Diseases. No one was surprised about it being chosen, because in fact ICID has a record for doing this kind of work, and its proposal was backed by the largest vaccine production facility in the world, Serum, and by the largest biotech producer in this country, Cangene. It had the backing of the International AIDS Vaccine Initiative. It had the support of numerous universities, including Manitoba, obviously, and Montreal. It clearly, as they were told, met the criteria and then some.

I think explanations are owed to them. I don't expect I'll get them today, but I will ask this one question. Will this government continue the annual funding of the International AIDS Vaccine Initiative or the International Partnership for Microbicides? The lack of any news on these fronts is causing both of these organizations considerable anxiety. I just want to know: will that funding be continued?

The Chair: Dr. Butler-Jones, before you answer that involved question, I just want to say this will be the last question. Following your answer, I will not be taking any more questions from the committee.

Dr. David Butler-Jones: Darn. No more?

I think this conversation will continue. I do need to... The last question—I'll start there—is a new question to me. I don't actually have information on it, so we'll have to deal with that later.

But I do need to state again that some of the assumptions really are wrong. The criteria did not change. If we were to build a facility in Canada, our expectation was that it would be not-for-profit. But the generation of this was not the issue of having a not-for-profit. The generation at the time was that it was lack of capacity; that was the issue. Then what the criteria would look like for a plant in Canada was outlined—I read that to you earlier—and the criteria were not met.

I don't know who said it, or where it was said, or to whom it was said, but it was wrong. No one won. I've seen the reviews; I've seen the original proposals. There was one that had potential—that's how it was put, that it had "potential"—but still had a lot of work to do, so it wasn't there. It did not cross the bar to where it would be acceptable for funding. It's not that the criteria changed, it's that nobody crossed the bar.

Looking forward, it really was again the Gates study that identified the capacity. The world had changed. So the terms of the capacity out there...that identifies capacity that sometimes research may not be aware of. One of the things the Gates Foundation and we are interested in is to match researchers with the capacity out there, to have those things addressed, obviously.

Finally, if any of the applicants still have questions—there have been conversations, discussions, and that will continue—it's really important, if they're not satisfied with the answer, that they ask the question, because we're being quite transparent about their proposals and what the issues are. It's unfortunate that none of them crossed the bar. It is fortunate that in Canada we will have international access to new capacity for trial lots, and now we can use that resource for something that will be value-added.

Thank you.

● (1045)

The Chair: Thank you, Dr. Butler-Jones.

I want to thank our guests who came today to answer the questions. We appreciate it so very much.

I thank the committee for their insightful questions as well.

We will suspend for a couple of minutes and then go into the voting of the estimates.

Thank you.

- _____ (Pause) _____
-

The Chair: Could I please ask committee members to take their seats?

I would like to go on to the voting on the supplementary estimates.

HEALTH
Department
Vote 1c—Operating expenditures.....$32,133,772
Vote 5c—Capital expenditures.....$241,000
Vote 10c—The grants listed in the Estimates and contributions.....$5,255,971
Canadian Institutes of Health Research
Vote 25c—The grants listed in the Estimates.....$1
Public Health Agency of Canada
Vote 40c—Operating expenditures.....$52,863,518
Vote 45c—Capital expenditures.....$1
Vote 50c—The grants listed in the Estimates and contributions.....$1

(Votes 1c, 5c, 10c, 25c, 40c, 45c, and 50c agreed to)

The Chair: Shall I report the supplementary estimates to the House?

Some hon. members: Agreed.

The Chair: Now we're going to vote on the main estimates.

HEALTH
Department
Vote 1—Operating expenditures.....$1,876,073
Vote 5—Capital expenditures.....$37,718
Vote 10—Grants and contributions.....$1,382,680
Assisted Human Reproduction Agency of Canada
Vote 15—Program expenditures.....$9,929
Canadian Institutes of Health Research
Vote 20—Operating expenditures.....$48,995
Vote 25—Grants.....$926,926
Hazardous Materials Information Review Commission
Vote 30—Program expenditures.....$4,980
Patented Medicine Prices Review Board
Vote 35—Program expenditures.....$11,163
Public Health Agency of Canada
Vote 40—Operating expenditures.....$406,216
Vote 45—Capital expenditures.....$36,774
Vote 50—Grants and contributions.....$203,200

(Votes 1, 5, 10, 15, 20, 25, 30, 35, 40, 45, and 50 agreed to)

The Chair: Shall I report the main estimates to the House?

Some hon. members: Agreed.

The Chair: Okay, everybody, the committee is adjourned.

Thank you so much.

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