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Chair

Mrs. Joy Smith

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● (0850)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning to you, and welcome to the health committee.

I want to make a special welcome to our witnesses who've taken the time and effort to get here. You think we don't notice who you are or what you say sometimes, because you see us talking, but we do. We meticulously go over everything you say and we value everything you say.

Ms. Libby Davies (Vancouver East, NDP): Madam Chair, I have a point of order.

The Chair: Already, Madam Davies? Okay, go ahead.

Ms. Libby Davies: Just very briefly, I notice we actually haven't had a motion to make sure that the study we're doing on drug shortages, which is very important, is reported to the House. So I have a motion that in relation to its study of the role of government and industry in determining drug—

The Chair: Ms. Davies, I'm sorry to interrupt you, but we have received that motion. It needs 48 hours' notice. We'll present it next.... Thank you so much.

It is very common to have motions at the committee, so thank you, Ms. Davies.

Pursuant to Standing Order 108(2), we are studying the role of government and industry in determining drug supply in Canada. We have witnesses from the Best Medicines Coalition: Gail Attara, chair of the operations committee, and president and chief executive officer of the Gastrointestinal Society; and Suzanne Nurse, a representative. Welcome, and thank you so much for being here.

From the Canadian Medical Association, we have John Haggie, the president. Welcome again. It's nice to see you here.

From Ordre des pharmaciens du Québec, we have Diane Lamarre, president; and Manon Lambert, director general and secretary. Welcome. We're so glad you could make it.

From the Canadian Society of Hospital Pharmacists, we have Myrella Roy, executive director. Welcome. We're glad you're here as well.

We have, via video conference from Buenos Aires, Argentina, from the Canadian Anesthesiologists' Society, Richard Chisholm, president.

Mr. Chisholm, welcome. Thank you so much for being here. We're very honoured to have you join our committee.

We will begin. We'll have a ten-minute presentation from all participants.

Mr. Chisholm, please make your presentation.

Dr. Richard Chisholm (President, Canadian Anesthesiologists' Society): Thank you very much.

Madam Chair, members of the committee, on behalf of the 1,900 members of the Canadian Anesthesiologists' Society who are practising anesthesia in Canada, I would like to thank you for this opportunity to participate in these hearings about the role that governments and the pharmaceutical industry play in ensuring Canada's supply of the drugs we require to meet Canadian health care needs.

This subject is drawing significant attention now from governments, from the media, and from the general public. Much of that attention arose from letters sent by Sandoz, a generic drug manufacturer, to its customers in mid-February of this year announcing that the company's Canadian manufacturing facility in Boucherville, Quebec, would be closed to redress manufacturing issues identified by a recent site visit by the U.S. Food and Drug Administration.

Those letters triggered a very real crisis in Canada's drug supply. I'll have more to say about that in a moment, but first I want to make it very clear that for Canada's anesthesiologists our drug supply concerns did not begin and will not end with the current Sandoz difficulties.

In January 2011, more than a year before the Sandoz letters, we wrote to the federal Minister of Health to say our members were reporting shortages of Propofol, a preferred anesthesia induction agent, and were concerned about reports of reductions in supply of Pentothal, an older but still useful drug.

We asked, “Does Health Canada have a methodology to identify situations where supply constraints meet the definition of a drug shortage that requires prescribers to choose an alternate therapy?” To her credit, the minister has taken a number of initiatives to begin to address our concerns. But the simple answer to our question about the department's ability to identify and anticipate drug supply problems was “no” then and is still “no” today. The fact that we desperately need an effective system to predict, identify, and manage around supply disruptions is even clearer today than it was then.

Nothing proves that more convincingly than the sorry history of the Sandoz manufacturing interruption. That interruption meant that dozens of critical medications would no longer be manufactured, while others would be available on allocation, based upon previous usage, for anywhere from 12 to 18 months. As I think you know, in many cases Sandoz is the only Canadian supplier of essential medications.

There were immediate impacts on our members and the patients we serve. Hospital by hospital, anesthesiologists began to encounter shortages, and they found themselves operating in an information vacuum. How bad was the problem? What measures were being taken to resolve it, to locate alternative suppliers or medications? Who was managing this problem?

Of course, the anesthesiologists called us, asking what was going on and saying they felt out of the loop. As we looked at it more closely, we realized that we weren't being left out of the loop of communications, consultation, and joint planning to manage the crisis; there simply was no loop. The information, consultation, and joint planning that should have been flowing to and among industry, governments, and health service providers just wasn't happening. That's because we have no system in Canada today to make sure it does.

Your committee is focusing on the roles of industry and government in the drug supply. Let's start with industry. In this case, we are talking about Sandoz, a reputable and competitive generic drug manufacturer that succeeded in obtaining sole-source contracts for key medications. The chronology here is interesting.

Sandoz was informed by the FDA in November 2011 that they would have to upgrade their manufacturing facilities. We don't know if or when Health Canada and provincial ministries of health became aware of this FDA order, nor do we know if they understood the potential impact closing this manufacturing facility would have on Canada's drug supply. But we do know that Sandoz did not inform their customers, Canada's health care system, until mid-February. On February 15 and February 17 they sent out letters, first reporting on the FDA order and two days later announcing an immediate reduction in the available supply of essential medications.

Could it have made a difference if governments and people such as Canada's anesthesiologists had been informed earlier? That question answers itself. There could have been time for hospitals to stockpile drugs. There could have been time to arrange alternative supplies from other manufacturers or to source suitable products from outside of Canada.

As we understand it, Sandoz was under no legal obligation to provide the earliest possible warning about these supply disruptions to its customers or to the Government of Canada. From a purely commercial standpoint, keeping their sole-source position as long as possible by delaying the announcement might seem to make sense. But it makes no sense at all from a patient's perspective. I repeat, there was no legal obligation here apparently, but I leave it to you as to whether or not there might have been a moral obligation on the company to share this information as early as humanly possible.

As we go forward and hope to avoid any repetition of this debacle, I hope your committee will recommend in the strongest possible terms that Canada adopt legislation placing a clear onus on companies to immediately inform governments and the health services system of any events that may jeopardize drug supplies.

● (0855)

What about governments and their role in all of this? I think it's fair to say that governments at all levels have been too slow to recognize the fragility of Canada's drug supply system, and that fragility affects drugs across the spectrum of costs. Oncologists are encountering supply problems with higher-cost medications needed for chemotherapy. Anesthesiologists are encountering shortages of drugs that, relatively speaking, are inexpensive.

We think the root of the problem lies in the fact that governments have, understandably, not focused on drug costs, while taking it for granted—given the tens of millions of dollars we have to spend—that supply would just naturally be there. Clearly, that's wrong. It's not the way it works in the real world.

Frankly, we don't have the answers to this problem. We're anesthesiologists. Our focus is the inescapable reality that the quality of health care—and the health services experience for millions of Canadians every year—depends on the capacity for anesthesia to contain and limit pain and suffering. You have to help us make sure we have the tools to do that all important task.

Some measures seem obvious: no more single sourcing, for example, and better monitoring of the pharmaceutical universe across health services in Canada. As to other elements in our overall efforts to contain drug costs, we need a renewed sensitivity to their impact on drug availability.

We need a requirement for industry to tell about events that might disrupt the drug supply and an acceptance by government of a requirement to ask, to monitor and make sure.

I have two last points. The first is the reality we are living with today. The truth is that the Canadian health service system does not routinely know, with any accuracy, which medications are or are likely to become in short supply. As a result, far too often these shortages are addressed clinic by clinic, hospital by hospital, city by city, region by region, province by province, drug by drug, and manufacturer by manufacturer. That's what's happening now in Canada with respect to the Sandoz supply disruptions, and that's simply not good enough.

The last point I want to make is just how well men and women throughout your health services system are doing and dealing with this crisis, clinic by clinic, hospital by hospital, city by city, region by region, and province by province. We hear a lot of doom and gloom about Canada's health services, but I assure you, you'd be proud to watch hospital pharmacists and anesthesiologists as they manage around the shortages by substituting one drug for another, or supplementing one with another, or manufacturing our own injectables from powder.

One final note. Canada is not alone in facing these challenges. Earlier this week, the WFSA, World Congress of Anaesthesiologists, in Buenos Aires, unanimously passed a resolution that called upon governments and industries to work with us to alleviate the drug shortage that affects patients all over the world.

So we're not alone, but the fact that there are new international problems of drug supply does not make it any less urgent that we take urgent action here in Canada.

That's the message Canada's anesthesiologists want to leave with your committee today. Our job is to keep pain at bay. We are very good at it. Please, urge the government to make sure we have the drugs we need to achieve that goal.

Thank you very much.

The Chair: Dr. Chisholm, you made a very profound presentation. I want to thank you for that. We heard it loudly and clearly.

We're going to listen to our other witnesses, and after that we'll have a question and answer period, so I hope you can stay for that. Can you? Thank you, Doctor.

Dr. Richard Chisholm: Thank you very much.

The Chair: You're welcome.

We'll now go to the Canadian Medical Association, with Dr. Haggie.

[*Translation*]

Dr. John Haggie (President, Canadian Medical Association): Good morning.

I want to begin by thanking the committee for the opportunity to appear before you on behalf of the Canadian Medical Association. The CMA also submitted a brief to the committee.

[*English*]

On behalf of the 76,000 doctors represented by the CMA, and the millions of Canadians they serve, I have one message for you today. As members of Parliament, you are among our country's leaders. At a time like this, when Canadians are facing what is nothing less than a national crisis, they look to you and your peers in legislatures across the country to exercise that leadership and live up to the trust that has been placed in you.

At the risk of sounding harsh, the early finger pointing between governments was anything but a demonstration of leadership. Since then, I believe there has been progress. Recently, the federal government announced that it would open its stocks of medicines to provinces experiencing shortages. While I'm not sure of the types of drugs this would cover, or what the process involves, it is nonetheless a step in the right direction.

Also encouraging is the fact that Health Canada has fast-tracked approvals of alternative drugs, but I am disappointed that the focus of the generic and brand-name pharmaceutical companies has been on providing information on drug shortages. Information about the problem of drug shortages is no substitute for fixing the problem of drug shortages.

I'm going to take a moment now to identify the impact of these drug shortages and the lack of information surrounding them on physicians and the patients we care for.

Clinical treatment is interrupted, putting patients at risk of relapse and worse. Surgeries are cancelled, leading at best to delays and at worst to a real deterioration in the health of those patients forced to wait.

Sometimes there are no alternative drugs, or the alternative is not covered by insurance. Sometimes people simply can't afford the new medication. Whatever the reason, when an appropriate alternative therapy is not available, sick people must go without.

As all drugs have risks, there is a risk of side effects from alternatives. Further, the alternative might not work as well as the drug originally prescribed, and it's even possible that the alternative is a drug that has been tried before without success.

Changes in the timing and dose of medications can be confusing, particularly for those on long-term therapy or those for whom learning a new regimen is difficult.

Finally, all medications being taken by a patient must be reviewed for potentially harmful interactions with any new medication. This might require blood tests or trials of dosage that will further delay treatment. Any of these situations can harm our patients and do damage to their health, particularly in the case of patients with complex problems.

At the CMA, patient organizations are telling us about the anxiety, pain, and harm that drug shortages are inflicting on patients. I committed to some of those patient organizations that couldn't join us to share their experience with you.

● (0900)

[*Translation*]

Allow me to read excerpts from a few messages we have received.

[*English*]

The Brain Injury Association of Canada told us, and I quote:

> Any drug medication shortage endangers Canadian patients. In the brain injury community, anti-depressants are prescribed to some, as is pain medication, so if there is a shortage some members in the community will be endangered even if the medication is altered.

The interim president of the Canadian Arthritis Patient Alliance, Louise Bergeron, wrote to us:

> Actually, I have had this happen to me on three occasions and it is quite scary when you know you will not have access to certain drugs for an extended period of time, since you know your health will be on the line.

Sharon Baxter, executive director of the Canadian Hospice Palliative Care Association, says:

> All are encouraging the government to find a solution very quickly as pain medication at the end of life is essential and urgent. I don't think we are at the stage where people are dying without access, but getting to that end is totally unacceptable in a country like Canada.

Shortages also lead to an increase in the consumption of health care resources because of the need for additional monitoring and multiple consultations among health care providers, including physicians and/or emergency room visits. To put it bluntly, while doctors are trying to source medications or alternatives for drugs that should be readily available to patients, other patients have to wait longer to be seen and cared for.

Last but not least is the greater cost to our economy. Healthy citizens are productive citizens, contributing to their families and communities and to our country's economic prosperity. How can it make sense from an economic standpoint to have people ill and off the job because of a lack of access to medically necessary therapies?

In order to deliver the best possible care to patients, physicians require timely, comprehensive, and accurate information about current and anticipated drug supply shocks and constraints. More to the point, our country requires an uninterrupted supply of medically necessary medication for patients—period, full stop.

With that objective in mind, we have provided input to government and to the pharmaceutical industries. As health care providers we must have a monitoring and early notification system for pharmacies and physicians, and there must also be a proactive, systematic mechanism to prevent interruptions in the provision of medically necessary medications to our patients.

In a survey of physicians conducted by the CMA in January of 2011, two-thirds of respondents said the shortage of generic drugs had negative consequences for their patients and practices. The gap between what we have in Canada and what we need is even more clearly evidenced by the current shortfall of injectable drugs.

We recognize that other countries are also grappling with drug shortages. We've noted with interest that President Obama signed an executive order last fall directing the Food and Drug Administration "to take steps that will help to prevent and reduce current and future disruptions in the supply of lifesaving medicines".

The CMA encourages the Government of Canada to consider every lever available, including the economic inducements it provides to the pharmaceutical industry, to ensure Canadians are assured of an uninterrupted supply of medically necessary drugs. Drug shortages are a serious and escalating problem, one that needs to be fixed and one that Canadians expect their elected representatives to act upon.

The bottom line is that the pharmaceutical industry itself must resolve its supply challenges. My responsibility as a physician is to provide care; theirs is to make sure we have the medications we need for our patients when they need them.

● (0905)

[*Translation*]

Thank you for the opportunity to come before you regarding this very important issue. I would be happy to answer your questions.

[*English*]

The Chair: Thank you so much, Dr. Haggie. We appreciate your testimony today.

We're now going to the Best Medicines Coalition. Ms. Attara is the one who's going to give the presentation.

Could you begin, please? Thank you.

Ms. Gail Attara (Chair of Operations Committee, President and Chief Executive Officer, Gastrointestinal Society, Best Medicines Coalition): First of all, Madam Chair, thank you very much for the invitation to come here and discuss some of the issues.

Our coalition is an alliance of 27 health charities and individuals who are advocating for better health care around access to medications, including the drug shortages and safety and supply.

I just want to touch base, so you get the context. Our submission is available through bestmedicines.ca, if you don't already have it and for those others who are listening.

We cover chronic illness for as many as 20 million Canadians. This is a huge number, and I just need you to listen to some of the diseases we cover: arthritis, asthma, breast cancer, epilepsy, hemophilia, pain, skin disease, intestinal—which I represent with gastrointestinal—and liver disease. Other coalitions are also members of our coalition, so we kind of stand as the figurehead across the country. There are coalitions within Alberta and British Columbia that also represent a whole number of other disease areas. We also have kidney cancer, lymphoma, ovarian cancer, and Tourette's, just to cover off some of the core illnesses.

We really are here to just remind everyone that the object of the exercise here is patients. If we didn't have patients, we wouldn't need drugs, and drugs are clearly what we're talking about today. We're looking to the government to take a role in that, a very active leadership role. We're looking for an in-depth study on what really went wrong and solutions. But in saying that we're looking for the government to take a leadership role, we're asking, please, for patients to be at the table, because if you don't get feedback, that intrinsic natural kind of feedback from the actual end users of a product, then you're probably missing a huge piece of the information you need.

So we're asking to be there all the way along, from figuring out what went wrong to looking at possible solutions, and we're looking for pragmatic solutions because we're patients and we want it to work. We don't want to look at lots of regulations and things like that. We want something that's going to be working and will pay attention.

The drug shortage issue is not just a recent issue. In gastrointestinal disease, we had this issue in 2006, 2009, and again recently. It is an issue that keeps coming up, and it has obviously come to a head because it has affected perhaps more groups recently, but it is really a critical thing.

We are absolutely looking for patient involvement. We have a couple of examples in our submission, but we actually have way more than what is in our submission. I just want to take a minute and ask my colleague, Suzanne, if it's okay with the chair, to give one example of epilepsy.

Can we switch and allow my colleague to say something at this point?

● (0910)

The Chair: Yes.

Ms. Suzanne Nurse (Representative, Best Medicines Coalition): Good morning.

I also am a member of the Best Medicines Coalition, and I'm also here today as a representative of the Canadian Epilepsy Alliance.

I'm going to describe, just as an example, what's been happening in the field of epilepsy as a result of drug shortages.

People with chronic medical conditions such as epilepsy require consistent access to medications.

Epilepsy is a chronic neurological disorder that's characterized by recurrent seizures. The main treatment for epilepsy is anti-epileptic drugs, or AEDs, and they must be taken daily to prevent recurrent seizures. When AEDs are stopped or changed abruptly, recurrent seizures can be more severe or more prolonged than previous seizures. Prolonged seizures lasting more than five minutes are a medical emergency and can be life-threatening.

Between late 2009 and now, there have been shortages of at least five different AEDs, and that's a conservative estimate. Some of these medications are manufactured by a single pharmaceutical company. The AED shortages have led to some people being switched to a different formulation, if there is one available, or being switched cold turkey to an alternate drug. It's actually not known if there have been other people affected by a shortage who have simply stopped taking their medication without seeking medical care.

Some people switched to an alternate AED have experienced episodes of prolonged seizures, which are life-threatening. Physicians who specialize in epilepsy have reported that they have had patients with previously good seizure control experience breakthrough seizures as a result of drug shortages.

Even if people have enough medication on hand to see them through a shortage or are able find a pharmacy that still has some stock of their drug, there is a tremendous amount of stress, because people are not sure they are going to have enough drug to last them through the shortage. They are concerned that they will run out.

People with good seizure control have worried about the potential impact of breakthrough seizures on their health and also on their independence, because they could result in the loss of a driver's licence. And unfortunately, for some people, it could result in the loss of their careers.

Parents, spouses, and other family members have been very concerned about the safety of their loved ones.

People have been extremely frustrated and upset by the lack of information about drug shortages. Individuals affected by shortages do not have a place to go for general information pertaining to drug shortages, for information about specific drugs, or for advice on what they should do. Some people have had very good support from their health care providers and/or their pharmacists, but they still seek an authority on drug shortages for additional information.

Many people with epilepsy who have been affected by drug shortages are initially shocked when they find that their drug is not available. They are often very angry when or if they find out that there is no regulation to ensure supply. And they are desperate to see their drug back on pharmacy shelves.

If the committee has questions later, I have examples of individual patient situations.

Ms. Gail Attara: Thanks for that.

In summarizing, what we're saying here are three clear things. First, patients need to be involved all along the way. Second, we're looking for the government to take leadership in an investigation as to what happened. Third, we want to know how we can come up with some really workable solutions, and we'd love to be a part of that.

One of the things we'd just like to put out there today is a premise that the approval to market a drug should include an obligation to have a consistent supply of that drug. For us it means a lot. We know there's a commercial enterprise out there looking at all these things that way. It really doesn't matter to us who's making money in health care as long as the patient's needs are met, and are met consistently, and that the physicians who are caring for the patients have all the tools they need to make sure it works for patients.

Again, we have a lot of examples of things that have gone wrong and where they've gone wrong. I think this committee clearly understands that things have gone wrong, and we don't have to dwell on that right now.

We're looking to the future, and we are hoping we can come up with something very quickly to resolve it. We don't think it's just a current issue; it's been an ongoing issue. We are concerned about putting all our eggs in one basket, which speaks to the idea of getting bulk medications from one source. It is problematic, no matter who takes it on.

I think we'll stop at that point. Thank you very much.

● (0915)

The Chair: Thanks so much for your very insightful witness today. I appreciate your being here.

We'll now go to the Ordre des pharmaciens du Québec.

I hope I haven't butchered that entirely. I'm working on my French. I have three kids in my family who speak it wonderfully. My apologies if I have not done that right.

We'll start, I think, with Madame Diane Lamarre. Will you be sharing your time with your colleague?

Okay, go ahead, Diane.

[*Translation*]

Ms. Diane Lamarre (President, Ordre des pharmaciens du Québec): Madam Chair, members of the committee, we thank you for providing the Ordre des pharmaciens du Québec with the opportunity to discuss disruptions in the drug supply and, especially, potential solutions for preventing those shortages and limiting their impact on the health of Canadians. Joining me today is Manon Lambert, Director General and Secretary of the Ordre des pharmaciens du Québec. She can also answer your questions.

Stability in the supply of pharmaceutical products was a key concern for the order well before the media began reporting on the crisis we are witnessing today. In March 2011, we established a multipartite committee to study the causes of the shortages and prioritize recommendations for possible solutions. We will present the results of that work in mid-April in collaboration with the Collège des médecins du Québec, Quebec's college of physicians; the Association des pharmaciens des établissements de santé, the association of health-care institution pharmacists; and the Association québécoise des pharmaciens propriétaires, Quebec's association of owner-pharmacists.

At the beginning of this process, our findings were cause for concern: the number of supply disruptions between 2006 and 2010 had quadrupled, and the disruptions would last several months. What is worse, it appears that the shortages entail major clinical risks, as exemplified by some 15 related deaths in as many months in the United States and, closer to home, 65 surgeries that were recently postponed in the Outaouais owing to a shortage of injectable medications. Some groups, particularly people living with cancer, are especially vulnerable to these shortages and are often their first victims.

The Ordre des pharmaciens du Québec and its partners view the drug supply problem today as a public health issue that calls for immediate and concerted action by the various players involved. At the federal level, our recommendations address three complementary and overlapping elements.

First, Health Canada must assume leadership in dealing with this major issue. To do so, it must create a monitoring unit. The role of this unit would be to monitor disruptions internationally and nationally, as well as to support the provinces in their efforts to prevent shortages. In addition, this monitoring unit will have to develop reciprocal relationships with other regulatory authorities, such as the FDA.

Second, the federal government must implement a legislative framework that requires companies to give notice of the following two situations: one year for any halt in production, and six months for any expected disruption in the drug supply.

Last, a Canadian list of essential drugs must be compiled in order to prioritize efforts to mitigate clinical risks and provide particularly proactive monitoring. I will expand on those three recommendations.

In the first recommendation, we are working from the premise that a drug, given its life-saving capacity, is an exceptional consumer product that, as such, deserves a customized legislative and organizational framework. We feel that the stability of the drug supply today should be the focus of a national vision, and our first recommendation is to establish a hub for monitoring and concerted action across Canada.

In the United States, the FDA monitors the global situation in order to eliminate the problem of drug shortages at the root. We believe that, in Canada, an independent national organization should be responsible for identifying risks that could affect the supply, and for encouraging information-sharing among the country's regulatory bodies. Beyond this simple observer role, the organization should also have mechanisms that would enable it to react quickly and prevent shortages, or at least reduce their impact on the health of Canadians.

We feel that Health Canada should take the initiative in creating this monitoring unit—in association with the provinces—by making it a priority on the agenda for the next conference of federal-provincial-territorial health ministers, to be held in Halifax on September 27 and 28. I will now discuss the second recommendation.

That being said, a unit like this will not have the means to carry out its mission unless it receives relevant information in time to implement mitigating measures. The entirely volunteer process the pharmaceutical industry currently uses to report production problems or changes that might affect a drug's availability seems to us to be clearly inadequate.

● (0920)

For example, manufacturers in France are required to inform regulatory bodies of any factors that could influence a drug's availability one year in advance. In some instances, such as single-source essential products, a manufacturer that wants to cut back or stop production may even be legally required to keep producing until an alternative can be put into place. Canada must enact a similar measure.

We also believe that Health Canada must impose a legislative framework for manufacturers, requiring them to report any significant changes in the production chain that could limit access to one or more drugs a minimum of six months in advance, or as soon as they know about it. A non-binding resolution would not provide the safeguards needed to protect Canadians.

Under a coercive system like this, Sandoz would have been required to inform the authorities, back in 2009, that the FDA had issued it a notice of non-compliance. In this specific instance, as in many others, the voluntary system appears to have shown its limits.

Lastly, as is done in a great many countries, we hope Health Canada will coordinate the compilation of a list of the essential “single-source” drugs used in the different provinces.

These so-called single-source drugs, manufactured by a single company, obviously present a greater risk for shortages, since no other supplier can step in to resolve a reduction or stoppage in production. In these cases, not only is the health of Canadians jeopardized should production difficulties arise, but the manufacturer's monopoly position also limits the negotiating power of regulatory bodies in the event of a crisis.

Once again, the recent example of disruptions at Sandoz, the sole manufacturer of many drugs, has made all the players in our health care system aware of the vulnerability that comes with dependence on a single supplier.

An interruption in the supply of essential drugs creates major problems of a medical, ethical and human nature. The disruption involving Caelyx™, a drug used to treat ovarian cancer, is a recent dramatic example. Faced with shortages, some Quebec hospitals were forced to give priority to those patients who had already begun treatment, thereby delaying administration of the first dose for other patients. We believe that no patient should have such crucial treatment suspended or delayed.

We are convinced that, by ensuring minimum stockpiles of essential drugs, Health Canada would increase the network's ability to adapt and thus limit the risk of out-of-stock products.

There is an urgent need for action. Such measures have already been adopted in other countries and must be introduced here as quickly as possible.

In the meantime, we hope Health Canada will adapt the special access program to the new reality of supply disruptions. We find it inconceivable that this program, which is the main recourse for hospitals for access to international stock, is currently not more effective in the fight against stock disruptions. The program should also be available to the patients of community pharmacists.

Our three recommendations represent a major paradigm shift that places the supply issue in the context of national public health and, above all, proposes a proactive and collaborative approach to replace the reactive mode that typifies current federal and provincial actions.

Therefore, our efforts are aimed at prevention and action, rather than at enduring situations that are unfortunately bound to recur. We want to reiterate that the measures we are proposing have but one aim: to protect the health of all Canadians.

Thank you for your attention.

● (0925)

[*English*]

The Chair: Thank you, Ms. Lamarre. That was a very profound presentation.

We'll now go to the Canadian Society of Hospital Pharmacists. Dr. Roy.

Ms. Myrella Roy (Executive Director, Canadian Society of Hospital Pharmacists): Madam Chair, honourable members, ladies and gentlemen, I thank you for the opportunity to present to you today.

My name is Myrella Roy, and I am the executive director of the Canadian Society of Hospital Pharmacists, also known as CSHP. Before accepting this position, I spent 17 years as a hospital pharmacist and clinical manager with the Ottawa Hospital.

The society is the national voice of hospital pharmacists in Canada. We are a not-for-profit organization with voluntary membership representing pharmacists committed to patient care through the advancement of safe, effective medication use in hospitals and other collaborative health care settings.

Today, I wish to bring to the committee the perspective of our 3,000 members across the country on the issue of the role of government and industry in managing the drug supply in Canada. I also want to propose concrete steps that our members believe governments, both federal and provincial, can take to help bring about resolution to the current crisis. These steps include a robust national drug supply management system that can anticipate and efficiently mitigate the impact of drug shortages, a strong drug supply chain that can prevent future shortages, and a strong role for the federal government in shaping global solutions to what is, in many ways, a global problem.

Before I delve into these solutions, I would like to tell you briefly about pharmacists who work in hospitals and other collaborative health care settings. This information should help you understand our perspective.

Hospital pharmacists do far more than dispense drugs. They work closely with physicians, nurses, and other health care professionals to make sure that the health goals of individual patients are met while keeping the medication system safe and effective. They help select the right medication for the right patient, adjust doses, identify and manage medication side effects and interactions, and educate patients on how to take and store their medication. Hospital pharmacists are integral to patient care. Their efforts help our publicly funded health care system.

During drug shortages, the work of hospital pharmacists becomes significantly more complex and the risk to patients grows. A recent survey conducted in the United States by the Institute For Safe Medication Practices revealed an association between drug shortages and medication safety incidents. The necessity of using alternative medications, or alternative concentrations, strengths, or dosage forms of the same medication, may introduce additional complexity and opportunities for error into the processes of prescribing, preparing, administering, and monitoring medications. What's more, the alternatives are often less effective, more toxic, and more expensive for patients and hospitals.

Furthermore, there is a significant potential for errors when hospital pharmacists and pharmacy technicians compound medications from raw materials without adequate expertise, facilities, equipment, staffing, and other resources. Our members understand these risks and must deal with them every day. Patient safety remains a fundamental value of our organization, and we are committed to proposing and contributing to concrete solutions that will address drug shortages now and in the future.

Now let us discuss some solutions. As you know, drug shortages have been occurring for around a decade, and the problem is only getting worse. What past experience has taught us is that Canada and Canadians need a national drug supply management system. When a drug shortage situation of the present magnitude, and without sufficient advance notice, occurs, a significant amount of pharmacists' time is quickly reallocated to developing reactive plans with other health care professionals, implementing temporary mitigating strategies, and finding suitable clinical alternatives for their patients. The lack of a single national drug supply management system that would set minimum timeframes for notification of impending drug shortages and drug discontinuation by manufacturers leaves health care practitioners scrambling to explore and implement mitigating strategies and leads to very significant duplication of efforts.

● (0930)

CSHP is already active in fostering this kind of nationwide collaboration and sharing of information. In order to alleviate some of this duplication, our society is hosting an online drug shortage forum for its members.

Since the spring of 2011, CSHP has also been intimately involved with other national health care professional organizations and drug manufacturer associations to develop a national drug supply management system. We are thankful to the Canadian Generic Pharmaceutical Association and to Canada's research-based pharmaceutical companies for their generous financial contribution to the development of such a system.

However, the sustainability of the system is challenged by a lack of financial resources. We believe that Health Canada should play an active role in delineating a sustainable funding model for this system with the provincial and territorial ministries of health, such that health care practitioners from coast to coast to coast can more efficiently manage drug shortages and ensure quality care for patients across Canada. Such a role would be within its mandate and mission as a department responsible for helping the people of Canada maintain and improve their health.

As I made clear in my earlier remarks, all drug shortages pose safety risks and may affect the health outcomes of Canadians.

The next two solutions we would like to propose are closely connected, and also point to an important role for Health Canada. In order to identify and procure alternative medications, pharmacists consult Health Canada's drug product database and may also request medications not approved for sale in Canada using Health Canada's special access program. Unfortunately, the drug product database is not being kept up-to-date, with some listed manufacturers no longer operating a business in Canada or some listed drugs no longer marketed in Canada.

Furthermore, the current drug shortage has served to highlight the chronic weaknesses of the special access program and has further underscored the need to modernize the program, drug shortages obliging or not. The tediousness of the request process adds unnecessary delays in receiving the drug and contributes to the additional workload for pharmacists and physicians. Timely updating of the Health Canada drug product database and modernization of the special access program are urgently needed to assist health care practitioners in dealing with actual or impending drug shortages.

Finally, CSHP would like to see Health Canada taking the lead in ensuring the continuity of drug supply at a global level. Drug shortages are not unique to Canada, and many other countries are experiencing them. Numerous mergers and consolidations of companies over the past 15 to 20 years have led to a mostly multinational drug manufacturing marketplace. In many instances, the production of medications is dependent on the provision of ingredients from other countries or the occurrence of different manufacturing stages around the globe.

During its most recent congress in India last fall, the council of the International Pharmaceutical Federation, representing 130 member organizations from around the world and more than three million pharmacists, met to discuss the emergent issue of medication shortages. The council then called on all stakeholders, including governments, pharmaceutical manufacturers, pharmacy wholesalers, pharmaceutical purchasing agencies, medicine insurance plans, pharmaceutical regulators, and the pharmacy profession, to urgently evaluate these issues and work to ensure continuity of medication supply, so that the appropriate treatment of patients can be initiated and maintained.

We encourage Health Canada to engage in discussions with their regulatory counterparts in the U.S.A., Europe, and other countries to collectively learn more about drug shortages and to contribute to local and global solutions. Drug shortages are a global problem that call for global avoidance and mitigation strategies, formulated and implemented by Health Canada and health care regulatory authorities from other countries in collaboration with multinational drug manufacturers.

● (0935)

The Canadian Society of Hospital Pharmacists continues to be an innovative part of the solution to the current crisis. We remain committed to protecting the safety of our patients and to working with all stakeholders in Canada's health care system to find and implement solutions to the present crisis and in the future.

Thank you very much for the opportunity to present our concerns and solutions. I would be pleased to answer any questions you might have.

[*Translation*]

You may ask questions in the official language of your choice.

Thank you.

[*English*]

The Chair: Thank you, Dr. Roy, for your very insightful presentation.

We'll now go to questions and answers. We have seven-minute Qs and As, and we'll begin with Ms. Davies.

Ms. Libby Davies: Thank you very much, Chairperson.

First, thank you to all the witnesses for being here today. I thought your presentations were excellent. A special thank you to Dr. Chisholm, who's here from Argentina. I don't know if there's a time difference, but it's wonderful that you took time out from your conference to participate in this very important committee hearing today.

What really jumped out at me is how remarkably close you all are, first of all, in identifying the serious and urgent problem we have of drug storages, but also what needs to be done.

We've already had one meeting when we heard from industry representatives, and I have to say the government members clearly went after Sandoz, which was warranted, but there's a huge issue here about government responsibility, or lack thereof, in what we've seen, and I think you've all identified that.

Frankly, it's quite shocking to hear today in the testimony that the anesthesiologists association wrote to the minister in January of 2011, drawing attention to and putting out an early warning about shortages. We know the Competition Bureau also issued warnings to the government in 2008. So it's really quite shocking that nothing has been done. While there are issues around how the industry has performed, I'm hoping that today we can focus on what the government needs to do to address this problem.

Dr. Chisholm, you noted in your testimony that we need to predict, identify, and manage around supply disruptions. You may be aware of the motion that was passed unanimously in the House of Commons that uses very similar language; it said “anticipate, identify, and manage”.

The CMA certainly said a very similar thing: we must have a monitoring, an early notification system.

I'm very interested in the Best Medicines Coalition's suggestions that we need a regulatory framework. We need mandatory reporting.

That's really my question. We know this is being looked at in the U.S. We know that New Zealand has a model whereby they require the manufacturers to provide much more information in terms of looking for alternate sources. Now that we have this motion passed, what is it that you want to see Health Canada specifically do and the Government of Canada come back with, and how quickly? If you could give us some idea of the priority, what needs to be done first, what needs to be done second, that would be very helpful.

To Dr. Chisholm, I note that you mentioned that a resolution had been passed unanimously at your world congress in Argentina, and I'm wondering if you could send that resolution to us when you get back home, plus anything else that came out of the congress, because obviously you had a lot of discussion there. I'd appreciate it if you could forward that to the committee.

I'd ask the witnesses to address that question of your immediate priorities and then the longer term, and your timeframe of what needs to be done.

The Chair: Who would like to begin?

Dr. Haggie.

Dr. John Haggie: I'll take a stab at that. Thank you.

I think there are two things that need to happen simultaneously. One is you have to remedy the gap that's there at the moment. I don't have any handle on what's in the supply chain. I don't know anything about the business of manufacturing drugs, but looking at it from the patient's perspective, these have vanished in an unpredictable way.

The first thing is to stabilize the problem, stabilize the patient, and find some new drugs. Boucherville, for example, is not the only plant in the world that manufactures injectables. At the same time, you need to address the problem. We've heard some solutions, and we've heard some very good suggestions from my colleagues on either side.

I hope this committee had some testimony from the pharmaceutical industry. This is their problem. Why is it these drugs have vanished? It's a complex problem manufacturing it. My role as a surgeon is to explain to a patient under the concept of informed consent what it is that I want to do. I have to make the functioning of your gastrointestinal tract, for example, something that you can understand. That's my job.

I would suggest that we need to get that kind of information so that it can be used on a go-forward basis to prevent it from happening again. I don't know what I don't know about drug manufacturers. All I know is that with the gaps at the moment, unless they are filled, Dr. Chisholm and I work on opposite sides of a drape on a patient, effectively. He can't do his job and I can't do mine, in the way that Canadians expect, without these medications.

● (0940)

The Chair: Do you want Dr. Chisholm...?

We only have a minute left.

Ms. Libby Davies: I just have a brief follow-up.

Do you believe that the voluntary system we've had so far has been adequate?

Dr. John Haggie: I'd turn that question around and be a bit cheeky. Imagine you're a patient lying there with acute appendicitis. They really don't care why the antibiotic isn't there or why their pain meds aren't there. That's for you guys to fix.

We need some leadership in terms of whatever levers you've got—and I don't know those because I'm not a member of government—and we need some security for the future. So that's a pharmaceutical issue. The facts of the case are that I can't make the drugs. Should the pharmacies be doing it off the cuff in the hospitals? That's another issue, and we've heard about that.

The Chair: Dr. Chisholm, we have less than a minute. Could you please try to address Ms. Davies' questions?

Dr. Richard Chisholm: To be very short, I would echo what Dr. Haggie has said. I agree with what he said. I just have one thing I would add.

You mentioned New Zealand. One of the things in New Zealand is that they have an agency that covers the entire country, which is not the way it is in Canada because we have our silos with our provinces. When I asked them about drug shortages, they said it was a problem. I forget the name of the agency, but they addressed it, found an alternative source, and the problem went away.

So talking to colleagues from other countries, they have less of a problem than we seem to have in North America. The question of why that is, as Dr. Haggie said, I don't know, and I turn to you to find out why.

The Chair: Thank you so much.

Dr. Leitch.

Ms. Kellie Leitch (Simcoe—Grey, CPC): Thank you very much, everyone, for your presentation today. I appreciate it.

Similar to Dr. Haggie, I'm also a surgeon. I'm a pediatric orthopedic surgeon. Your points were well taken. I don't think a patient gets too worked up about who decides when. They just want to make sure they can have their surgery or have their procedure.

Dr. Haggie, you're a surgeon. You've worked in a hospital. Dr. Chisholm has as well. We had met before, but there's an anesthetist....

It's very clear to me, and I stated this in the House. When I run into a problem with a drug in my operating room, I don't pick up the phone and call the Minister of Health; I call my pharmacist. We also deal with our provincial formularies, and we deal with the circumstance of our hospital making sure that the supplies are available to us. That's who's actually doing the negotiating.

I want to be very clear that I think we understand that this is health care and the provision of those medications is a provincial responsibility, a provincial negotiation, a hospital negotiation. I just want to make sure that we're on the same wavelength on that, and then I have another couple of questions for you.

Dr. John Haggie: I take your point. I think to be fair, and this is a slightly different perspective, it's a collaborative endeavour. The analogy that was used in an article recently about the blind men feeling the elephant and each getting a piece of it, that kind of resembles the provinces in this situation. This is a global matter. There is no mechanism that I'm aware of—and again, you're the experts in government—for the provinces to have a role on the international stage in addressing these kinds of issues.

Yes, the provinces are responsible for purchasing, but one could argue that they're doing it in isolation, in silos, and what we need is a more coordinated approach so that we don't end up with a lot of unintended consequences.

I think whatever happens, however it pans out, if you look at it from the patient's perspective, they would regard the hospital board, the provincial government, and the federal government as the fixers, the organizers. And whether you want to break it down into silos in how you do that, it doesn't really matter, so long as at the end of the day you get rid of the shortage now and make sure it doesn't happen again in the future.

I'd adopt a slightly different perspective.

● (0945)

Ms. Kellie Leitch: I have two other quick things.

I have a different perspective. I actually think my patients expect me to answer their questions, not the government. I think it's extremely important that we, as physicians, take that responsibility.

One thing I'd like to point out is that on September 28, 2011, the CMA was part of and signed a letter to the minister outlining their support of a voluntary drug monitoring system. I recognize a change in your approach now. I'd like to know a little bit about that.

Secondly, as the CMA has a responsibility for educating physicians, making sure that we're aware of what is going on, what has the CMA done to make sure that physicians know what's going on? You seem to be throwing it all back on our lap here as parliamentarians. I think the motion that has been put forward is actually a very sound one, and our government is supporting it.

I think it's extremely important.

Doesn't the profession have a little bit of a responsibility as well to make sure that individuals who are physicians actually know what's going on?

Dr. John Haggie: I'd love to know what's going on.

Ms. Kellie Leitch: That's why I'm saying—

Dr. John Haggie: I can't find out.

Ms. Kellie Leitch: I think you can.

Dr. John Haggie: I beg to differ because I've actually tried.

Ms. Kellie Leitch: I'm a surgeon in your organization and I've been able to figure it out.

Dr. John Haggie: If I may respond, that group, the working party that sent the letter....

You're right. Events have overtaken us. The bottom line with that group is quite simply that we were there to provide the health care provider and the patient's perspective to a group that did not have that mix, quite frankly.

We're agnostic on the subject of whether you want to legislate a fix to this, or have a voluntary mechanism, or you want to use economic levers. I really don't mind. One could almost say I really don't care, as long as the end result is security of drug supply.

In terms of what I know about the issues of drug shortages, quite frankly, we rely on the drug companies to tell us. That system, to call on my teenage daughter's phrase, sucks. It really does not work. The lists of supply are incomplete, there are gaps there in drugs that I know have been in short supply for two or three years, and they're still not there on what is allegedly up to date.

They are a poll system, which means in my terminology you actually have to go there every day and spend time going through this shopping list of medications. There are often no alternatives listed. It's simply a rudimentary system, and quite frankly, we cannot find out from the manufacturers, be they generic or branded, what these shortages are and how long they're going to last with any accuracy.

We are in the position the patients are in, one of complete ignorance.

Yes, we have to try to explain it to our patients, but we're the middleman. We're stuck in the middle. I would suggest that as an answer to your question.

Ms. Kellie Leitch: Is there any more time?

The Chair: You have another minute.

Ms. Kellie Leitch: I will point out once again that you are on this letter stating for a voluntary system.

One of the other items that was discussed in this working group was exactly that information.... And I know; I've gone to do it as a physician, to make sure that it did work so that I would have access. I will give a significant amount of credit to the pharmacists who helped develop the Saskatchewan system to make sure that physicians are informed, that there's a place for us to go and know where that information is.

I leave it with you that, first, you did sign on to a voluntary system, and also that there is one for which I give credit to pharmacists and some of the pharmaceutical companies for actually trying to build. But I know Gail had a comment she wanted to make, so....

Ms. Gail Attara: Quickly, while the provincial and territorial bodies have a role in reimbursement, it's actually Health Canada that has the role in notice of compliance for medications. There's certainly an area on which to piggyback safety and supply.

● (0950)

Ms. Kellie Leitch: I think it's extremely important that we recognize that when you're standing in an operating room and you get your medication, it comes from the pharmacist. That pharmacist works with the hospital—that provincial hospital, under provincial jurisdiction—to deal with receiving those medications.

The federal government under the Constitution has no responsibility in dealing with that issue.

The Chair: Thank you, Dr. Leitch.

We will now go to Mr. Hsu.

Mr. Ted Hsu (Kingston and the Islands, Lib.): Thank you, Madam Chair.

[*Translation*]

The drug shortage is a problem that has international implications and has been known about for a number of years, even a decade.

Are any efforts being invested internationally to solve this problem? Is Canada participating and should it participate in those efforts?

Ms. Diane Lamarre: We are not trying to place the blame here, but rather to find solutions. Across Canada, the responsibility for this complex mechanism is shared by federal and provincial entities.

We have a many ties with European countries. As my colleague from the Association des pharmaciens des établissements de santé said, this is a global issue. I went to the same congress organized by the International Pharmaceutical Federation, and I can confirm that statement. So, it is not a matter of feeling more or less guilty, but rather of asking ourselves what needs to be done so that Canadians can have proper access to their medications.

So, various aspects are involved. The government is responsible for approvals. We met with Sandoz officials. That company has 37 factories abroad, but very few of them can produce injectable medications. Therefore, Sandoz was really limited to one or two close factories that could offset that deficiency here.

The only organization that can recommend expediting the approval for importing drugs from other international pharmaceutical companies is Health Canada.

That said, there are some province-wide responsibilities involved. Incidentally, we have a long list of responsibilities in our report we will present in two weeks; there are some adjustments. However, since we are here before you today and you are open enough to welcome us, we have made our objectives and requests specific to the federal government.

Other countries have some more explicit requirements, and that is the second point: the industry should really inform the authorities when it receives a notice of non-compliance and when it anticipates a stoppage—at times voluntarily—in the production of certain medications. That is its choice. We cannot stop the industry from doing that. A very exceptional measure must be involved, but when the industry decides to stop production, we must allow it and we must find other international pharmaceutical industries ready to produce those medications. That information is currently missing.

[*English*]

Mr. Ted Hsu: Madame Roy, we talked about the global problem. What role do you think international cooperation will play in resolving this problem?

Ms. Myrella Roy: International manufacturing corporations?

Mr. Ted Hsu: No, cooperation.

Ms. Myrella Roy: I think cooperation is critical. As I said, this is a global problem and it calls for global solutions. Discussion needs to happen at a global level.

And to answer your previous question, certainly health care practitioners don't have these solutions. As Dr. Haggie said, we're the front-line practitioners.

The discussion needs to happen between regulatory authorities around the world and the multinational drug manufacturing associations. They can discuss potential solutions and implement reasonable solutions to prevent drug shortages.

We can't do that. We can raise the issue. We can raise the flag. We can illustrate what challenges we face when we have drug shortages and not enough notice to deal with these shortages.

Mr. Ted Hsu: Do you have contacts with your colleagues and counterparts around the world?

In Canada our government has highlighted the issue of single-source suppliers for the provinces. Do you think that's the root cause of the problem around the world?

Ms. Myrella Roy: It's one major cause, but it's not the only cause. There are multiple causes to drug shortages, as I'm sure you are aware. Some causes are national and could be dealt with within Canada, but many causes are global and need to be dealt with globally.

I've heard that 70% of drug products that are supplied here in Canada are actually partially or completely produced elsewhere, outside of Canada. It could be that the active ingredient came from a different country. It could be that the whole product was produced and manufactured elsewhere, came to Canada, and was packaged here in Canada. So 70% of drug products are completely or partially produced outside of Canada.

It is a global problem, a global issue. We have to deal with it at the global level.

● (0955)

Mr. Ted Hsu: Thank you.

I guess I would take from what you say that it's the responsibility of our federal level of government to deal internationally.

Here is a quick question for the pharmacist.

What is the view of pharmacists on the ground, would you say, with regard to the online databases, the websites that have been set up? Are they accurate enough? Do they reflect the reality that pharmacists are seeing on the ground and the needs of pharmacists?

Ms. Myrella Roy: If you're asking about the current temporary solutions that we've put in place, as was mentioned, Saskatchewan Drug Information Services is one option. The other group we've made arrangements with is a group from Montreal; the database is called fridaypm.ca because typically when all hell breaks loose it's on Friday afternoon.

These current arrangements are good but insufficient. We really want to have a more robust system and a single national system that everybody can go to and that would convey all the same information. Right now, there is so much duplication of effort between all health care practitioners—certainly between pharmacists within hospitals and in communities.... You have something like 30,000 pharmacists across the country, and without such a system, you have potentially 30,000 pharmacists all looking up the same information. It's the same thing for physicians. That's not acceptable. While we're looking up all this information all at once, there is something else we're not providing: we're not providing appropriate care for our patients.

The Chair: Thank you, Ms. Roy.

I'm sorry, we'll have to go to Dr. Carrie and Ms. Block. They'll be sharing their time.

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

I want to thank all the witnesses here today for your input on this very important topic. I want you to know as well that quite often we share your frustrations with the way Canada's health care system works. You mentioned internationally the example of New Zealand —I think it was brought up—where they have one national system, so that a lot of things can be input.

But I think that saying where these silos are is just a question of where you want to draw the lines. As far as the delivery of health care in Canada is concerned, the reality is that it is a provincial jurisdiction. The provinces are responsible for delivering this health care.

One thing that I think is important to get on the record is—I think, Madam Attara, you brought it up—about piggy-backing. Health Canada does have a role. What we do is look at the safety and the efficacy of the drugs that are on the market, and we test for these.

Right now, just to give you an update, we've had submissions from other companies—17 recent submissions—and have already approved seven. With the SAP program, there were 61 applications received recently; in the last couple of weeks, 39 have been approved.

In our role, whether the drug is coming from the U.K., whether it's coming from the United States, what we do is approve how safe it is and whether, where it was manufactured, there are good manufacturing practices that are effective. Then we permit the provinces to go shopping with that approval.

That's one of the frustrations, and I want to ask you this. If you were a health minister, or if you were in one of these buying groups, first of all, would you sole-source a drug that is deemed to be medically necessary or essential? Is that the way you would do it?

Ms. Gail Attara: Absolutely not; I would not do it.

I'm co-author of a study looking at patients who switched from one brand name to another—so I'm not even talking about generic drugs. It was predicted by B.C., where I'm from, that it would save $42 million in health care costs, and it actually cost $43 million. It's a published study.

This was just from switching patients to a cheaper medication. It didn't work. Patients are not all the same. You can't do that. What works for me is not going to work for you. Even if you bring it down to a simple thing like fruit, we can't even eat the same fruit, probably.

Mr. Colin Carrie: The answers seem to be quite obvious, but the reality is...let's say you were one of those buyers and you found yourself in a situation where you were going to have a sole-source contract. It's well within your means. If you wanted to, you could put in things like.... Would you put in financial penalties? Would you put remediation clauses in there?

● (1000)

Ms. Gail Attara: You mean for not having consistent supply?

Mr. Colin Carrie: Yes. You signed a contract with them, and it's a legal contract. Wouldn't that be something you would put in remediation, risk management things, if they weren't able to deliver those products? Is that something you would put in?

Ms. Gail Attara: I think it would be an important factor to put in. If I were in those shoes, I probably would try to build in a lot of those kinds of things, except I imagine if I were in that role there would be a lot of pressure back for concessions in other areas.

What we saw, again, in my experience in B.C. was that there was a lot of pressure on the government there in the B.C. pharmacare plan to prioritize that medication among the patients in that area, and that was not a good health decision.

The thing is those health decision-makers have to be so careful about cause and effect.

Mr. Colin Carrie: That's what I think is really important, the communication, because we all have to work in this together. The reality is, because it is a provincial jurisdiction, the health care providers really do have to get that input back and forth between the people who are actually buying the products for their services so they can deliver those services. I do take your comments because I do think they're very important.

I believe my....

Ms. Gail Attara: Be there. The patients need to be there. Feedback about that particular disease would have been so helpful had the decision-makers known how different these medications were.

The study is available, should the committee want it. It's in the PPI class, which is for proton pump inhibitors for gastroesophageal reflux disease, which is a seemingly easy disease to manage, and yet 25% of the people failed when they had to go onto the designated products.

Had the decision-makers known about this kind of variance.... These medications all work. They all work, but not for everyone.

Mr. Colin Carrie: But you're helping to educate the decision-makers?

Ms. Gail Attara: We're trying. We're doing our part.

Thank you.

Mr. Colin Carrie: Thank you very much.

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): Thank you very much, Madam Chair, and I want to thank our witnesses for attending today and for your presentations. I've appreciated your answers to the questions that have been asked so far.

Madam Chair, I want to start by following up on the reference made by my colleague. She's left the room, but I want to follow up on the reference she made to a letter written by the Canadian Anesthesiologists' Society dated January 2011. I don't have a copy of that letter. What I do have is a copy of correspondence sent by that same organization dated August 23, 2011, and a response by the minister dated September 7, 2011. Then I have a copy of their most recent correspondence from a couple of weeks ago this month.

I'm wondering if the member would be able to table with the clerk a copy of that letter for the rest of the members on this committee.

The Chair: Yes. Absolutely. Thank you.

Mrs. Kelly Block: Okay.

Do I have time for my question?

The Chair: You have a minute and a half.

Mrs. Kelly Block: Thank you very much.

I want to follow up with...I think it's Ms. Lamarre, your presentation. You made three recommendations, or you've captured three recommendations—a monitoring unit, a legislative framework, and a list of essential drugs—and you've referenced the United States and France in your remarks.

I'm wondering if you are aware of other best practices in other countries that you'd be willing to share with us that support your recommendations or would add to them.

The Chair: You have less than a minute, Ms. Lamarre.

[*Translation*]

Ms. Diane Lamarre: Of course, there are measures in place around the world. The current president of the Ordre national des pharmaciens de France, France's national order of pharmacists, is also the president of the European Union group. We can therefore assume that the message approved in France will be passed on to the European Union.

What I wanted to emphasize is that our American neighbours are similarly afflicted.The Sandoz situation comes from the FDA. The Caelyx issue came from Health Canada, and its impact has been felt across the United States. So we really are in a situation where we must establish international relations, but we certainly must also establish privileged relations with the United States.

[*English*]

The Chair: Thank you, Ms. Lamarre.

We will now go to Ms. Quach. You can continue that question, if you'd like. It's whatever you want to do.

● (1005)

[*Translation*]

Ms. Anne Minh-Thu Quach (Beauharnois—Salaberry, NDP): Thank you, Madam Chair.

I want to thank all the witnesses. Your comments are somewhat reassuring, but they also call for government involvement.

I was rather confused and concerned when Dr. Leitch said that the federal government had no responsibility regarding this issue, even though you all agree that it is a matter of public health. This morning on Radio-Canada, the Association médicale du Québec, Quebec's medical association, and the Fédération des médecins spécialistes du Québec, Quebec's federation of medical specialists, said that the federal government should get involved. All of you agree with that.

As has been said here, the regulations on drug safety, effectiveness and quality fall under federal jurisdiction. Suppliers must be approved, and that also comes under federal jurisdiction. It is being said that drugs are produced abroad and that shortages are an issue. I believe it was you, Ms. Lamarre, who said that, since 2006, shortages have quadrupled. The situation is serious. Something must be done. Patients are the ones caught in the middle of this.

I would like to know whether you feel that a security clause should be included in supply contracts to ensure that alternatives are always available. That echoes what the Canadian cancer association suggested before this committee last Tuesday. Ms. Attara talked about a Canada-wide guide for patients and doctors. That would make it possible to obtain the information in a consistent manner and to react to those issues.

I would first like to hear from Ms. Lamarre, and then from Ms. Attara.

Ms. Diane Lamarre: Sandoz already has supply contracts with Canada's three biggest wholesalers. Unfortunately, it's become clear that was not enough to meet the needs. Our three conditions overlap to an extent. For instance, we will certainly want to protect essential painkillers like morphine and ensure access to a number of producers who will guarantee its availability. At the provincial level, in terms of group purchasing, penalties are already set out for cases where companies fail to supply the products. However, that does not seem to provide sufficient protection.

When it comes to drugs, we must also keep in mind the ripple effect, which very often forces us to obtain supplies abroad. For instance, when a specific painkiller is no longer available, we use another one. However, if the production of that other painkiller was planned to meet the needs of perhaps 50% of the market and not of the whole market, the result is a domino effect. That really makes us very vulnerable. It is a very important issue.

I agree that a security clause should be included, but I think it would have a limited effect as long as access to medications through two or three suppliers is not guaranteed and as long as a balanced rotation and allotment mechanism involving a certain number of distributors and producers is not implemented.

Ms. Anne Minh-Thu Quach: Thank you.

Ms. Attara, you talked about a guide for patients. That is what you are asking for.

[*English*]

Ms. Gail Attara: I think it's really important—again going back to the leadership—in that we really need to have some central kind of place where those reporting can be. We also absolutely need a safe supply of medications and whatever it takes to get there.

Even when I say leadership, I don't necessarily mean that it's regulatory, other than taking these meetings and going forward. I'm not saying what it has to be, but I'm saying that we need to come together, and who better to take the lead on it than the federal government, because it is a global situation, as we have clearly understood. I think it would be more challenging for provinces to negotiate on a global scale than it would be for the federal government to do it.

That's why, from our perspective as patients, we say it's really important that someone has to be the one to take the lead. And it is time; it's really time.

[*Translation*]

Ms. Anne Minh-Thu Quach: In Canada, there aren't necessarily any resource persons who deal specifically with shortages. However, the FDA has 11 employees who deal only with that. For instance, had Sandoz wanted to alert Health Canada....

● (1010)

[*English*]

The Chair: I'm sorry, Ms. Quach, if you have a timer in front of you I'm sure you know it's past five minutes.

Mr. Lizon.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much, Madam Chair.

Thank you, witnesses, for being here this morning. My question goes to the Canadian Anesthesiologists' Society. It was stated in the news that Minister Aglukkaq did not respond to your letter. We have a copy of the minister's response to your organization from September 7, 2011, explaining all the action she has taken to encourage the industry association to come up with their plan to share drug shortage information. I understand you sent out a follow-up letter just a couple of weeks ago, on March 6. I understand that the response to your letter is being drafted at the present time.

Do you not think that the minister and her department were busy 24/7 dealing with this drug shortage, trying to address the shortage on the ground, identifying suppliers and fast-tracking approvals so that patients get the medication they require? Can you comment on it?

Dr. Richard Chisholm: When I wrote to Minister Aglukkaq in January I did receive a response to our letter in March. We didn't say in our brief that she did not reply. In fact we give credit to the initiative she has started, but unfortunately, despite that, where we are today with drug shortages is far greater than when we first started last year.

Mr. Wladyslaw Lizon: As members of the committee stated several times today, and at the previous meeting, when we met with the drug manufacturers and associations, this is a provincial responsibility. The federal government does not negotiate contracts for medication, to purchase drugs. Even manufacturers stated that they have their own problems.

This will go to the comments made by Dr. Haggie. They stated they have problems even getting their components, some active components, for drugs. Of course, this is their own manufacturing issue. However, we have to realize that we are in a market situation on the supply and demand basis, and the fact that the provinces and territories decided on a single supplier...it's a very risky decision in any business. Any serious business that would rely on a single supplier has to be responsible for the risk associated with it. There are shortages of other supplies in the world that we don't know about and they don't involve patients. It is very important.

I don't think that even an executive order of the President of the United States of America will actually address drug shortages. This is a market issue, and unless the policies of the provinces and territories are changed, I don't think we're getting anywhere close to the solution.

Dr. Haggie, could you comment on this, please?

Dr. John Haggie: I have a couple of things in no particular order. I think it's heartening that you seem to be getting to the bottom of some of big pharma's issues, or the pharmaceutical industries' issues with their processes. As I say, it's a black box to me, and I've tried to open that unsuccessfully.

I would take a slightly different view. Everyone at the moment is talking about team-based care and collaborative approaches for physicians and health care providers. I really think that what I'm seeing here is an example of the pot calling the kettle black. Really and honestly, you guys need to have a collaborative approach to health care. You can't just hive off a bit based on one interpretation of a piece of legislation that's 170 years old or more. You can try, but it really is not an edifying spectacle for the patients who don't have their medications. The bottom line, from the patient's point of view, is that drugs are not like gas, for example. Just imagine what would happen if we had rotating random shortages of gasoline in communities and how the response may differ from random rotating shortages of drugs. Drugs are different. Drugs have become an essential part of chronic disease management and acute disease management in a way that nobody ever envisaged when medicare was set up.

● (1015)

The Chair: Thank you, Dr. Haggie.

Now we'll go to Dr. Sellah.

[*Translation*]

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): Thank you, Madam Chair.

I want to thank all the witnesses for joining us today to tell us more about this crisis. As I have said, unlike some of the colleagues from across the table, I am aware of a huge elephant in the room. For now, I am not looking to figure out who brought it in. What I am trying to do is address this pressing issue.

At this point, we can refer to it as a crisis, since this phenomenon has been around for a decade. However, it has been getting worse for the last few years. I think it's too bad that the government is not taking on a leadership role, that it is not adopting a proactive attitude to try to ease the current crisis.

I had already put the question to some of the witnesses who attended our hearings.

Do you think Canada should opt for a monitoring system and a mandatory—as opposed to voluntary—system of reporting, similar to what is in place in the neighbouring United States and in New Zealand?

Ms. Diane Lamarre: We are convinced that a mandatory system is necessary, because there is the issue of the ability to respond to these shortages as well as the required response time. We are seeing that right now. Findings have been made. At the end of the day, the Sandoz case brings to light all the problems, all the causes and all the consequences. It is an unfortunate situation, but it still gives us an opportunity to learn and respond.

These considerations must be recognized. A mandatory system is needed, because every minute counts. Sandoz was notified in November, and the warning was issued in February. I am not trying to single out Sandoz, but I want it to serve as an example for us, just as health professionals would learn from a patient's case.

There was a three-month window when they could have responded. The lack of a mandatory requirement made us more vulnerable and put us at the mercy of others. Companies, even after they are given the go-ahead for production, take months to respond and adjust their production. That is key.

I have also seen that, on the American side, the FDA has managed not quite to eliminate all the shortages, but to reduce them dramatically. We are seeing that in 2010, a total of 38 shortages out of 178 were avoided. In 2011, some 195 shortages out of 250 were avoided. That is a meaningful improvement. In 2012, from January 1 to February 9, there were 18. That is significant.

We have to use these methods. We have a social responsibility toward Canadians to take all measures necessary. Various levels come into play. Certainly, there is the monitoring component and the obligation to report problems as soon as they are identified.

Sometimes, certain companies make choices. We can respect those choices, but they must be announced immediately. When you are dealing with situations that affect production increases—as in the case of Sandoz—warning must be given, and the manufacturer must have an obligation to alert authorities immediately.

Mrs. Djaouida Sellah: What concerns me is the fact that the FDA sounded the alarm on Sandoz, saying there were sanitation issues in its manufacturing facilities, but that Health Canada did not sound that alarm.

What can you say about that? Does the U.S. have more stringent standards than Canada?

[*English*]

Ms. Gail Attara: I have a bit of information about that.

What I understand from that situation is that this drug was for export only when they discovered a problem with it. It wasn't a drug that was used within Canada. So that company is making products that go outside Canada, when maybe a priority should be on getting drugs for Canadians, if they're manufactured in Canada.

I don't have a whole lot more information on that.

To your earlier point that while mandatory reporting could be a viable option—and I'm not totally sold that it has to be mandatory, but I might be able to be convinced—the other part of that is really the sole-sourcing issue. If you have competition and you have multiple sites, if one site comes under attack, it doesn't make sense from a practical point of view to have one source for anything.

● (1020)

The Chair: Thank you very much.

We will now go to Mr. Strahl.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you very much. Thank you to everyone for being here on a very important issue.

I don't know who to throw this question to. Numerous witnesses have referenced different countries and their responses.

I guess I will ask a very direct question. Are you aware of any countries in the developed world, perhaps the G-7, that are not experiencing drug shortages or the threat of drug shortages? Does anyone know of any?

The Chair: Who would like to answer that?

Dr. Richard Chisholm: I have talked to colleagues in anesthesiology from Britain, Australia, New Zealand—some of them are a little outside of the G-7, I realize. They do not have the problems we have or our American colleagues seem to have had. They smiled and said they had a little bit of a blip two years ago and it was addressed by their central agencies.

It hasn't been a problem. They seem to source a lot of their medications in Asia and get them there. The Brits just don't seem to have a problem.

Mr. Mark Strahl: You identified two countries that have a central health care delivery system, with one level of government essentially overseeing the system, that have been able to avoid this problem.

Dr. Richard Chisholm: That appears to be the case, yes.

Mr. Mark Strahl: Do we know of any multi-jurisdictional countries with states or provinces that also have a role in delivering health care that haven't experienced this problem? If Britain and New Zealand are the examples, do we know of any with a similar system to Canada that haven't experienced a similar problem?

Dr. Richard Chisholm: I believe Australia has a series of states. I'm not exactly sure how their health system is set up, but they too have not had a problem.

Mr. Mark Strahl: Thank you.

The Chair: Ms. Lamarre.

[*Translation*]

Ms. Diane Lamarre: I do believe, however, that no country has experienced as widespread of a shortage as what Canada is going through. Right now, injectable drugs are severely affected in Canada. I believe it is incumbent upon us to learn from this specific case. I think it is in our best interests to show others the way. Despite dual legislation, I think the responsibilities and oversight are shared, and lessons must be drawn when it comes improving our processes.

Health Canada's special access program is a federal initiative that has never been tested in a shortage situation like the one we are in right now. It has always applied to rare situations, for patients who needed a drug with limited or no availability in Canada. A doctor would request it for a patient. This is the first time a group of doctors has needed a wide range of drugs for a group of patients. This is a first that we must learn from.

When the special access program was launched, it met certain needs. We are realizing that those needs are going to be felt again, unanimously around the world. I think that what we are experiencing should guide us in changing existing structures so we are better equipped to respond to needs quickly and much more appropriately. As it stands, the special access program has made it possible to import drugs more quickly for a large number of patients and in large quantities, and that is a first.

[*English*]

Ms. Myrella Roy: I think I'll restate what I said before. We're health care practitioners. We're not fully familiar with how all the political systems work and how the health care systems work around the world. That is Health Canada's responsibility. If there are solutions and there are other countries that have systems similar to ours and we can learn from their system, that is what we expect Health Canada to do.

● (1025)

The Chair: Thank you, Mr. Strahl.

Mr. Morin.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you, Madam Chair.

First off, I want to offer a special thanks to my colleague Anne Minh-Thu Quach for being the first member of Parliament to raise the drug shortage issue involving Sandoz in the House of Commons. I am proud to belong to a party that sees drug shortages as important and one that shows leadership.

Ms. Quach then addressed a question to the Parliamentary Secretary to the Minister of Health, Mr. Carrie. He replied that he would see to it that the appropriate information was provided to the right people at the right time and that, as a result, doctors, pharmacists and patients would be informed of what was happening with enough advance notice to adjust treatments if need be. That was his reply. If I go by that, I am inclined to think that the government is showing leadership, although everything you have said suggests that the federal Conservative government has failed to show any leadership in this matter.

Furthermore, Ms. Lamarre, I was quite struck by something you said: between 2006 and 2010, shortages had quadrupled. You even said the most recent shortage was widespread. That is disturbing, indeed.

I want to pick up on what my colleague Libby Davies pointed out. In 2008, the industry minister, Tony Clement, was made aware through a report by the Competition Bureau. In 2011, the Canadian Anesthesiologists' Society also contacted the Minister of Health, Ms. Aglukkaq, who has been on the job for four years. Unfortunately, raising the matter with cabinet or even Ms. Aglukkaq's office does not do any good. I agree with you, the government is failing to show leadership on this issue, and I find that appalling.

What's more, as Dr. Haggie mentioned, the current government prefers to point the finger at the provinces. Ms. Leitch, a Conservative member, repeated that position today. She blamed health professionals for not monitoring the situation, and the provinces, saying it was their problem.

What it boils down to, in my opinion—and I would like Dr. Haggie to comment on this—is a lack of leadership by the federal government and a passing of the buck to the provinces. It is already common knowledge that there is a doctor shortage in the provinces, at least in Quebec, and given the scarce drug supply, some treatments and surgeries are being delayed. Provincial wait times to see a doctor and receive treatment for a variety of conditions will increase. So that will be the provinces' problem, not the Government of Canada's. I am appalled by this lack of leadership. I want to hear your thoughts, Dr. Haggie, on what I just said.

[*English*]

Dr. John Haggie: Looking at it from a patient's perspective, they don't have a grasp of the niceties of jurisdictional disputes. They really don't understand how it is that the drugs they get actually get to them. To be perfectly honest, before these last few weeks, I was pretty well completely ignorant as well. I'm not sure I'm any wiser now, because what this whole exercise has highlighted to me is that there isn't a seamless approach to health care. There isn't a seamless approach to the issue of pharmaceuticals.

You could almost argue that pharmaceuticals now are the defining modality of medical management. When I trained, we were on the end of fixing things surgically. Diseases I treated with a knife, as a resident, are now treated medically, for the benefit of the vast majority of patients. Drugs are no longer just one of those things that are there as an optional extra.

I turn it back from the patient's point of view and say that the constitutional debate, the funding debate, the financing debate between health boards, provinces, and the national group has not informed them. It has not made them feel comfortable. It has not made them feel as though things are moving in the right direction. Finger pointing and blame....

You need to learn from case studies, and where you stand on that depends on where you sit, quite frankly.

As Rick Hillier, another Newfoundlander, said, no good crisis should go to waste. The one good thing that could come out of this is that we can do it a hell of a lot better next time and we won't end up in this pickle in the future. If that requires that the feds and the provinces and the territories sit down together and actually talk to each other, is that such a bad thing?

● (1030)

The Chair: Thank you, Dr. Haggie.

We'll now go to Mr. Gill.

Mr. Parm Gill (Brampton—Springdale, CPC): Thank you, Madam Chair.

I also want to thank the witnesses for your wonderful presentations and for taking the time to be here with us today.

I'd just like to mention one thing for the record. My colleague, Mr. Lizon, pointed this out. One of the members of the NDP yesterday issued a press release claiming that the Minister of Health had not responded to the letter or the request that was made by Dr. Chisholm and his organization. I'd like to quote from that release: “Despite the warnings, Conservatives refused to act – or even respond [to] the letter from the Anesthesiologists Society.”

I'd like to thank Dr. Chisholm for clarifying for the benefit of the committee the fact that the minister had responded to the correspondence on September 7, 2011.

I have a question for Dr. Chisholm. Health Canada is speeding the review of more than 35 submissions for the additional supply of drugs. It has also fast-tracked approvals of replacement drugs, including at least one used in anesthesia. How will this replacement drug help patients?

Dr. Richard Chisholm: I would have to know which drug that was. I'm sorry. I don't know.

Would you know which drug it is?

The Chair: Dr. Haggie?

Dr. John Haggie: I think it's rocuronium, Rick. I think it's one of your wake-up medicines.

Dr. Richard Chisholm: Rocuronium is a short-acting, non-depolarizing muscle relaxant. If you needed to have your appendix out, we'd need to relax the muscles in your abdomen for a short period of time for the surgeon to remove the appendix. It makes the surgery easier.

It has been in short supply in some places, with no supply in others. Having it available will improve surgical access.

Mr. Parm Gill: I would also like to clarify further the dates that I mentioned on the letter. There was also another correspondence apparently that was sent in January, to which the minister responded in March of this year.

The other question I have I'd like to maybe direct to Dr. Chisholm, but anyone else is welcome to take a shot at it.

As the minister has written to you, a multi-stakeholder working group was established to address drug shortages in Canada. A national reporting system is being created so that health professionals have timely and accurate information in order to adjust their treatment plan as needed.

Another important component of this plan is to provide advice on alternatives to medically necessary drugs that are in shortage. You're representing health professionals on the front line. Are there further contributions that physicians could be making to help us collaboratively respond to drug shortages?

Dr. Richard Chisholm: As you mentioned, there are two online resources. When I go to those, in fact, I don't find enough about the ones I use. There are some industry links there, where Canadian pharma generic manufacturers list the drugs that are in short supply.

I didn't see, as you alluded to, alternatives and things like that. Unfortunately, in terms of what we find out, I'll get an e-mail in the morning that this drug is not available. That's the only way I know it's not there. There is something that is not in my cart, and that's the only way I find out whether a drug is available or not.

We could feed back, but the problem is the only place I can feed back to at the moment is my pharmacist, and they have to pick up the phone in order for you to do that.

● (1035)

The Chair: Ms. Roy.

Ms. Myrella Roy: Our association has been a member of that multi-stakeholder working group since last spring, so I can speak to that.

Although I think we've made significant strides towards having a drug supply management system, as was mentioned earlier, currently we have a temporary arrangement with two existing drug shortage or drug supply systems. Our biggest challenge is coming up with one single robust national system that would also provide the full scope of information that health care practitioners need to provide quality care to patients.

Our biggest challenge is the sustainability and financing for the system.

The Chair: Thank you, Ms. Roy.

Now there will be shared time between Mr. Brown and Ms. Block. It's only five minutes, so watch.

Mr. Patrick Brown (Barrie, CPC): Kelly has a quick point, so Kelly can start.

Mrs. Kelly Block: I do, Madam Chair. Again, I'm sorry. It's just a matter of process.

I had requested that the letter that was referenced be submitted to the clerk. I understand that we will be asking Dr. Chisholm for that letter. Because that letter was written in January 2011, and he did state that there was a response in March 2011, I wonder if I could ask that the response be tabled to the committee as well.

The Chair: Dr. Chisholm, could you make sure that we have both of those letters tabled with the clerk? Could you do that, Dr. Chisholm?

Dr. Richard Chisholm: Yes, we'll do that.

The Chair: Thank you so much.

Go ahead, Mr. Brown.

Mr. Patrick Brown: Thank you, Madam Chair.

There have certainly been interesting comments today. Mr. Strahl asked about other countries that may not have had shortages. If I recall, Australia, New Zealand, and the U.K. were mentioned.

One of the challenges we have in Canada obviously is that we have several levels of government involved in the administration of health care, with the provinces administering health care.

Are there things that have been done in Australia, New Zealand, and the U.K. that you suggest should be utilized or looked at in Canada? And how would they apply, given the jurisdictions we have in Canada?

The Chair: Would you like to take that question, Dr. Chisholm?

Dr. Richard Chisholm: We could rewrite the British North America Act, but that would be historical.

In New Zealand and Australia, they source to other places where we cannot go. For England, again, I'm not sure. We need some dialogue at a level higher than I am to find out exactly how they have managed to avoid these problems. As I said, they did have problems a few years ago, but certainly not to the extent that we and the U.S. have had.

The Chair: Ms. Lamarre.

[*Translation*]

Ms. Diane Lamarre: Our examination of shortages—which we had already begun a year ago—revealed that more than 43% of shortages had to do with manufacturing quality, so products that did not meet either Health Canada or FDA standards. So there is a significant responsibility at all levels.

The current crisis has prompted us to adopt a different outlook, one where we do not point the finger at those who came before. When we saw shortages in the early 2000s, they did not last long, generally speaking. Now, they are longer. We are being told they will last three or six months. That is a new reality.

Legislation is adapted in response to new needs of patients and the public, and new problems. We are facing a new problem. Thirty years ago, no one would have ever thought there would be a need for legislation on counterfeit drugs or Internet pharmacies. But that is where we are heading, where countries all over the world are heading.

The drug shortage problem falls in that same category. It is a global problem whose repercussions have not necessarily been felt, a problem caused by globalization, the worldwide concentration of the pharmaceutical industry—both ingredient suppliers and drug manufacturers—and distribution methods, among other things. As you can see, all those areas need to be addressed.

Clearly, we have certain needs that have yet to be met. We used to rely solely on the good faith of organizations, which did not necessarily act in bad faith. They were simply caught in a historical context that dictated a certain way of doing things. It is now time to realize that we must do things differently. And to make these organizations do things differently, legislation is needed, because this is an area where people want to protect certain markets, or could eventually do so.

● (1040)

[*English*]

The Chair: Mr. Brown.

Mr. Patrick Brown: I know my time is limited. I have another question I want to get on the record before my time evaporates, as it does very quickly here.

The question is for the CMA. When a drug shortage is identified, and we're looking at an alternative drug, some have suggested that it should be a government body that does that. Wouldn't it make sense to have pharmacists and physicians look at what the alternatives should be? What role do you think physicians should have in that process?

Dr. John Haggie: I think you need to involve them, but it's a reactive thing. This is a palliative approach.

The issue of shortages and how you manage them is part of the problem, and part of the solution, as you correctly point out, is to involve pharmacists and physicians. Really, at the moment we don't have a system that allows that to happen in a way that's useful to the person writing the prescription.

The Chair: Thank you, Dr. Haggie.

Sorry, Ms. Roy. Maybe if someone asks you a question you can... because that was pointed at a pharmacist.

We'll now go to Mr. Hsu. I don't know, Mr. Hsu, if you would like to hear from Ms. Roy on this issue or not. It's your time.

Mr. Ted Hsu: Thank you, Chair.

I want to explore this question of international supply that Dr. Roy brought up. You said that something like 70% of drugs are manufactured elsewhere. I want to ask you if there is a body that keeps track of that, perhaps calculated at 70%, or keeps track of which drugs that we use in Canada come from which countries.

Ms. Myrella Roy: I'm not aware of which body would do that. I think the drug manufacturing associations probably have a better sense than we have. Certainly, as a health care professional, I have no idea.

This number that I quoted earlier about the 70% was big news to me when I learned that a couple of months ago. I don't know who has that sense. I think, as I said, it's the drug manufacturing associations, the drug distribution agencies as well.

Mr. Ted Hsu: There's a World Health Organization meeting in May, I believe. Somebody, and it may even have been your organization, had asked Canada to try to get this issue on the agenda of the World Health Organization meeting in May. I was wondering if you could comment on that.

Ms. Myrella Roy: I think the suggestion probably came from the Canadian Pharmacists Association. It may be that we did write to Minister Aglukkaq about a month ago, jointly with the Canadian Pharmacists Association. In that letter we did raise the issue that drug shortages are a global problem and finding global solutions should be something that should be addressed through the WHO.

Mr. Ted Hsu: To your knowledge, has that happened?

Ms. Myrella Roy: Not to my knowledge, no.

Mr. Ted Hsu: Thank you. That's all I have.

The Chair: Thank you, Mr. Hsu.

I want to thank the witnesses so much for coming to this very important dialogue today. Our committee is very grateful for your input.

I want to thank the committee for their questions. Our committee is dismissed.

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