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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1100)

[*English*]

The Vice-Chair (Ms. Libby Davies (Vancouver East, NDP)): We'll call the meeting to order.

This is a meeting of the Standing Committee on Health. Our chair, Joy Smith, is away today, so as the vice-chair I'm stepping in.

We have a number of witnesses here today. Thank you very much for coming. We have Lyne Thomassin and Carole Lemire from the Université du Québec à Trois-Rivières; we have José Côté and Diane Saulnier from the Université de Montréal; Michael McBane is from the Canadian Health Coalition; and on video conference we have Dale Lacombe from the Manitoba Chambers of Commerce.

Welcome to the committee, everybody. We have an in camera portion for committee business at 12:30.

Dr. Sellah.

[*Translation*]

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

Before starting, I would like to have the consent of all members to the following motion:

[*English*]

> That the Committee immediately commence a study, as it has been requested by the Standing Committee on Finance in their motion adopted on October 31, 2012, into the subject matter of clauses 269 to 298 in C-45, A second Act to implement certain provisions of the budget tabled in Parliament on March 29, 2012 and other measures, and that the Committee report to the Finance Committee suggested amendments to these clauses by November 20th, at 5 p.m.

The Vice-Chair (Ms. Libby Davies): Thank you very much.

Is there any discussion on this motion? I believe we'll need unanimous consent to consider it.

Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Madam Chair, I think the appropriate time to discuss this will be the time set aside for committee business at the end of this meeting. I would like to defer it so that we can discuss it then.

The Vice-Chair (Ms. Libby Davies): Dr. Sellah, are you okay with that?

I think we're all aware that we've had this request from the finance committee to consider particular matters related to the budget. The clerk is saying we need unanimous consent to deal with it now. If we don't have that, I think we'll just put it at 12:30, when we will deal with committee business.

● (1105)

[*Translation*]

Mrs. Djaouida Sellah: Thank you for your suggestion, Madam Chair. We could include it later in committee business, to have it passed. I just wanted to present it, to get the consent of the entire committee. Thank you.

[*English*]

The Vice-Chair (Ms. Libby Davies): Thank you very much.

We'll now go to our witnesses. The first witness is Ms. Thomassin from the Université du Québec à Trois-Rivières.

Please begin.

[*Translation*]

Ms. Lyne Thomassin (Coordinator, Clinique multidisciplinaire en santé, Université du Québec à Trois-Rivières): Good morning, ladies and gentleman. I am here today with Carole Lemire to talk to you about an innovative practice at the Université du Québec à Trois-Rivières: the multidisciplinary health care clinic.

The multidisciplinary health care clinic is the most recent of the university's clinics. There are also four other clinics. The oldest, the psychology clinic, has been in existence for nearly 25 years. The multidisciplinary clinic opened this past September.

With the opening of this clinic and a desire within the university to promote more of a team approach, a new official committee was formed: the Collectif des cliniques universitaires en santé. This collective brings together all the teaching and administrative representatives of the clinics. They meet once a month to discuss all matters relating to the management of a university clinic.

A university clinic is a place where trainee students provide services to the public, that being the clientele we want to serve, under the constant supervision of qualified people who are recognized by their professional order.

The collective works very hard. There is a real desire for interdisciplinarity and multidisciplinarity. In the last year, the fruit of our joint labours has been really visible. Because we are in the start-up phase, there is still work to be done to reach our cruising speed.

The multidisciplinary health care clinic covers three disciplines: occupational therapy, speech therapy and health care. Ms. Lemire, who is with me today, will talk to you about health care. I am going to talk to you about occupational therapy.

The occupational therapy department was established in September 2011. The clientele we serve is made up of children who come from early childhood centres, schools and social pediatrics. The department wanted to offer services to a clientele that is underserved by the public system.

This clientele is underserved because often, the people it is composed of do not use the public services, or because the problems the children are experiencing are not important enough, or high enough priority, to be at the top of the waiting lists. By definition, these are children who were not receiving services, or at least the waiting time to get services was a little longer. That was an asset for us, because our students are less experienced and so they are able to offer these kinds of services.

In occupational therapy, we have undergraduate and graduate students who are working with these children, but in the next few years an adult clientele will also be taken on.

For speech therapy, we serve a clientele composed of people of all ages who are having specific problems such as stuttering, aphasia and various difficulties with spoken and written language. These services are offered by master's level students. We also offer services in schools, in childcare centres and directly to parents who request our services.

I will conclude my presentation by adding that at the clinic, we have a governance committee composed of all the clinical directors, who are the people from the departments concerned who oversee the clinic from the academic and pedagogical perspectives. The administrative directors of the multidisciplinary health care clinic, like myself, also sit on the committee. The governance committee meets about once a month. We ensure that the clinics are operating properly.

I should also note that, in general, the professional orders visit the clinic when they come to the university in connection with accrediting its programs, and so the clinic is part of the accreditation process.

I will now yield the floor to Ms. Lemire.

● (1110)

Ms. Carole Lemire (Director, Nursing department, Université du Québec à Trois-Rivières): Good morning. I am going to talk about the university's nursing clinic.

The nursing clinic was established primarily to meet the needs of our primary health care nurse practitioners, or PHCNPs. One goal was to give them more clinical practice time. We also wanted to improve the professional exam success rate. This clinic has allowed us to offer student practitioners a learning environment developed and shaped not only by PHCNPs, but also by partner physicians who want to contribute to the training of our NPs, in a very important pedagogical environment.

This has also enabled us to develop a clinical training environment that supports testing of an innovative approach, in that the clinic very accurately reflects nurses' work in the Quebec health care system. The NPs, or nurse practitioners, find the same operating methods in the clinic as they would find as student trainees in a medical clinic. This also means that our NPs are quickly exposed to the roles and functions they are going to have to perform as soon as they begin their training placements.

In the NP program, there are three courses that relate to the practical application. These courses prepare our students to deal quickly with decisions and with certain pathophysiological problems they have to resolve. They must also apply pharmacological and non-pharmacological treatment and develop their clinical supervision process in dealing with a real clientele.

The program includes two courses in which there is integration training. Our students can now do those placements at our university clinic, since it was recognized as a training centre in June 2012. We need students at various levels to apply the physician-nurse-NP partnership process.

In terms of innovation, in September, we developed an exam preparation course so that NP candidates for the exam or practitioners who have unfortunately failed the professional order exam on one or two tries can come to the clinic and do a 10-day integration placement and a preparatory placement for taking or retaking the exam.

In terms of the service description, the target clientele in the first phase is employees of UQTR and their spouses and children, retired employees of the hospital and their spouses, and all students in the university communities. The clinic is open one day a week. A physician is present in the clinic at all times, along with nurse practitioners at various levels, either observing or on training placements, or students who have already completed their courses and are doing exam prep. We see an average of 24 patients a day, or about four patients an hour. The patients are seen by both NPs and the partner physicians.

In terms of supervision, as I explained earlier, there is always the student NP/partner physician pair. For the intervention steps, the initial patient evaluation is done by the student in the examination room. Immediate supervision is provided by the physician and the qualified NP, by video. We have a camera system in each examination room and a common room where the physician and supervising NP observe and evaluate the practice of the student with the patient being treated. The student NP then consults with the supervisors. They discuss the clinical case and determine the treatment plan. The supervisor and the student return to the examination room to meet with the patient, complete the evaluation and determine the treatment plan, or at least discuss it with the patient.

There are four stations available for real-time viewing of the patient examinations. This also means that at the end of the day's work, we can review the clinical cases using the recordings. For confidentiality reasons, the recordings are destroyed each day. Only one person has access to them, to avoid duplication or breaches of confidentiality, among other things.

● (1115)

I neglected to mention that patients at the university clinic sign a document stating that they consent to be seen not only by a partner physician or supervising NP, but also by students. The consent form is essentially identical in all clinics at the UQTR campus. The second phase, implementation, involves integrating undergraduate students into the clinical practice. For example, some students could do triage.

In conclusion, this innovative project focuses on clinical training for our NPs. It strongly encourages collaboration between partner physicians and NPs, as well as multidisciplinary collaboration, since we work with the various clinics on campus. There is also collaboration with network partners, since we do a lot of patient referrals.

[*English*]

The Vice-Chair (Ms. Libby Davies): Ms. Lemire, could you please wrap up quickly?

Thank you.

[*Translation*]

Ms. Carole Lemire: The most important conclusion is that people from various training placement settings contacted us last summer, when our students arrived to do their training placements, to tell us that the process of integrating these new students had definitely improved and they took much less time to adapt.

Thank you.

[*English*]

The Vice-Chair (Ms. Libby Davies): Thank you so much.

Our next presenters are Ms. Côté and Ms. Saulnier from the Université de Montréal.

Madame Côté.

[*Translation*]

Ms. José Côté (Holder of the Research Chair and Professor, Research Chair in Innovative Nursing Practices, Université de Montréal): Thank you, Madam Chair.

Good morning, everyone. I would like to thank the committee for giving us this opportunity to speak about innovative health care practices.

We are a team. I am a professor and the holder of the Research Chair in innovative nursing practices in the faculty of nursing at the Université de Montréal, and a researcher at the CHUM research centre. My colleague Diane Saulnier, who is also a nurse, is the coordinator of the Chair for the research program.

In the next 10 minutes, I am going to touch on the main points in the brief on innovative health care practices that was submitted, and of which you have the English and French versions in front of you.

What am I referring to when I talk about innovative health care practices? These are information and communications technology or ICT-assisted health care interventions for chronic illness.

Why for chronic illness? Because offering health care and services designed to support this clientele better is a major challenge for our health care system. In Canada, 65% of the population 12 years of age and over reports suffering from at least one chronic health problem. This is a major challenge.

Living day-to-day with a chronic health care problem involves detecting signs and symptoms of worsening. It also involves managing day-to-day therapy, managing treatment, and applying healthy behaviours. We talk a lot about how the person needs to be learn self-management behaviours. The illness is experienced not in hospital, but in the home. It is an irreversible illness; a life-long illness. People need to be better equipped and better supported.

This explains the use of the innovative practices that ICTs offer. ICTs enable us to reach people in their home using new methods, new approaches for health care interventions.

Because I am a researcher, I have seen the extent to which this research niche has expanded over the last 10 years. We have developed many interventions in ICT-assisted health care. The current state of our knowledge means that we can really appreciate these innovative practices. The results are genuinely promising in terms of improving these individuals' capacity for self-management, healthy behaviours and adherence. For example, we have observed certain health indicators among patients with diabetes, including better blood glucose control.

These interventions really represent promising avenues. They have been mainly evaluated with patients with cardiac disease, diabetes or chronic obstructive lung disease. If you look into these ICT-assisted health care interventions more deeply, you will see that there is really a spectrum, a wide variety, ranging from a website that offers very broad informational content and minimal assistance, to more sophisticated intervention. For example, there are programs that help the individuals affected to acquire skills or offer them on-line support in real time with a health care professional. There is really a whole spectrum of services.

At present, the state of the knowledge is not sufficient that we can present an accurate picture of what works best, with whom, and in what situations. We are therefore continuing the research in order to expand these innovations and evaluate them, but also to assess their cost-benefit ratio.

It is in the context of this trend toward chronic illness being managed at home, rather than in hospital, that our research chair has developed a virtual nursing intervention concept. We have distributed the portfolio to you. It will give you a little more information. Because I am allotted only 10 minutes, I will not go into the details.

There are no longer any geographical limits on the health care provided, particularly to patients living with a chronic health problem. Given that fact, we have developed TAVIE, the French acronym for treatment, virtual nursing assistance and teaching. These are virtual nursing interventions that target the capacities of the people affected to act and equip them to self-manage their health condition.

That goes beyond a website that conveys information, because information never leads to behavioural change. We work more on people's skills.

● (1120)

The first application we developed is VIH-TAVIE, to help patients living with HIV manage their antiretroviral medications better. These patients, who have HIV, meet with their health care team three or four times a year. However, these patients need real-time support, and that is what we offer with our VIH-TAVIE.

This involves interactive computer sessions, where the person is invited to get involved in a skills development process with a virtual nurse. It is done asynchronously. Everything was thought out and simulated in advance, and so it does not call for additional resources, strictly speaking.

The nurse gives advice tailored to the person, based on the person's answers to the questions asked and the needs they are experiencing. We might say that these are more sophisticated programs where personalized interventions are targeted at capacities. How do we see it?

[*English*]

The Vice-Chair (Ms. Libby Davies): Ms. Côté, you have four minutes left.

[*Translation*]

Ms. José Côté: In fact, I have done the whole presentation. I may be speaking a little too fast. No?

[*English*]

Okay, I have time. That's perfect.

I'll present and we will share the questions. So I'm okay with my time.

[*Translation*]

For us, as nurses in the group, and of course we have alliances with people in computer engineering and software engineering at the Polytechnique Montréal, it was important to offer virtual nursing intervention as a tool that supplements a real consultation with a nurse, which is done in the care setting when the person visits the hospital, or in another setting, three or four times a year. We wanted to provide them with access to a real-time, 24/7 service when they needed it. We see it somewhat as an extension of the nurse's role, which is now being played virtually.

That tells you a little about our innovation practices. You have the portfolio in front of you. If there are questions, we will be pleased to answer them. I will conclude with a few thoughts about the issues, concerns and recommendations relating to the development of ICT-assisted health care interventions.

The development process is very onerous. It calls for the marriage of some unusual teams. Often, this means health care professionals working with computer science and media teams. We try to pool our expertise to produce a product that is innovative but will benefit the clientele. In this respect, computer science plays a real supporting role for the solutions we propose.

Our concern is to a large extent related to introduction. We develop. But how will these innovative practices be introduced? How are we going to build bridges between the different computer systems in the network? How can we make sure that these health care practices mature? What strategies can be put in place to support them in harnessing these new technologies? Introducing them into health care settings prompts a lot of questions for us: how do we promote access to the technologies among the most disadvantaged groups in our society?

I will conclude with a few recommendations. The development of health care technologies is a field where there are few guideposts. Researchers are laying the groundwork at present. This is a field that should have more guidelines and mechanisms to enable researchers, clinicians and industry to be closer partners and make more rapid advances.

As well, there is definitely a need for investment to support the professionals in harnessing and introducing these technologies. They are always very interested and see these technologies as tools to empower their clientele, but they never have the budgets to introduce the technologies and train their personnel.

I am also very happy to see that the Canadian Institutes of Health Research have now opened a new research program that supports these innovative clinical practices, the eHealth Innovations program.

Thank you.

● (1125)

[*English*]

The Vice-Chair (Ms. Libby Davies): Thank you very much.

Next we're going to go to Mr. Lacombe, who is with us by video conference.

If you like, please proceed.

Mr. Dale Lacombe (Chair, Health Committee, Manitoba Chambers of Commerce): Good morning, and thank you for the opportunity to present to the committee this morning.

I've been asked to share an innovative approach that we've taken here at the Manitoba Chambers of Commerce.

As a means of introduction, I sit on the board of directors for the Manitoba Chambers of Commerce, as well as the policy committee, and I was asked last year to chair a president's advisory committee on health services in Manitoba by Graham Starmer, the president of the Manitoba Chambers of Commerce. In my day job I oversee our public sector consulting practice for PricewaterhouseCoopers in Manitoba and Saskatchewan.

What I'd like to do in the 10 minutes I am allotted this morning is share some background on the committee's efforts, provide an overview of our activities in the last year, some of the findings we have seen based on our activities, some recommendations we're making, and then next steps as we move into 2013. Again, I appreciate the time.

If we go back to the spring and summer of 2011, in the province of Ontario, PwC conducted an initiative called the citizens reference panel on Ontario's health services. We brought in two individuals, a male and a female, from each of the regional health authorities, or the Local Health Integration Networks in Ontario, over a series of three weekends to provide them with some baseline information on health services. That was on the first weekend. On the second weekend we provided a workshop on recommendations based on what you know are the recommendations you may have for Ontario's health system. On the third weekend there was a report produced by the 28 citizens that eventually was presented to the Ontario government as a means of sharing what the citizens were feeling.

I share that with you because that was really what tweaked the interest of the Manitoba Chambers of Commerce, specifically Graham Starmer, the president. He thought that was an innovative approach to engaging the public in a dialogue on health care.

I was asked to chair the committee, and I accepted on the condition that we would undertake our efforts in a collaborative and supportive manner. I have a tremendous amount of respect for health care executives here in the province and across the country. Their jobs are difficult, and this is a very difficult emotional and personal issue.

That's some background on the committee itself. There are about a dozen members. We have two doctors on the committee. We have representatives from the Canadian Mental Health Association, Eli-Lilly Pharmaceuticals, the department of economics at the University of Winnipeg, the executive from Sport Manitoba, and a number of other stakeholders. As well, we were supported by the Manitoba Chambers of Commerce management team.

With regard to our activities, we met as a committee in December 2011 and January 2012 to itemize what our priorities would be for the coming year. Our mandate was really to start the dialogue on health care within the Manitoba chambers' membership.

In the first discussion, the committee members shared approximately 15 or 16 areas that were important to them, everything from mental health to customer service to wait times to economic sustainability, and a number of other topics. We decided as a group that to focus our efforts we should bucket those into three manageable areas, which we did. The three areas we focused on were economic sustainability, healthy living, and patients as partners, or customer service.

Throughout 2012 we had three subcommittees in each of those areas go away and research the current state in Manitoba. We asked them to do a jurisdictional review of what other jurisdictions in Canada, other provinces, and, frankly, other jurisdictions around the world were doing in those areas, be it economic sustainability, healthy living, or patients as partners. Then we asked them to come back with some recommendations.

The three committees spent a good amount of time preparing that information. In the April timeframe we presented to our AGM our activities to date, some of the findings, and some very basic information about the health care system in Manitoba. It was very enlightening, because we found with only some very basic information there was a good amount of very positive feedback from the 90 or so Manitoba chambers of commerce, leaders across the province. They appreciated this information very much. It gave them some good insights into some of the challenges and opportunities in the health care system.

Throughout the summer of 2012 we pulled together the three reports from the subcommittees into one report focused on the three areas, eventually with recommendations. I'll talk to those in a moment. We're currently in the stakeholder consultation phase, so we are reviewing now with community leaders, government departments, and both the Minister of Health and the Minister of Finance. We presented to them, as well as a number of deputy ministers, with some very good feedback.

The biggest piece is probably what the business community can do, and I'll talk to that in a moment in terms of going ahead in 2013.

● (1130)

What we found was that, when asked, the public was extremely interested in being engaged in the discussion on health care.

When we talked about economic sustainability, we saw that there were pockets of experimentation or innovative programs across the country, including here in Manitoba. We believe that with a better view to some of those approaches around economic sustainability and educating the public on the economics of health care, we can achieve benefits as a country. We looked at other jurisdictions. Some jurisdictions presented a statement to the population: here are the services that you have used in the health care system that the province is costing. Provinces are using various techniques. We saw some other jurisdictions around the world where they're experimenting with private and public health care. We saw some interesting things on economic sustainability.

With the healthy living group, there is some basic research. There are a tremendous number of good programs throughout the country and around the world. Our representatives on the committee who had expertise in this area suggested that perhaps there are gains to be achieved with coordination. So we got some good feedback on how we can use all those energies. As we did with the 15 or 16 priorities, we consolidated all this into three areas. Perhaps there is a better method for consolidating. One of the pieces of feedback that came out of the healthy living group was that within the major cities across Canada—within the city proper—there is great access and there are great facilities. But once you get into the more rural areas, there are significant challenges. These are some of the areas that we highlighted from a healthy living perspective.

From a patients as partners perspective, just about all provinces across Canada have initiatives, whether they're called Patients as Partners or something else. In Saskatchewan, for example, it's Patient First. We believe this is a terrific initiative. We know from our dialogue and from community events that we held in rural Manitoba and here in Winnipeg that people want to be more engaged. So when we looked at patients as partners, we chose the word “partners” because we believe that the patients need to take an active role in their health care, along with their providers and along with the health care system. When that happens, there are gains to be achieved, from a personal health perspective and also from a perspective of economic sustainability as we move into the next generation for our kids and our grandkids.

To summarize, in economic sustainability we saw different tools that provinces and other jurisdictions were using. In healthy living, we saw a need for better coordination of the programs, because there are some great ones there. In patients as partners, we saw more of a defined role or a defined expectation for the patients to take an active role in their well-being.

As for recommendations, we want to synthesize that work and pick one area in each of those three subcommittee reports to focus on.

With economic sustainability, we're proposing a Manitoba health advisory council formed of business leaders, community leaders, and government leaders. The council would take a look at some of the realities of the economics of health care in our province and work together to find solutions. That's not to say there isn't collaboration already going on, but we believe there is a role for a provincial group to help, in a collaborative manner, share the economic realities of health care. We think that business leaders, community leaders, and government leaders, if they're building a plan together, will help educate the public and get them more involved.

With respect to healthy living, we thought, why not set a goal for Manitoba to be the healthiest province in Canada. The Minister of Healthy Living has gone on record in the past, saying he would like to have that as a goal, so we want to support it. In 2013 you'll see committees for each of these three move into the action phase. If we're going to agree to set that as a goal, what does it mean? We talk about coordination of programs, we talk about facilities, and we talk about bringing the business community in. Those are all areas you'll see in 2013.

In patients as partners—

● (1135)

The Vice-Chair (Ms. Libby Davies): Mr. Lacombe, you have less than a minute to wrap up.

Mr. Dale Lacombe: Very good. Thank you.

From a perspective of patients as partners, we believe there is more opportunity to be interactive.

As for next steps, I mentioned you'll see the three subcommittees moving into an execution phase in 2013.

Finally, we believe that through better education and greater awareness in the general population of economic sustainability, healthy living, and patients as partners, we can have a long-term impact on not only the cost curve in health care, but more importantly, we believe, the demand curve. We think there are efficiencies there.

I appreciate your time this morning and look forward to any questions.

Thank you.

The Vice-Chair (Ms. Libby Davies): Thank you very much. That was right on time.

We'll now go to Mr. McBane from the Canadian Health Coalition.

Mr. Michael McBane (National Coordinator, Canadian Health Coalition): Thank you very much, Madam Chair.

Thank you to the committee for this invitation.

The Canadian Health Coalition was formed in 1979 in response to the crisis around extra billing that people were experiencing in the 1970s.

We are pleased that we had three major federal parties participate in the founding of our coalition. We had Tommy Douglas, Justice Emmett Hall, and Monique Bégin. That symbolizes the fact that we're a non-partisan organization, and also that Canadians, no matter what their political stripe, support an improved and strengthened public health care system. So that's really the focus of our work.

I want to speak on one topic, because obviously innovation is a very broad topic and it's better in 10 minutes to focus.

I just returned yesterday from a conference in Toronto organized by the Conference Board, which had a lot of presentations about innovation. There were two presenters who struck me, and I wanted to share their perspective with you on the topic I want to raise, which is an innovative approach to managing pharmaceuticals in the health care system. The first was the head of the Canadian Blood Services, who gave an example of bulk purchasing. In just one category of blood plasma products, one product line, a national approach to purchasing saved $160 million over three years—for one product. Now, of course, you can't do that unless you're prepared to work together as a nation, all jurisdictions. Prince Edward Island or British Columbia or Ontario or Quebec cannot make those savings on their own. Together there is strength.

The second person who presented—he was the last presenter—was the Minister of Health from Alberta. He made a very powerful case that medicare was about sharing risk and then sharing resources, and he said we're failing today. He said the federal government is failing in that responsibility. He said it is especially true with pharmaceuticals. There is no collaborative leadership and national coordination, and I would argue there is not an innovative approach to pharmaceutical management.

I want to make the case here for a national pharmaceutical strategy, national purchasing. The first of the three objectives really is to make pharmaceuticals accessible to everyone. We have nearly eight million Canadians who are falling through the cracks. It's a myth to think that if you're in need you're taken care of. Actually it's not true. There are a lot of Canadians who don't have access to essential medicines. You know that, I'm sure, from your constituents. Medicines are very expensive, and if you're not fortunate enough to have a good private drug plan at work, or if you lose your job, you don't have access. So we would focus on access.

We would also focus on making pharmaceuticals affordable. Canada spends 30% more on new brand-name drugs than the industrial average. That's a lot of money.

The third objective is appropriate prescriptions. We are getting over-prescribed. There are too many prescriptions and inappropriate use. There's over-marketing of pharmaceuticals. We also, of course, want safe prescriptions. Adverse drug reaction is one of the leading causes of death in Canada. That clearly has to be addressed with a national pharmaceutical management approach.

In a sense, what we're saying is only pay for what works and make sure you get value for money. It sounds like common sense, but actually if we really did that in pharmaceuticals, it would be a major innovation.

My colleagues from Quebec used a couple of words: *collégialité et équipe*. These are very evocative words for health care because health care is not a business. Health care professionals are not trained to compete; they're trained to cooperate. There are fantastic examples of innovation within the public system, and most of the innovations are in the public system, whether it's surgical clinics or whatever. I think as you all know, the problem is that a lot of these things are just pilot projects, and what we need to do is.... The colleague from Winnipeg mentioned the issue of coordination. The system is crying out for coordination. We're hearing that all the time.

● (1140)

Of course, I would make a strong appeal for the irreplaceable role of the federal government. The reason I raise the issue of pharmaceutical management is because this is one area of health care that nobody with credibility could argue there's no federal role.

I want to address a federal role in innovation. Clearly the federal government regulates pharmaceuticals and is setting the price of new drugs through the Patented Medicine Prices Review Board at a level that is way too high. It is 30% above the industrial average. In Quebec the prices are 40% above the international average. Just think of what you could do to make our system more seamless, with more integration and more home care but with all those savings. I handed out a sheet with a cost breakdown of how much we would save: $10.7 billion a year.

This is a very credible study from Marc-André Gagnon. We have to consider this. We don't have enough money to be throwing away overpriced drugs and using drugs inappropriately and yet having Canadians go without essential medicine. We have the worst of both worlds: too much for some, not enough for others. We have the know-how to be smarter. We're one of the only countries in the world that does not have a universal public drug plan. It's time to move forward.

We're very pleased to see the provinces...and in this case there is a lot of leadership coming from the Province of Alberta on this file. I'm convinced that all the provinces are there. We need a federal partner. I would encourage you to really look seriously at this area of health care.

I'll stop there and maybe leave some time for questions.

The Vice-Chair (Ms. Libby Davies): Thank you very much.

We'll now hear from Mr. Seely, who is the executive director of the Ottawa Integrative Cancer Centre.

Thank you.

Mr. Dugald Seely (Executive Director, Ottawa Integrative Cancer Centre): Good morning, everyone.

Thank you very much for the opportunity to be here to speak to you today.

[*Translation*]

Our documents have not been translated into French, and I apologize, but we are in the process of doing that. For the moment, they are in English only. That is also the case for my presentation.

● (1145)

[*English*]

To start off, this is a bit of a different approach, and I think it certainly fits within the innovative framework.

I'm a naturopathic doctor and the director of research for the Canadian College of Naturopathic Medicine as well as the executive director of the Ottawa Integrative Cancer Centre. We opened in November 2011, almost exactly a year ago today. In fact, tomorrow is our birthday, if you will. We're very much the new kids on the block.

We're aiming to provide complementary medicine in combination with, as a complement to, and ideally integrated with conventional medicine in a community clinic. We're working towards improving communication between complementary practitioners and conventional practitioners so that patients don't feel they're torn between two different worlds when they look at discussing with their conventional practitioners some of the complementary medicine care options they are using.

We know that a large proportion of patients are actually using complementary medicine, particularly people living with cancer. We're looking at anywhere from 40% to 80%, depending on which survey of which population of people is being looked at. Typically, in the past, women with breast cancer have been much more likely to use complementary medicine. However, we're seeing that shift to more usage across many different cancer types.

We are looking to conduct research in the area of integrative oncology so that we can demonstrate, assess, and evaluate the potential benefits for patients when they combine complementary medicine with conventional care.

One of the main goals for patients when they come to see us is to control post-surgical healing and some of the side effects associated with some of the conventional therapies, such as chemotherapy and radiation. There are a lot of ways we can help patients. People are using this therapy, and there is evidence to support it.

What we don't have, though, is integration among the systems, and we have a real communications gap. That really needs to change, because patients feel great anxiety and a lot of stress when they try to bridge these two worlds. It's very difficult for them. We're about providing a place where we're not an alternative source of care, but a source of complementary and, ideally, integrative care. We're not there to provide a replacement, by any means. We want to work in conjunction with and help support patients and improve their quality of life.

There's also data that we can potentially extend life as well with this combination.

To give you a better flavour or a better idea of the kind of centre and the kind of care this is, we have a number of different disciplines working together to provide this complementary care. We have five naturopathic doctors and three medical doctors. There's an acupuncturist, a physiotherapist, two counsellors, and a nutritionist. A number of people are working to provide these different types of care for patients who are seeking it. The care doesn't necessarily address the pathology of the disease in the same way a hospital would, with chemotherapy or radiation, but it addresses very important aspects of a person's health that patients feel are incredibly relevant to them.

We are committed to providing this care in a clinical setting that provides safe and effective therapy that does not interact negatively with any of the conventional therapies. This is something that is of prime concern to oncologists in particular, and of course to patients as well. We look to provide therapies that are safely combined and at the right times.

In addition, we want to be doing the research to assess whether or not there is any benefit, and what benefit there is, from that combination, and to do so in a whole-practice setting. So we want to look at, for example, when a patient comes through the care and they're also doing conventional therapy, what additional benefits they accrue from having that complementary therapy. We want to look at outcomes that are patient-relevant outcomes, as well as harder outcomes, like recurrence and mortality. These are, really, the way to demonstrate benefit, to improve communications, and then, potentially, to move into a more integrated health care system that does include complementary medicine.

Governance comes through from the Canadian College of Naturopathic Medicine, which is one of the seven accredited teaching colleges across North America. It's accredited by a board that's certified through the federal government in the United States. The college provides the foundation for us and provides some of the infrastructure, so it gives us the stability and also some of the framework for the research that we've done and we continue to do.

We work with some key partners, including the Ottawa Hospital Research Institute, OHRI. I'm an affiliate investigator with the OHRI, and we work with some of the scientists there on some of the research we're doing, which involves both synthesis-type research, which is basically collecting data from the literature and systematic reviews, meta-analyses-type work, and then also in the conduct of clinical trials, which is something we are doing and are committed to doing more of.

We have also worked with the Champlain Regional Cancer Program's Ottawa Hospital Cancer Centre, with some people in leadership positions there, who also recognize from surveys with their patients that they are very keen on including complementary medicine within the spectrum of care that they are considering and that they do access, and they want this to be recognized formally.

We've been very well supported by different foundations, in terms of some of the research we're doing. That includes the Lotte & John Hecht Memorial Foundation, and also the Ottawa Regional Cancer Foundation as well. We've been funded by the Canadian Institutes of Health Research.

As part of the integrative oncology whole, if you will, a lot of different people are trying to work together to move the science of this field forward. That includes patient advocates, oncologists, naturopathic doctors, other complementary practitioners, and researchers, who are looking to better evaluate and assess what kind of a model of care is effective.

So the OICC is a new place. There is a great demand from patients. We're seeing that growing very rapidly. We've just expanded our facilities recently, and we see that continuing to grow. What we're looking for is to assess this in the right way through rigorous research and to be able to enable people who are of low-income means to be able to access these services as well, and then to do this in the context of a pilot study, which I think is a good fit because it's really not being done in Canada very much. There is an example in the west, a centre that is doing work in this area, but nothing in eastern Canada. We want to be evaluating, assessing, and documenting benefits and outcomes, and we want to be able to present this and to analyze it.

● (1150)

The Vice-Chair (Ms. Libby Davies): You have less than a minute to wrap up.

Mr. Dugald Seely: I will just give you a couple of quotes. I'm not just a representative of a naturopathic college, but of patients who are seeking this, and also physicians who do see the value of this.

One of our supporters who does refer patients to us is a lead oncologist in the Ottawa area, Dr. Shail Verma, and his quote is:

> For far too long, disciplines have worked in isolation without communication and our patients have often felt caught between differing therapeutic philosophies, often to their detriment. This is a wonderful initiative. An integrative program will help provide a much needed bridge.

Another quote, by Dr. Stephen Sagar, a radiation oncologist at the Juravinski Cancer Centre:

> Integrative cancer care enhances conventional therapies and bolsters the prevention of recurrence. In addition, integrative oncology provides systematic strategies to prevent cancer through lifestyle modification, such as nutrition and exercise. Recognizing synergy from a whole systems approach, integrative oncology provides new models for dealing with the epidemic of cancer.

● (1155)

The Vice-Chair (Ms. Libby Davies): Thank you very much, Dr. Seely. We can come back to you later if you have other quotes you want to read in.

Thank you very much to all of the presenters. I think it was great information that you gave us about what innovations are taking place or could take place in terms of service delivery and providing support to patients.

For our remaining time now we'll go into questions and comments. The first round is for seven minutes, for both the question and the response.

We will begin with Dr. Sellah.

[*Translation*]

Mrs. Djaouida Sellah: Thank you, Madam Chair.

I would first like to thank all of the witnesses for coming to talk to us about their innovation initiatives today.

My first question is for Ms. Thomassin and Ms. Lemire.

As you know, Quebec is always in the vanguard when it comes to certain projects, particularly in the socio-medical field. If I understand correctly, the UQTR multidisciplinary clinic offers health care to the public in the region and to employees, retired employees and their families, in a training environment designed for students in a number of health care disciplines. It offers on-going care, particularly in speech therapy and occupational therapy. I applaud that initiative. I was one of the physicians when I did my residency in Quebec. At that time, I said that the best thing was for physicians to be multidisciplinary in a closely related field. I see here that you are ahead of the physicians. I therefore applaud the work you are doing. This might be a case of best practices that could be reproduced elsewhere in Canada.

Do you know whether there are models like yours elsewhere in Quebec or Canada? What is the main obstacle to setting up a clinic like yours?

I would also like to focus a little on access to health care and ask you whether a clinic like yours means that waiting time for seeing a general practitioner or specialist physician can be reduced.

Ms. Lyne Thomassin: I will answer part of your question, if I may, and let Ms. Lemire handle the rest.

I am going to talk to you about the challenges. It really is not a simple matter. As a university clinic, we also work with the departments. Their prerogatives are very specific when it comes to training. The fact that the needs of each department or program, and the training objectives, have to be coordinated within the clinic is an on-going difficulty.

Even though we are going to acquire more experience over the years to come, that will still be significant. As well, the multidisciplinary and interdisciplinary concern is not necessarily something that comes spontaneously to people in the departments, given that we are dealing with students who do not have the minimum skills for working in their profession. We start with professional skills, and so that means that the multidisciplinary vision is upstream from there.

Ms. Carole Lemire: In terms of the innovative project, and more specifically the nursing clinic for primary health care nurse practitioners, PHCNPs, we are at present the only clinic in Quebec that offers a partnership with physicians and NPs, to supervise ours students. This means that the students see real patients, in real time, from the university community. At present, we are considered to be the only NP school/clinic in Quebec.

Perhaps the biggest problem, as you noted, is the partnership with physicians. In general, our students do their training placements in medical clinics or GMFs, family medicine groups. Perhaps the biggest difficulty I have had to overcome is getting physicians, on contract, to come to the PHCNP clinic to work in partnership with our nurses. So that was something novel. As well, we had to initiate talks with the MSSS, Quebec's health and social services department, and the FMOQ, Quebec's federation of family practitioners, so that this "first" could happen. Essentially, there are not a lot of physicians who teach nurses directly.

I address the last point in my presentation. At present, we serve the university's employees and students. Of the UQTR students, at the hospital, about 20% of the patients we see are foreign. They come from outside Canada. Many in that 20% represent an orphan clientele: they have no family physician because they are from outside Canada. And there is an excellent partnership with insurance companies to provide payment for their health care.

At present, we are really serving a significant orphan clientele. The plan is for the clinic to be open two days a week within a fairly short time. We plan to open it later to the orphan clientele in the Trois-Rivières region, region 04, where there are, for example, a lot of patients with chronic illnesses who are not under the care of a family physician. This is really with the goal of providing a service to a population that is not receiving it at present.

● (1200)

Mrs. Djaouida Sellah: Thank you.

[*English*]

The Vice-Chair (Ms. Libby Davies): You have about one minute left, if you'd like a quick follow-up.

Mrs. Djaouida Sellah: Yes, a quick question, please.

[*Translation*]

My question is for José Côté.

I congratulate you on the work you are doing on innovative practices. I know your goal is to support and equip patients using virtual interventions.

What are the factors that distinguish a patient who is capable of managing their own care from another patient who has trouble doing it? Are there social factors that come into the equation?

I recall the case of a transplant patient who decided not to take her anti-rejection medication, who had to make a choice between her medication, being on the street, and paying her rent. She is now on dialysis, unfortunately.

Ms. José Côté: Thank you for your question.

[*English*]

The Vice-Chair (Ms. Libby Davies): You only have 15 seconds to reply. We'll have to come back and try to pick it up again. Perhaps you want to say a couple of sentences.

[*Translation*]

Ms. José Côté: The condition that has the most effect on an individual's capacity to act is depression. We see this co-morbidity among our patients: they have a chronic illness and also suffer from depression. It has an enormous effect on their capacity to act. I work with a diabetic clientele, and 30% of that clientele, representing about 300 patients, suffer from depression. That is where we see that these people's capacities are very limited.

It seems I will have to come back to the subject.

[*English*]

The Vice-Chair (Ms. Libby Davies): Thank you very much. I realize how tight time is and that it's difficult to get the questions and responses in.

We'll now go to Dr. Carrie.

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

I'd like to start by thanking all the witnesses for being here.

I want to start my questions with Dr. Seely.

I was really pleased to be able to attend your opening last month to see it first-hand. One of my colleagues, Ms. Block, told me that integration is innovation in health care. I was really impressed how patient-oriented your clinic was and how you're focusing on education. I was impressed to see you had a kitchen in your facility, because nutrition is such an important part of things, and to see the cooperation among the oncologists, the naturopaths, and all the different professionals who work with you.

Your centre really does strive to assess and reduce the possible causes of cancer in people who've undergone these treatments, to get them back on track. I was wondering if you could expand on the kind of innovative treatment and management programs you use in the clinic.

Mr. Dugald Seely: Thank you for the question, and thank you for participating in the grand opening event. We had a lot of people who were very affected by that.

In terms of innovation through the kinds of treatment modalities we use, we do really try to touch on different types of therapies that work from the physical standpoint, the psychological standpoint, and even the spiritual standpoint, to some degree.

For example, you mentioned the kitchen. We're running nutritional workshops. That provides a way in which patients can come and get hands-on experience with how to cook foods that are more healthy, from a cancer perspective. That's one thing.

In terms of the naturopathic care options that we provide, we look at a lot of lifestyle approaches—helping people to do exercise and to build that into their lives in a way that is safe. We know for sure that exercise is incredibly effective, an additional thing that people can do to help prevent recurrence and as a treatment modality.

We also use targeted supplements in ways that are used in other countries as almost conventional therapy. One example would be the use of a mushroom extract from coriolus versicolor. PSK is the extract they use in Japan. That's considered conventional medicine there, and there is a lot of very good data to back that up. We use that to help support the immune system. That's a particular therapy that really is nice because there is very little risk of any interaction with some of the chemotherapies and other things. We can look at supporting the body's internal environment to help fight off the cancer itself by using a very different approach from what's conventionally used. It does work well in combination and it's something that's helpful.

Those are some examples.

Also, there is massage therapy and lymphedema therapy. For example, someone who has had a partial mastectomy may have some lymph nodes being removed and they have a higher predisposition to lymphedema. With someone who's trained in lymphatic drainage therapy, you can include that, and you can help to reduce the likelihood for development of that.

I think having these different services available in one place and integrated within that clinic is very innovative in and of itself. The approach and the reaching out to conventional doctors to enable patients to feel comfortable doing both of these things is one of the most innovative components of it.

● (1205)

Mr. Colin Carrie: Thank you very much.

I was impressed too that some of the guests you had there were survivors. You mentioned in your comments now the importance of an exercise lifestyle to help prevent recurrence. We're finding with the research now that so many cancers are related to lifestyle issues, and the cost of recurrence is not only emotional to the family but to society as well.

I was wondering if you were working with any international researchers. You talked about having some funding from CIHR, especially on these issues of recurrence and the cost benefit of taking an approach like this. Do you have any comments you could give the committee on that?

Mr. Dugald Seely: We haven't done any research on the cost-effectiveness component of that in terms of cancer. We've looked at cardiovascular disease and we've looked at the cost effectiveness of including a naturopathic approach to care for people who are at higher risk for cardiovascular disease. This was actually a study in three centres across Canada involving Canada Post workers. We showed dramatic societal benefits in terms of cost effectiveness there. I think it was just over a thousand dollars per individual.

That's representative of a kind of chronic disease that responds to a whole-person approach to care. Cancer is definitely a chronic disease now. It's more of a disease that is managed rather than attempted to be cured, so it fits very well within that.

We do need to do the cost-effectiveness research to see what benefits there are there, especially if we're able to prevent recurrence. There is no question there would be a massive benefit from that.

In a lot of the cases, people will come to us after conventional therapy. They've just finished their chemotherapy, their radiation, and they wonder what they do now. They feel let go and they don't know what else to do.

Complementary practitioners are often a place that people will go for that. That's definitely an area where we see patients. My bias is very strong that we're able to improve recurrence rates, and there is data for that as well.

● (1210)

The Vice-Chair (Ms. Libby Davies): Thank you very much, Dr. Seely.

That's the seven minutes. Time is short today because we're going to go on to committee business at 12:30. I'm going to try to keep to the time so that we can get in as many people as possible.

Go ahead, Dr. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much, Madam Chair.

I want to thank everyone for coming.

Some of the innovations I heard you speak about are ones we've all known, through evidence, would work. I'm glad to see you're moving forward with them.

My questions are for Mr. McBane.

Mr. McBane, I was delighted to hear your presentation. I want to read something for you from the 2004 health accord, which had indeed stipulated that one of the five things meant to be a result of the accord was a national pharmaceutical strategy. All 13 premiers and the prime minister of the day, Paul Martin, agreed on this. I just want to read what it says:

> First Ministers agree that no Canadians should suffer undue financial hardship in accessing needed drug therapies. Affordable access to drugs is fundamental to equitable health outcomes for all our citizens.

Then, of course, they decided to establish a ministerial task force that would achieve a minimum of about eight things that would constitute a strategy.

You are absolutely right that the kind of bulk buying, etc., that the premiers are now trying to undertake through the Council of the Federation is something they shouldn't have to do alone. It is absolutely essential, as the accord said—and the accord talked about jurisdictional flexibility—that the federal government has to be a player in this.

This is now how many years later? We just have two more years left in the accord, and the federal government walked away from this particular thing in 2006.

My question is this. I would love to know what happened to that money that was put into the accord specifically to develop a national pharmaceutical strategy. I don't suppose you could tell me what happened to it. The point here is simply this. The Conference Board, as you say, had a good meeting. One of the things they talked about is bulk buying, but they also talked about access to generic drugs.

There's a real question here that I want to put to you. There is a shortage of drugs in Canada currently, as you well know. That shortage comes mostly from generic drugs. Once the patent expires, generic drugs are made and sold, but because generic drugs are so much cheaper, a lot of companies that are no longer making the kind of profit they used to make from selling generic drugs have stopped making them. This is a really important question because I think we all need to struggle with this as we talk about health care. What do you think one should do to ensure that generic drugs are available and that they don't just go off the market and are no longer made by companies because they're no longer profitable? Is there an innovative suggestion that you have for this?

I want to go back to look at the fact that earlier on, in Trudeau's day and in Mulroney's day...obviously Connaught Laboratories was a government laboratory that provided medications that weren't being made anymore. Putting that on the table, if we go to generic drugs, which obviously are going to be cheaper, could you tell me of some innovative ways that you see us ensuring that they're there for us—seeing that they're not?

Mr. Michael McBane: Thank you, Dr. Fry, for your questions.

I have a very quick comment on the national pharmaceutical strategy. I was delighted to see that as part of the 2004 accord. I considered that the most important piece of the accord, aside from the secure financing. Therefore, I don't think you can exaggerate how much damage the abandonment of it by this government does to the health care system.

I believe you cannot have health reform without getting pharmaceutical management under control. Right now pharmaceutical management is out of control. Spending is out of control in pharmaceuticals. The federal government is directly responsible for the escalation in the costs. In fact, the government is currently negotiating a trade agreement that would add another $2 billion, but it's not paying the bill. It's going to give the bill to the provinces and to Canadians to pay out of their pockets.

So there's an uncontrolled cost escalation and sabotage in terms of Canadians' health, because there are a lot of other pieces in the national pharmaceutical strategy, in terms of appropriate prescribing and other essential elements. Also, not everything should be a prescription drug. Alternative therapies should be considered as well—appropriate therapies.

I really think we have to get the federal government back to the table. It's the one area where there's unanimous consent in all the jurisdictions. Unilaterally walking away—

● (1215)

Hon. Hedy Fry: My question is about these generic drugs. How do we get them, and how are they made?

Mr. Michael McBane: I'm glad you referred to Connaught Labs, because that was a public company, a crown corporation. It's interesting. They were left certain patents by Banting and Best, given to the people of Canada, which were later privatized. So there is a precedent that the public sector can play a role in ensuring the manufacture and the access to essential medicines. I think that's one thing we can look at.

The Government of Canada has contracted for certain vaccines that they considered essential to public health. There's no reason that there can't be public contracting for generic medication to ensure access, to ensure supply. I think we should be looking at that. Certainly other countries can provide some examples for that.

The Vice-Chair (Ms. Libby Davies): You have less than a minute left.

Hon. Hedy Fry: That's fine, Madam Chair. I'll let you move on.

The Vice-Chair (Ms. Libby Davies): Thank you very much.

Mr. Lizon.

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

Thank you to all the witnesses for coming here today.

The first question I have is to Mr. Lacombe.

In your presentation you stated many times that you want to involve, or you are involving, patients as partners. Can you maybe elaborate in more detail on how you want to do it without concrete plans to get these people involved? I suppose you want to involve potential patients, to prevent illness.

Mr. Dale Lacombe: Certainly, and thank you for the question.

We talked quite a bit about the patients as partners or the customer service element as we were setting up the committee and the three subcommittees. We chose patients as partners as opposed to patients as service, because we believe that inherently, in the word "partner", they need to work collaboratively with their providers—and not just work with their providers, but they also need to be educated about the system.

As an example, at the annual general meeting we presented to 90 executive teams from chambers across the province. I would hazard a guess that 60% of them—I don't want to say had no idea—did not have an understanding of the costs of the health care system. We believe that partnership means you want to be involved, not only in your health, but you want to be involved in long-term solutions. You want to have all the information at your disposal. We think when you have that information—it's always going to be emotional, sensitive, political—you can act much more as an informed participant and add a whole lot more value.

From a health perspective overall, there's been a lot of discussion over a long period of time now around bending that cost curve. We support that, but we also think that through better education, involving the public and the patients more aggressively and more and more interactively, we can bring the demand curve down.

The need for health services is not going to go away. If you're sick or if you hurt yourself, you need to see a doctor.

We think that through more engagement of the public, whether it's through a patient contract...as an example, an individual having a patient contract with their doctor: "These are your achievements. These are your meds; we need to make sure you're taking them. We understand you're smoking or you're not exercising now. We'd like to see a plan because we're interested in your health, so we're working together."

So it's really about education and ownership of their health.

The other piece I'll mention is that we were glad, frankly, we didn't mention patient service. We respect the Patient First program in Saskatchewan, but what really came through in our dialogue is that providers and everyone in the health care system really do put their patients first. We thought, you know what? That passion is there. We see it in the providers. We now need the patients to be more engaged. They need to be partners in the discussion.

● (1220)

Mr. Wladyslaw Lizon: Thank you.

I read on your website that health care is the number one priority for Manitobans. Your website states that 43% of the Manitoba budget is spent on health care. These funds should be used in the most efficient way to provide the best standard of care.

What kinds of examples do you see of efficient and cost-effective health care delivery in the province of Manitoba?

Mr. Dale Lacombe: That's a good question.

A recent example is the merger of the 11 regional health authorities down to 5. There's a very concerted effort to manage the administrative expense of the health care system, and we've seen evidence of that. That is a major undertaking. It's been implemented, but the government is still working through that. We thought that was encouraging.

We've also seen a very strong focus from the department on managing expenses, so the growth rate is down. We are seeing those types of examples.

The merger of the regional health authorities from 11 to 5, I would say, is the most evident and the most recent.

Mr. Wladyslaw Lizon: Thank you.

How much time do I have?

The Vice-Chair (Ms. Libby Davies): You have one and a half minutes.

Mr. Wladyslaw Lizon: I have a question for Madame Côté.

You are currently working on a number of research projects with funding from the Canadian Institutes of Health Research. How is this funding assisting with the creation of new jobs and innovation in the health care system?

[*Translation*]

Ms. José Côté: I have received a few grants from the Canadian Institutes of Health Research to develop and evaluate innovative health care practices. Of course, that creates work for the research assistants who do the evaluation of these new technologies, but it also enables us to form unusual health care teams, in terms of computer science and media. On my research teams, there are a lot of people who work in computer science and media. Developing these innovative health care practices creates jobs on an ad hoc basis.

I don't know whether that answers your question.

Mrs. Diane Saulnier (Chair Coordinator, Research Chair in Innovative Nursing Practices, Université de Montréal): If I may, I would like to add to that answer.

In fact, our objective is not so much to create jobs as to evaluate the effectiveness of new health care interventions and determine whether those interventions will have a positive impact on the public's health. This should not be considered as a gain in jobs in health care. These computer-based virtual tools may involve creating a few new jobs, but it is mainly the expertise of the nurses, pharmacists and physicians that is being put to use in this case.

The indirect impacts will be more in the health care technologies industry than in the health care system, given that the professionals who work with us already have jobs in a clinic, a family medicine group or a community network. We therefore cannot talk about job creation as such. In any event, we will have to make sure that this is eventually marketed, which is another matter.

[*English*]

The Vice-Chair (Ms. Libby Davies): Thank you very much, Madame Saulnier.

Now we'll go to our five-minute round, and we'll have time, probably, for one question. We'll begin with Mr. Kellway.

Mr. Matthew Kellway (Beaches—East York, NDP): Thank you very much, Madam Chair.

Thank you to all the witnesses today. I found your stories very interesting, and, frankly, depressing in a way, in that we come to this study about innovation and what we find here is a very old idea of collaboration. When one looks at the evidence you've put forward today, it's a reminder of all the great opportunities we've missed, all the billions of dollars needlessly spent on health care, to say nothing of the health care implications for Canadians for things such as adverse drug reactions and over-medication and those sorts of things.

On the brighter side of things, I guess that idea is still with us today; it's a matter of applying it. What we have before us particularly, Mr. McBane, in the documents you provided, is this low-hanging fruit that's available for us to pick off the tree, and what a huge piece of fruit it is, too. I mean, even if the studies are wrong, we're still talking about savings in the order of billions of dollars for Canadians, and a better health care system along with it.

I was wondering if you could perhaps provide us with a few details on what a country like New Zealand does, in fact, to reap these 50% savings and maybe, too, comment on Australia, if that's a more applicable political system for us to compare ourselves with.

● (1225)

Mr. Michael McBane: In terms of New Zealand, it's referred to in Marc-André Gagnon's study because that's kind of the source of the major savings, if we were to implement their purchasing strategies.

In a nutshell, I remember asking the head of the New Zealand drug program, “How did you do this? Is there a document? Can we read it? Can you share it?” He said, “Well, it's not really on paper. We bargain prices.” New Zealand bargains. Canada does not. So billions of dollars are saved in New Zealand.

There's an example of a study at UBC with four classes of drugs only, where you bargain for four classes, like New Zealand does. We'd save $2 billion in just four categories, $2 billion for exactly the same product. It's because we're not bargaining for purchases.

Mr. Matthew Kellway: It's just the application of another old idea.

Mr. Michael McBane: Australia is even more like Canada in size and jurisdictional makeup, so instead of letting the states go on their own, it's the national government of Australia that establishes the formulary and establishes the bargaining with these multinational companies. That's actually a pertinent example of having one purchasing agent do the bargaining and saying, “If you want access to Canada, you have to give us a break on the price.” These companies will give you a break. We're not even asking for a break.

Mr. Matthew Kellway: Okay.

Very quickly, you mentioned 30%, the extra cost we pay in Canada compared to most industrial countries, and in Quebec it's even higher, 40%. Is that incorporated into the 50% and the 9% that you're talking about in comparison to New Zealand and Australia?

Mr. Michael McBane: The 30% comes from.... Basically, if you analyze the impact of the Patented Medicine Prices Review Board, what they do is pick a basket of seven countries that have the highest prices to set Canada's introductory average, so it's an artificially high introductory price. Instead of taking the OECD average, say 30%—

Mr. Matthew Kellway: Do you know why they do that?

Mr. Michael McBane: Well, I do know why. At least my theory is, if you look at the history of the Patented Medicine Prices Review Board, it was established by Brian Mulroney's government as a gift to the drug companies. The rationale at the time was that if we gave them higher prices, they would give us research in return. They promised in that deal under the Mulroney government, when the Patented Medicine Prices Review Board was set up, to invest 10% of sales revenue in R and D. Now we're down to about 5%. They never met their promise, so we should not be rewarding their price.

The Vice-Chair (Ms. Libby Davies): I'm sorry to cut you off, Mr. McBane, but thank you very much. We've now concluded our time to hear from the witnesses and members of the committee.

Thank you all very much for coming. It was a very good discussion, and it will help us in our study. I'm sorry to the other members of the committee who were waiting to ask their questions. Maybe another time.

Welcome, Mr. Toone, to the committee.

Thank you very much for coming. We'll suspend now for a minute, and then we'll come back in camera.

[*Proceedings continue in camera*]

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