HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 064 • 1st SESSION • 41st PARLIAMENT

EVIDENCE

Tuesday, November 20, 2012

Chair

Mrs. Joy Smith

Standing Committee on Health

Tuesday, November 20, 2012

● (1105)

[*English*]

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

I want to extend a special welcome to the Minister of Health. We are very pleased that you could join the committee. It is a real treat to have you here.

Pursuant to Standing Order 81(5), we are examining supplementary estimates (B) for 2012-13. We are going to be studying the particular supplementary estimates referred to us.

We're going to begin with the minister, and following that, we will have questions and answers. Minister.

Hon. Leona Aglukkaq (Minister of Health and Minister of the Canadian Northern Economic Development Agency): Good morning, and thank you for the invitation to speak to you regarding supplementary estimates (B) for Health.

I would like to start by congratulating Mr. Lobb on his appointment to the committee.

I will introduce the officials who are with me this morning: Deputy Minister Glenda Yeates; Jamie Tibbetts, chief financial officer for Health Canada; Greg Taylor, deputy chief public health officer; Krista Outhwaite, who is here with me for the Public Health Agency of Canada; James Libbey, senior financial officer for PHAC; and James Roberge, chief financial officer for CIHR.

Madam Chair, I want to begin by talking about the 2012 economic action plan. As you know, all federal departments and agencies were asked to review their operating and program spending. The health portfolio's efforts to reduce a deficit will modernize and strengthen the way our government operates. We will also achieve our core functions effectively while delivering the results Canadians expect.

Our review focused on finding the vast majority of savings through increased internal efficiencies. Every effort was made to protect the core front line services delivered by Health Canada and the Public Health Agency of Canada, as well as the Canadian Institutes of Health Research.

In total, we are going to save Canadian taxpayers $307 million. The measures taken are fair, balanced, and moderate.

Health Canada is a leader in health policy, is a service provider for first nations and Inuit, and remains focused on delivery of our core mandate as a regulator.

One of these core services involves providing direct health care and certain non-insured health benefits for first nations and Inuit people. The importance of this work is reflected in the new funding for the non-insured health benefits program that is presented in the supplementary estimates.

The Public Health Agency of Canada will continue to provide core emergency preparedness and response functions, as well as a national leadership role in health promotion, disease prevention, and public health capacity.

CIHR's grants and contributions envelope was minimally impacted; in fact, new funding was allocated for the strategy on patient-oriented research. Our support for basic research, student scholarships, and industry-related research continues.

This information is clearly reflected in the information provided recently to the Parliamentary Budget Officer.

The report shows that the majority of the savings are coming from administrative efficiencies in shared services, such as by merging such back office functions as human resources and information technology at Health Canada and at PHAC.

Other measures include re-focusing policy capacity at Health Canada, making business process improvements at the Public Health Agency of Canada, and making more efficient use of office and lab space.

All three organizations have been working very hard to minimize job losses for those wishing to stay in the public service. They have used attrition, retirement, and other management strategies where possible. In some cases, employees have decided to pursue a new career path and have volunteered to leave. There have also been examples of alternations, which allow people who wish to stay in the public service to trade places with those who wish to leave. Employees impacted by this process have been and will continue to be treated fairly.

Budget 2012 reconfirmed that health remains a key federal priority for our government. Federal actions and investments help strengthen Canada's health care system so that Canadians can stay healthy and be protected from harm as well as get the care they need when they need it.

Most notably, our government has significantly increased transfers to the provinces and the territories for health care and has put this funding on a long-term growth track that is sustainable and responsible. Unlike past governments, we will not balance our books on the backs of the provinces and the territories. Our government has been clear that we respect provincial and territorial jurisdictions when it comes to health care. We recognize that decisions on how to deliver health care services are best left to provincial, territorial, and local levels.

● (1110)

Record levels of funding will provide provinces and their territories with the certainty and flexibility they need to address health care needs of their population and to plan for the future. Federal action on health doesn't stop at annual transfers. The provinces and the territories have highlighted health care innovation as a key priority area and our government supports this approach through a range of initiatives.

We protect and promote the health of Canadians. We regulate drugs and medical devices so Canadians have access to safe and effective therapies. We invest in research so all Canadians can better understand whether health reforms are working for them and we work to improve the health of aboriginal people and northern Canadians.

We invest in a range of health programs, services, and benefits for first nations and Inuit to improve health outcomes for the population that faces the biggest health challenge in Canada. We are also investing in groundbreaking new research into aboriginal health, which I would be happy to speak about during the question and answer period.

It's not enough to invest lots of money. We need to make sure that it is used well. We are showing leadership in containing costs. The non-insured health benefit program expenditure growth is in general comparable or lower than similar provincial and territorial programs.

We are cracking down on fraudulent billings to the program. When there is evidence of fraud or wrongdoing, we take immediate action. I have raised this issue with my provincial and territorial counterparts and have encouraged them to look for similar types of practices in their jurisdictions.

As members of this committee know, there have been a lot of discussions recently about OxyContin and whether or not Health Canada should authorize generic versions of the drug. I want to reiterate what I have said all along on this issue, which is that it should not be up to politicians to determine which drug should be approved for medical use. Drugs will continue to be approved or restricted based on the scientific evidence. This means that Health Canada will continue its scientific review process of generic versions of OxyContin based on whether the drug is safe and effective when used as prescribed.

I believe we're leading by example at the federal level and have implemented rigorous controls in the first nations and Inuit non-insured health benefit program to address prescription drug abuse. I have offered Health Canada's officials to share the best practices of this program with the provinces and the territories to see if there are approaches that they can draw on from our own without having to reinvent the wheel. This is a challenge we can tackle together as federal, provincial, and territorial governments.

Under the non-insured health benefit program, changes made over the past few years have resulted in 50% reduction in the amount of long-acting oxycodone provided since 2010 without a significant shift to other long-acting opioids. These measures include a prescription monitoring program that addresses potential misuse and helps prevent double-doctoring, establishing maximum monthly and daily drug limits, changing the listing status of extended release oxycodone to exception status, and a real-time warning message to pharmacists at the point of sale. I encourage my counterparts to continue to build on any efforts they have taken to fight against those who would abuse the system.

As I have mentioned, we regulate drugs and medical devices. We also invest in the development and authorization of drugs for rare diseases. This will help improve access to new treatments that might have been harder to get or not available at all without these new rules.

Last month, we launched Orphanet-Canada, an online resource for people with rare diseases and the health professionals who care for them. This portal will give Canadians with rare diseases a new avenue for help. Federally we accelerate change through our support of pan-Canadian organizations, like the Canadian partnership against cancer, the Canadian agency for drugs and technologies in health, and Canada health infoway.

● (1115)

For example, Madam Chair, our government recently announced a significant investment in the Canadian Institute for Health Information. This funding will help build on CIHI's excellent work of providing reliable, nationally comparable data on more aspects of the health system and the health of Canadians. The information helps provincial and territorial governments measure performance of their systems. It also helps them apply innovative approaches that lead to improvements. It will also help Canadians track progress of their health care system.

This summer I was proud to welcome home double lung transplant recipient Hélène Campbell. To help more organ transplant recipients, our government committed $10 million to support a national transplant research program to increase organ donation and to help those who receive transplants.

Our government recognizes that health research is central to innovation and makes an important contribution to the quality and sustainability of health care at the provincial and territorial level. The federal government is the largest single investor in Canadian health innovation, primarily through grants and contributions by the Canadian Institutes of Health Research.

On any given day there are thousands of federally funded research projects involving more than 14,000 Canadian researchers. In particular, I wish to mention the Canadian Institutes of Health Research strategy for patient-oriented research. This strategy is about innovation and innovative practices, therapies, and policies from the research world to the decision-makers and health practitioners on the front line of health care. It is a new way of working with the provinces and the territories to leverage resources and to support research that will transform Canada's health care system. I'm confident this work will help the provinces and the territories meet the challenge of delivering high-quality, cost-effective health care.

The strategy for patient-oriented research's first focus will be on adolescent and youth mental health. The goal is to improve the care delivered to these young Canadians. Another initiative, called pathways to health equity for aboriginal peoples, will see researchers partner with aboriginal communities to carry out work linked to reducing suicide and a number of other key health priorities.

In addition to investments that help drive innovation in health care, we are also making investments to protect and to promote the health of Canadians, in other words to help keep them from getting sick and needing care. These family-friendly initiatives encourage Canadians to play a more active role in their own health. For example, we are investing $5 million in community-based activities that help Canadians make safe choices when they get involved in sports and recreation. I am pleased to note that the private sector organizations are joining the federal, provincial, and territorial health ministers in supporting the movement to healthier weights and more physical activity for children and all Canadians.

Our government is also using legislation to help protect the health and safety of Canadians. We recently fulfilled our promise to introduce tough new health warnings for cigarettes and little cigars. Members will also recall media reports last spring about a very serious and dangerous recreational drug known as “bath salts”. One of the key ingredients in bath salts is a substance known as MDPV. Our government acted quickly to make activities related to MDPV illegal in Canada. This means it will be harder for people to deal in or manufacture bath salts and easier for border officials and police officers to get these products off our streets. It was a move that received widespread public support from law enforcement officials, including the Canadian Association of Chiefs of Police.

With respect to mental health, I know this committee welcomed the release of Canada's first national mental health strategy from the Mental Health Commission of Canada, called “Changing Directions, Changing Lives”. The strategy was developed in consultation with health care professionals, patients, and their families. It contains recommendations that will help these groups make better decisions about mental health services and treatments in years to come. The strategy also reflects the first nations and Inuit priorities and actions outlined in the mental wellness strategic action plan.

● (1120)

Our government has also committed up to $10 million in matching funds to establish the Canada brain research fund in partnership with Brain Canada. This investment will help fund research to identify and treat brain disorders, including mental illness. Canada is recognized as a global leader in this area.

Our government plays an important role on the world stage when it comes to health and wellness. This summer we succeeded in bringing the issue of aboriginal AIDS to the forefront of the International AIDS Conference. This was the first time that the impact of HIV-AIDS on indigenous communities had been given such a high profile at an international conference.

At the World Health Assembly, I had the opportunity to discuss Canada's experience and support for universal health coverage and accountability. I also reinforced Canada's position on maternal and child health and encouraged countries to strengthen their systems in this area. I will continue to advocate for these issues at international forums.

I am proud of the vital role our government plays in health care in this country. Financial investments through the Canada health transfer are at an all-time high. Every day research and new discoveries are increasing our understanding of healthy living and our ability to treat and prevent diseases. However, there is much work to be done and many challenges ahead.

Healthy living and chronic disease prevention are complex issues that require sustained efforts from all levels of government, the private sector, NGOs, and all Canadians. Our government will continue to do its part. We will continue to invest in health care and research. We will continue to work with the provinces and territories as they try to improve Canadians' health, promote innovation, and ensure the long-term sustainability of the health care system.

Thank you, Madam Chair.

The Chair: Thank you very much, Minister, for that very insightful presentation.

We'll now go into our round of questions and answers. We'll begin with Ms. Davies, who is sharing her time with Monsieur Lapointe.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Chairperson.

Minister, thank you for attending today. It's very important that you are here. I regret that it's only one hour and I hope that we might encourage you to stay beyond that hour, because there will be very little time for questions.

You mentioned a number of things in your comments, but the issue that I'd like to focus on is drug safety. I'm sure you're aware that this is becoming a bigger and bigger issue in Canada. In fact, there were two major articles on this issue very recently, one in the *Toronto Star*, and one that came out yesterday in *Maclean's* magazine. Reading through that information as well as other information that we receive as MPs, it is clear that there is a lot of concern about the inadequacy of safety with the system in place.

I wonder if you could tell us how much money is spent on drug safety measures at Health Canada and why Health Canada is not investigating drug reaction reports and taking more concrete steps to prevent Canadians from getting sick or dying from adverse reactions.

These articles show that Canada is lagging far behind the United States, France, and other countries in the EU. For example, in the U. S. they've adopted plain language labeling, something which we've been talking about for a decade in Canada and still it hasn't happened. In other jurisdictions, clinical trial data enable people to see what information is being used to support a drug's approval. We're far behind in many of these aspects.

I think there's a great public concern about drug safety in this country. I wonder if you could tell us why Health Canada is not investigating drug reaction reports and taking concrete steps to prevent Canadians from getting sick or even dying from adverse reactions.

● (1125)

Hon. Leona Aglukkaq: Thank you for the question.

I can start off by saying that our government has taken action to deal with the issue of monitoring drugs that are on the market. In fact, our government established the Drug Safety and Effectiveness Network, which I announced, I believe it was back in 2008, to start the process. An investment of $32 million was made in that particular area to monitor adverse drug reactions and whatnot in Canada.

We've also been taking steps to report side effects. Those reports are investigated through Health Canada's health products and food branch. We've also been working with doctors to share more information on potential adverse reactions of any particular drug prescribed to patients. We have a number of initiatives on the issue of reporting side effects of drugs that have to do with all the regulatory processes and the scientific review required in the process. We are making significant progress in this area in Canada.

Ms. Libby Davies: I would like to ask a brief follow-up question, Madam Chair.

It is curious what you're saying, which is that basically, it's only after a drug has come onto the market that we're following up on concerns. I know that the article in *Maclean's* pointed out that close to 20% of these new active substances are now being identified as problematic. It seems that we are taking too long to identify what the problems are. It's when they're on the market that adverse reactions are taking place. Again, there is a concern, first, that the study isn't taking place early enough, and second, that when there are adverse reactions, they're not being followed up. Now we see these stories, some of which are horrific, of people who have become sick or have died from some of these medicines.

The Chair: You are well over five minutes, so your partner will have no time.

Minister, could you take a minute to reply, please,

Hon. Leona Aglukkaq: There are processes in place within Health Canada for a thorough review before a drug is approved for market. Pre-market surveillance is completed. At the same time, once that process is done and a drug is approved, we have a system in place, which we introduced, that addresses that through the Drug Safety and Effectiveness Network. Some of those adverse reactions can only be reported after the fact. There is a system in place to allow patients, as well as doctors, to provide that information to Health Canada so that we can follow up and investigate. There are two processes—

Mr. François Lapointe (Montmagny—L'Islet—Kamouraska—Rivière-du-Loup, NDP): Madam Chair, can I go for it?

The Chair: I will call you. I know that you are anxious to go. You may go now.

[*Translation*]

Mr. François Lapointe: On August 13, 2012, an oncologist submitted an application for a nonmarketed drug to treat the cancer of a patient named Ms. Lajoie, a Canadian citizen who lived in Saint-Pascal in my riding. The application was made under Health Canada's special access program. The treatments were supposed to start in September. With no reply received, Ms. Davies and I had to make a number of requests. It was not until November that the treatments were finally scheduled to start. All those requests went to you, Madam Minister.

If the process had taken two weeks instead of ten, it would have been possible to delay or prevent Ms. Lajoie's death. She died two weeks before the treatments could begin. Ms. Lajoie's family join all concerned Canadians in wanting to know what happened.

Madam Minister, do you acknowledge that the response time did not conform to the special access program timelines? In the wake of a failure of this kind, can you commit to establishing the position of Health Canada ombudsman as quickly as possible, so that someone can investigate it?

● (1130)

[*English*]

The Chair: Go ahead, Minister.

Hon. Leona Aglukkaq: As I stated in the House with regard to your response to your constituents, my condolences to the family of the individual who passed away. I stated in the House of Commons that the special access program provides emergency access to products that are not approved for sale in Canada—

Mr. François Lapointe: Ten weeks is not an emergency, Madam Minister.

The Chair: Excuse me. Let the minister finish, please.

Hon. Leona Aglukkaq: The applications must be made by the physician to Health Canada.

Mr. François Lapointe: It was done on August 13.

Hon. Leona Aglukkaq: We investigated the process, and I believe that a response was issued. I offered every member of the House of Commons a special access program briefing, and I was happy to organize—

Mr. François Lapointe: You did that on August 13, Madam Minister.

The Chair: Excuse me, I'll give you an extra minute if we let the minister finish, please.

Go ahead, Minister.

Hon. Leona Aglukkaq: Yes, thank you, Madam Chair,

I said before that we'd be happy to organize a briefing on how the special access program works when applications are made by physicians to Health Canada. As soon as those are received, the physician receives a call. On an annual basis, we receive about 25,000 applications, and most of those are processed within 24 hours as opposed to 18 months. We do our part to respond to that. I don't want to be speaking to the specific case the member is raising, but the process is in place.

The Chair: I'm sorry, Minister, we're way over on this question. Perhaps the member could meet with you on this after the committee.

We'll go to Dr. Carrie.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): I have a point of order.

Madam Chair, I must remind you that, on March 27, 2012, my colleague Mr. Lapointe did the same thing. Then Ms. Leitch questioned the president of Sandoz and interrupted the witness in order to get an answer to his question. On that occasion, you said:

[*English*]

"Excuse me. At the committee, sir, you were asked a question. I will ask you to answer it specifically."

[*Translation*]

Mr. Lapointe has been trying to get an answer to his question for some time now. If you want to be consistent, you must allow him to do so.

[*English*]

The Chair: Dr. Morin, I've given a whole lot of extra time for this question to try to get everything in. I need to be mindful of the time of all the committee. As much as the member thinks his question is the most important, I've given it extra time. It is very important, but we need to allow the rest of the committee members time to ask their questions as well.

[*Translation*]

Mr. François Lapointe: A point of order.

The question was very specific: can the minister commit to putting in place an ombudsman who could objectively investigate cases like Ms. Lajoie's? Nothing…

[*English*]

The Chair: It's not a point of order, I'm sorry.

We'll now go to Dr. Carrie.

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

Actually, I think Mr. Strahl would like to start.

The Chair: Okay, do you want to share your time?

Mr. Colin Carrie: Yes, thank you. We're going to split it.

The Chair: Okay.

Mr. Strahl, go ahead.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you, Madam Minister, for coming.

I'll do my best to ask questions and allow you to answer.

You held a press conference yesterday regarding OxyContin. You mentioned it in your remarks. I have some questions for you regarding that. First of all, could you give us a brief summary of what was announced yesterday?

Hon. Leona Aglukkaq: Thank you for that question.

This is a very complex issue that requires us to balance access to drugs for therapeutic purposes while protecting the individuals and the communities against the harm caused by prescription drug diversions or abuse. Addressing the area of prescription drug abuse involves many stakeholders in the health care systems, from the federal, provincial, territorial governments, to physicians, to prescription drug manufacturers and distributors, and health care providers as well as law enforcement officials.

With respect to the generic OxyContin, under the Food and Drugs Act, there is no basis for the health minister to withhold approval of a drug where the drug is otherwise considered safe and effective for its recommended use. The law does not permit approval to be withheld on the basis of potential misuse or abuse. Our government is doing everything in its jurisdiction to address the issue, so Health Canada will now impose tougher new conditions on the licences of dealers who manufacture and distribute products that contain the controlled release formulation of oxycodone.

Part of the reason for the abuse of OxyContin is that it was sometimes prescribed for conditions it was never intended to deal with. There's overprescribing and giving it out in amounts far greater than what was needed.

Yesterday, and in my letter to my provincial and territorial counterparts, which I mentioned in my comments, I called upon the provincial and territorial governments and medical practitioners to look at what they can do within their areas of jurisdiction to tackle the serious problem of prescription drug abuse. I am open to considering a greater federal role, as I stated yesterday, in overseeing the use of potentially addictive drugs, including restrictions on prescribing or dispensing practices.

There is a high risk that creating more bureaucratic hoops for physicians and pharmacists to jump through will have a negative impact on patient care. My strong preference is that we work together to address this issue within the existing laws and authorities. I want to remind all of us that the most important factor in every decision is the patient.

● (1135)

Mr. Mark Strahl: Thank you, Madam Minister.

I did meet with a constituent, James O'Reilly, recently who lost his son after a long battle with drug addiction that started with OxyContin, so I think these measures and working with the provinces and territories will certainly help address the problems with addiction to that.

I want to share some time with Dr. Carrie. I know he has some important questions to ask as well.

Mr. Colin Carrie: Thank you very much, Minister, and thank you, Mr. Strahl.

Minister, you know I've been very involved with the natural health product community. First of all, I want to congratulate you and officials at Health Canada for consulting and working with the industry in a way that has been very much welcome, with improvements in cutting red tape and things like that. I was wondering if you could give the committee an update on what has been the result of these consultations you've had with the natural health product community.

Hon. Leona Aglukkaq: Thank you for that question. We've come a long way since we started this review. Our government's aim is to protect the health and safety of Canadians while respecting that there is consumer choice. We have heard many stories from stakeholders, consumers, and parliamentarians that there is a need for increased access to products while maintaining consumer safety. They also want to reduce unnecessary administrative burdens for companies trying to bring safe products to the market.

As a result, we have introduced a new way of regulating natural health products that focuses on reducing, as you mentioned, red tape and increasing consumer access to safe and effective products. In fact, the officials who were doing the consultations and round tables in British Columbia yesterday received a standing ovation from stakeholders, so I think that is a testament to the great work being done.

The approaches that we are taking include a new product review system, where systems will review in as short as 10 days products that are at lower risk. It used to take up to 180 days to review most products, but now only 1% to 3% will require this amount of review time. We've also introduced new tools for bringing products to market. These changes will provide a stable, predictable, regulatory environment for the efficient processing of applications. I think there has been great progress since we started dealing with this issue.

Mr. Colin Carrie: Thank you very much.

The Chair: You have just under a minute.

● (1140)

Mr. Colin Carrie: The minister mentioned something in her speech and I wanted to ask her a follow-up on that.

You mentioned actions taken by the government to restrain cost and address fraud in NIHB. This is a very important issue. Could you expand on the measures you've taken in that regard?

Hon. Leona Aglukkaq: Yes, thank you for that question. As I stated in my opening remarks, under the federal program that we're responsible for, the non-insured health benefit program, we've put in a number of measures that have produced great work and results. In fact, the Auditor General commented that this is a model of putting in systems with checks and balances and commended Health Canada for its efforts in monitoring this particular program.

Through the work that we have introduced through the non-insured health benefit program, as I stated, we're able to track spikes in prescriptions, such as OxyContin, across the country. We're able to investigate which physicians are actually prescribing. We have also been able to detect fraud in the program and those particular incidents have resulted in RCMP involvement and charges being laid and going through the court systems.

We take that matter very seriously. This program was designed to provide services to the most vulnerable in this program. It concerns me that there is abuse in the system, and we will take corrective actions.

In Nova Scotia a pharmacist has now been incarcerated for the fraud that was committed. In Ontario we continue to investigate, and in Manitoba as well as Saskatchewan. We are doing our part to monitor this program very closely.

The Chair: Thank you very much, Minister.

We'll now go to Dr. Fry.

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

I want to thank the minister for coming. I would like to echo Ms. Davies' concern that we only have her for an hour.

However, I'd like to ask a couple of very specific questions with regard to spending itself. There are specific programs that are no longer funded and organizations that are no longer funded under the budget cuts. Can you tell me exactly what is not being funded any more? What programs are not being funded?

Hon. Leona Aglukkaq: I will ask the deputy to go through the details, line by line.

Ms. Glenda Yeates (Deputy Minister, Department of Health): Madam Chair, the minister mentioned in her opening comments that the entire portfolio, all of the operations of the portfolio in all the areas we've funded, was looked at.

I can break down the reductions that are outlined in four categories. The first, I would say, is administrative efficiencies and rationalizations of structures. We very much looked internally at how we do business, looked at Gs and Cs, the very process of government which over time builds up. We found a good proportion of our savings there. We looked at how we might share things with our portfolio partner, the Public Health Agency. Again, there was another internal set of changes there.

We did look at grants and contributions. We reviewed those as well.

Hon. Hedy Fry: Specifically what I'd like to know—

Ms. Glenda Yeates: I would say by category, the first category is that we asked some of our partners, our pan-Canadian organizations, to take some administrative reductions. For example, very good work is done by CIHI, by the Canadian Partnership Against Cancer, by the Mental Health Commission. We asked them to take a reduction of 5% over the course of three years. They are working very hard to do that.

We looked at the first nations and Inuit health branch. As the minister said, we wanted very much to protect front line delivery, so we looked at non-service delivery areas. Both regionally and nationally, we had grants for areas such as research or building capacity. The minister has mentioned in the past the National Aboriginal Health Organization. Those were some of the organizations where we reduced funding.

Hon. Hedy Fry: I could use up all my time on these answers, so I'd like to clarify specifically.

The Chair: I think she has another question, Ms. Yeates.

Hon. Hedy Fry: Are the maternal and child health programs within the Inuit health care budget being cut?

Ms. Glenda Yeates: No, all of the front line delivery services are being protected, so no community services for maternal and child health are being reduced.

● (1145)

Hon. Hedy Fry: Thank you.

Are there any suicide prevention programs being cut?

Ms. Glenda Yeates: Again, all the community-level programs for suicide are retained.

Hon. Hedy Fry: Are these direct delivery programs?

Ms. Glenda Yeates: Yes, so—

Hon. Hedy Fry: The direct delivery programs remain.

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

Hon. Hedy Fry: Thank you.

There is one question I'd like to ask, which is about staff layoffs. I think you said you have laid off a fair number of staff. I'd like to know, what are the layoffs in research and in scientific evidence-based work at the policy-making level? Have any staff been laid off there?

Ms. Glenda Yeates: Again, I think this is obviously an extension of the supplementary estimates that we're speaking about that talk about the impacts on staff.

There were about 200 vacant positions that we had been, in a sense, not staffing for some time, so we offered up those. In addition, we estimated there were about 840 additional positions under the economic action plan. The vast majority of those are in the administrative services area. We estimate that about 70% of those numbers are in areas of administrative services. They do include some of the policy capacity, for example.

Hon. Hedy Fry: Are the evidence-based research scientists being cut?

Ms. Glenda Yeates: Our reduction in science was very limited. We wanted to make sure that we retained—

Hon. Hedy Fry: What would be the reduction?

Ms. Glenda Yeates: There are some reductions. There may be about 3% reduction, is the number that comes to mind, in areas that were of lower priority research, but all of the research areas, the scientific areas involved in compliance and enforcement, all of the drug reviews the minister spoke of, the pre-market and post-market, all of those areas have been retained or strengthened.

Hon. Hedy Fry: Madam Chair, knowing I only have seven minutes, I do have another question I would like to get in.

The minister suggested that the government has significantly increased transfers to the provinces and territories. I would like to know if there have therefore been any increases above and beyond the already agreed on and signed 6% increase through the 2004 accord. Is there any new increase in transfers beyond that, which is all completely signed and agreed to for 10 years anyway and will not sunset until 2014? Is there more money other than that in transfers?

Hon. Leona Aglukkaq: Many of the programs through Health Canada and Public Health Agency are available for provincial and territorial governments to access.

Hon. Hedy Fry: You noted specifically on page 5 that you have significantly increased transfers. That's the terminology that was used. I wonder if you could tell me if there are specifically any more transfers than the 6% that was already agreed on in 2004 and will sunset in 2014.

Is there any new money there? A simple yes or no would be fine, Ms. Yeates.

Ms. Glenda Yeates: The major transfer is the CHT. We have a number of small partnership arrangements with provinces and territories. One example is the Quitline. There is a phone number and web link on every cigarette package. We have a number of agreements, contribution agreements, partnership arrangements, with the provinces and territories.

The significant transfer is obviously the Canada health transfer.

Hon. Hedy Fry: I have another question.

The minister talked about health care innovation being a priority area. I wonder if pharmacare is seen as an innovation. A national pharmacare strategy was seen as an innovation in the 2004 accord. Nothing has transpired in that national pharmacare strategy. We now find that many patients don't have any access because of cost. They cannot afford to pay for their drugs for chronic or terminal diseases in the home or in the community.

Why has nothing been done about setting that kind of pharmacare strategy, specifically looking at decreasing the cost to patients?

The Chair: Dr. Fry, you're over time, but, Minister, could you respond, please.

Hon. Leona Aglukkaq: As I stated in my comments earlier, the transfers to the provinces and the territories have increased, and each province and territory will allocate those resources in areas of their particular priorities.

On the issue related to pharmacare and prescription drugs or bulk purchasing, the provinces and the territories continue to work together to try and tackle some of those challenges. Back when this item was discussed, there was never consensus at a national level on how we would go forward on that. I was there as the territorial health minister at the time and there was no consensus.

Some of the things we're doing to tackle the issue of increased prescription costs is to tackle fraud, to have a better coordinated approach to drug shortages, and to deal with over-prescribing. A number of efforts we're doing, including bulk purchasing by jurisdictions, we will continue to do in partnership with the provincial and territorial health ministers. There has been great progress on that.

● (1150)

The Chair: Thank you, Minister.

We'll now go to Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): Thank you to our Minister of Health for coming back to the health committee to answer these questions.

I will be sharing my time with Wladyslaw Lizon, so I'll try to get two questions in as quickly as I can. There are two important matters I want to raise.

One is the issue of priority access for vaccines. We held a health committee meeting a few months ago, and there were firefighters who mentioned that they were listed in the secondary list and were not able, in many cases, to get first access despite working as a first responder, side by side with paramedics and other EMS officials.

Does the Government of Canada have any plans to work with the provinces and territories to rectify the concern raised to us by firefighters?

Hon. Leona Aglukkaq: Indeed, the firefighters community does a lot of great work in many of our communities. To provide you with an update, first I will state that we do not want to have a Canadian pandemic influenza plan be a barrier for provinces and territories in responding to a pandemic, including the area of vaccine rollout.

Having said that, the unique characteristics of each pandemic must be considered when determining health risks for Canadians, which then informs decisions on priority access.

The revised Canadian pandemic influenza plan will outline a risk-based approach to decisions on priority access and will include consideration of the first responders to other individuals such as the elderly or pregnant women, which they may face. The first responders would include the firefighters in jurisdictions where they exercise that role. The consultation process for the Canadian pandemic influenza plan will be occurring over the next year, and key stakeholders, including the firefighters, will have an opportunity to provide their views on that process. I would encourage you to notify the firefighters in your regions to participate in that process.

We are always looking at ways to improve the pandemic plan for Canada, and we are evaluating that plan again. I encourage you to convey that to the firefighters, to participate in that process and put their views forward.

Mr. Patrick Brown: That's fantastic. I know they'll be very encouraged to hear that this is being looked at.

I have one quick question before we switch over to Wladyslaw, and it's on rare diseases. I met with Kirsten Harkins, a constituent of Andrew Saxton's. She's passionately involved in the cause of rare disorders and rare diseases. I know you've taken on some important initiatives that you might highlight to the committee as well.

Hon. Leona Aglukkaq: Yes. We are taking steps to help Canadians with rare diseases, as well as to support their physicians. It is an area that affects a small number of people when compared with the general population. Some of these diseases affect only a few Canadians, but all together, thousands are suffering with a disease and need effective treatments.

We recognize there is a unique circumstance of rare disease that requires a new framework for the authorization of treatment that makes the most of informed scientific judgment and enhanced international collaboration. The new framework we've announced will provide greater predictability for drug companies to develop and market orphan drugs in Canada and will also help patients with rare diseases to participate in their own health care and gain access to needed treatments.

A key focus of this new approach will be on sharing information internationally when developing and regulating particular drugs. This will also help pool the scarce resources for maximum benefit. Once authorized, the drugs will continue to be closely monitored for effectiveness and safety while in use.

The proposed framework is in its final design stage and will go through public consultation. Comments and feedback are being gathered during the consultation and will be incorporated into the overall version of the proposal.

● (1155)

The Chair: Thank you.

Mr. Lizon, you have a minute and a half.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): I'll try to be as brief as possible.

Thank you, Minister, and everybody else for coming to the committee this morning.

The question I have is also on a disease or disorder, autism. As we all know, unfortunately it affects many Canadian families. Recently, and I suppose it was earlier this month, a new research chair was announced that would aim to improve the treatment and care of Canadians living with autism spectrum disorders.

Minister, could you elaborate on how the funds were leveraged and how the new chair award will benefit Canadians living with autism spectrum disorders?

Hon. Leona Aglukkaq: On November 5, my colleagues, Colin Carrie and the honourable Mike Lake, announced that Dr. Weiss of York University accepted the position of chair in autism spectrum disorder treatments and care research. This followed a rigorous selection process through the Canadian Institutes of Health Research.

Dr. Weiss is a clinical psychologist at York University who works with children, adolescents, and adults. His research focuses on the prevention and treatment of mental health problems in people with autism spectrum disorder.

As the new chair, he will work to improve the lives of Canadian children and adults with autism and of their families. He and his team will study innovative approaches to expand treatment and care research to address mental health problems in Canadians with autism across their lifespan. They will also examine why people with autism are prone to develop mental health problems. They will also evaluate novel treatment strategies to help youth and young adults with autism deal with these issues as well as with other stressful events, such as bullying, and find ways to improve access to care for these individuals.

To achieve their goals, they will also work with people with autism and with their families, service providers, governments, and agencies to share cutting-edge research that informs mental health care policy and practice across the country. This research will also have a lasting impact on families that are dealing with this situation and on generations to come in Canada.

The Chair: Thank you, Minister. Our time is up.

Dr. Sellah, we're going into five-minute rounds now, and it's 12 o'clock. I'm sorry, but we'll have to—

Ms. Libby Davies: Madam Chair, given that the minister didn't show up until about seven after, maybe we've got another—

The Chair: Excuse me, Ms. Davies, let me finish, please.

I've just been informed that the minister is able to stay for 10 more minutes. Thank you.

Dr. Sellah, I'm glad you will get your chance.

[*Translation*]

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

Madam Minister, thank you for coming before the committee. With all due respect, I would ask you to give us clear, succinct and specific answers.

I would like to go back the matter of the Health Canada ombudsman. Are you going to establish the position, yes or no? That is my first question.

This is my second. The matter of transfers to the provinces is not going to go away; it is always going to be with us. Imposing the new funding formula unilaterally on provincial and territorial governments is going to deprive them of $36 billion. But the Prime Minister promised that there would be a 6% increase. In his Fiscal Sustainability Report 2012, the Parliamentary Budget Officer confirmed that this funding formula would hurt the provinces and territories and would increase the pressure they are under. This would put our public, universal health care system at risk.

Why impose that funding formula despite the promise your party made to Canadians? Why conduct the war on the deficit on the backs of the provinces, as the Liberals did previously?

Your government also decided to make major cuts to the public service and your department was not immune. It is the fourth to have been affected. According to Treasury Board figures, we are talking about 1,416 jobs lost and annual cuts of over $300 million by 2014-2015. Not only did you refuse to provide the details to the Parliamentary Budget Officer, you have also refused to answer questions clearly.

We know that the First Nations and Inuit Health Branch has been severely affected. Your deputy minister has just said that organizations like the Assembly of First Nations, Pauktuutit, an Inuit women's organization in Canada, or other programs in research, education, nutrition and policy development would also be affected. I know that is not front-line care, but do you not think that all those cuts will have an impact on the promotion of Aboriginal health and, eventually, on their health itself?

Could you tell me, in whatever way you want to handle the question, what is going to prevent disease and save money in the health care system?

Thank you.

● (1200)

[*English*]

Hon. Leona Aglukkaq: I'll try to be very precise in answering the many questions that the member raised. With respect to the issue of an ombudsman, we have no plans to establish that position.

The increase in transfers to the provinces and territories, at $40 billion, is not a decrease. There are no cuts to health transfers to the provinces and territories. I was in the health care system, as finance minister for Nunavut, when the Liberals cut transfers. The $40-billion increase is not a decrease.

In regard to the areas of front line and whatnot, every effort that we took in Health Canada was to not cut front line health care services. On the reductions in programs with organizations, those organizations do not deliver front line health care services.

In terms of the areas of prevention, we're doing a lot of great things through the Public Health Agency of Canada. At the federal, provincial and territorial health ministers meetings in Newfoundland two years ago, the first declaration was signed in this country that starts to concentrate its targets and efforts in relation to chronic disease prevention.

As well, in the next year we'll be reporting on those through a conference in Ottawa. We'll be bringing in not only governments but the private sector, in their efforts to reduce chronic disease in Canada. This is the first of its kind in Canada, and it was our government's efforts to mitigate some of the preventable illnesses we're seeing in our hospitals.

Equally important is to keep people from getting ill in the first place. Much of the work we're doing is to tackle areas where we're trying to prevent illness, for example, tobacco use, obesity prevention, injury prevention in a number of physical activities, and to stress the importance of that in our health care system. Many of the investments we're making are targeting that, and at the same time we're protecting the transfers to the provinces and the territories.

The Chair: Thank you.

Mr. Lobb, go ahead.

Mr. Ben Lobb (Huron—Bruce, CPC): Minister, thanks for coming here.

Obviously, when it comes to first nations, Inuit, and Métis communities in Canada, there's huge potential not only with what they can share with us, but the contributions they can make to our economy and the betterment of Canada.

You've made some announcements in terms of investments to better the health and the research of those communities, to give them a better chance. I wonder if you could elaborate on that aspect.

I will be sharing my time with Ms. Block.

● (1205)

Hon. Leona Aglukkaq: Again, congratulations on your appointment to the committee.

Overall, our government has invested over $30 million a year in aboriginal health research and more than $2.2 billion in first nations and Inuit health programs.

In June I made an announcement with my colleague, Minister Duncan, involving a federal investment of $25 million over two years. This will be used to conduct innovative health research that responds to pressing needs identified by first nations, Inuit, and Métis people across Canada. The long-term plan will focus on four areas: suicide, obesity, tuberculosis, and oral health.

The health researchers will only be able to access that funding if they work with leadership in aboriginal communities. This aims to find meaningful health solutions that will lead to healthier communities. Basically, in a nutshell, all the investments in research that we are making must involve partnerships with aboriginal communities at the community level.

The Canadian Institutes of Health Research recently hosted a partners forum in this initiative. The forum brought together national first nations, Inuit, and Métis organizations along with government representatives and researchers from the private sector. The efforts show that CIHR and our government are committed to a new and better way of working with first nations, Inuit, and Métis people in looking at research for better health outcomes of the most vulnerable population.

In the coming months I look forward to reporting on the progress of this investment. We will continue to work hard with aboriginal communities to improve the health outcomes over the long term.

The Chair: Mr. Kellway, you have time for one question, if you could get it in.

Mr. Matthew Kellway (Beaches—East York, NDP): I'll try to be quick.

Minister, thank you for being here today.

This has to do with access to medications and the speculation that, in the current negotiations over the comprehensive economic trade agreement with the European Union, there will be provisions to extend patent protection, which is going to cost our health care system up to $2 billion, but the speculation seems to be around $1 billion.

I am wondering how, when there are such great challenges to access to pharmaceuticals already within our health care system, we can justify adding those kinds of costs to our health care system and those barriers to Canadian citizens in their efforts to access health care.

Hon. Leona Aglukkaq: The Minister of International Trade is the lead on that file. The CETA negotiations also involve consulting with my departments on other related issues, but the provinces as well as territorial governments and stakeholders are part of this forum. What I can say is that the negotiations are continuing, and negotiation teams are engaged in focusing discussions on a wide range of remaining issues.

I don't want to speculate on the outcome of those negotiations and the final outcomes as the negotiations continue.

Mr. Matthew Kellway: I would just like your perspective on this issue, as the Minister of Health, of increasing barriers to health care for Canadians through increases to the cost of pharmaceuticals.

● (1210)

Hon. Leona Aglukkaq: Again, those negotiations continue. I won't speculate what the outcome will be.

With regard to the increased cost of pharmaceuticals, we have to do our part within what we're dealing with today. I made it very clear in my opening remarks that currently within our own health care system we have to look at why, for example, we are seeing increases in prescription drug abuse. We need to do our part with the current systems we have in place to mitigate what is happening across the country.

Under the non-insured health benefits program, we have been able to detect fraud and we are now recovering up to millions of dollars. This fraud is costing our health care system. We need to continue to look at some of those challenges that we are facing today. I encourage my provincial and territorial counterparts to work with us to address some of those challenges.

The Chair: Our time is up. I apologize to you.

I am going to suspend for three minutes to give the minister a chance to leave. Thank you very much, Minister, for coming today and giving us your insightful presentation. Thank you to the committee for all their questions.

We will suspend for three minutes and resume at 12:15.

● (1210)

(Pause)

● (1215)

The Chair: I very much welcome the department, the Public Health Agency of Canada. I am so pleased. We really appreciate all that you do. You've been here for a couple of hours and .

We're going to begin at the top of the chart. We're going to begin with Mr. Kellway, who has four minutes, and Ms. Davies is going to take three.

Mr. Kellway.

Mr. Matthew Kellway: Thank you, Madam Chair.

Thank you to all of you for being here today. I had my questions framed for the minister so I'll try to reframe them appropriately for you, given your roles in all of this.

I had asked about CETA and the potential for adding about $1 billion to the cost of pharmaceuticals and the challenges that creates for Canadian citizens accessing health care in this country.

We've heard testimony at this committee about the cost of pharmaceuticals in Canada. They are about 30% above the average cost in industrialized countries, and they're even higher in Quebec, about 40% higher. We've also heard testimony about the potential cost savings of having a national pharmaceutical strategy in the order of $10 billion a year. We've heard as well about best practices around the world. New Zealand is getting 50% in savings in the cost of their pharmaceuticals through plain and simple negotiations with pharmaceutical companies.

I heard the minister say on the issue of the cost of pharmaceuticals and that detecting fraud is reaping potentially millions of dollars in savings. The order of magnitude that we really need to consider in this country at this point in time is in the billions. I'm wondering if there is a policy justification for not taking major steps to reduce the cost of pharmaceuticals in this country, by setting aside, for the moment, the CETA issue and the potential impact there.

Ms. Glenda Yeates: Madam Chair, I think this is a very important question and I'm very pleased to address it with the committee.

The cost of pharmaceuticals is an issue worldwide. It is an issue for health systems generally and there are many facets to it. The minister referenced the appropriate use of pharmaceuticals. That's an area where we see variation internationally in terms of the use of pharmaceuticals. We see that variation within the country. There are a number of agencies, including the Canadian Agency for Drugs and Technology in Health that try to support provinces, the colleges of physicians and others to try to give people the tools to use best practices in terms of appropriate prescribing.

We also have a number of factors like the common drug review. Again, Canada has moved to a one common drug review. Provinces and territories are able to take up those recommendations or not, but we do the kind of evaluation of the cost benefit of the appropriateness of the drugs once in the country and give that as a tool. That's a considerable commonality in drug programs that wasn't there before.

● (1220)

Mr. Matthew Kellway: If you forgive me, Ms. Yeates, it seems that we're playing around the edges of the main issue here when we are talking about billions of dollars of potential savings and that we know how to get those savings, it would seem. Why do we continue to retain a barrier for Canadian citizens to get access to health care by retaining average pharmaceutical costs at 30% above industrial averages? All these programs I understand, but it's nibbling around the edges of a very large problem in access to health care for Canadians. Why don't we tackle the problem directly?

Ms. Glenda Yeates: I'm not aware of the precise study that's been cited, Madam Chair, but I think there are a number of aspects that countries tackle to try to get their drug prices down. Some of it is in things like price control. Canada has the Patented Medicine Prices Review Board, for example, to try to deal with the prices of patented drugs. Again, you see various reports on how our drug prices compare there.

One of the ways that I think we get costs down is through bulk purchasing, and the minister spoke of that as well. One of the ways is through, again, common listing, having formularies that list drugs that have a common basis. There are a number of factors, but I think the policy world would say these are the things that help bring drug prices down. It's typically not one specific angle—

The Chair: Ms. Yeates, I have to tell you that Mr. Kellway went overtime, so Ms. Davies has only two minutes. Maybe we should give her a chance to ask a question.

Ms. Libby Davies: Thanks very much. I'll try to be brief.

I also wanted to follow up on another aspect of the whole drug question in Canada. I'm sure you're aware that in March the House unanimously passed a motion concerning drug shortages. The key words in that motion were a call for a national strategy “to anticipate, identify, and manage shortages of essential medications”.

I don't see any funds in the estimates pertaining to the prevention and management of drug shortages. What has the department done since that motion was passed to anticipate, identify, and manage shortages of essential medications?

Ms. Glenda Yeates: Thank you very much, and I will try to be brief in my answer, too.

We have been working extensively with a number of partners. I think we've all understood from the situation that it is no one area of government or one sector that can handle all of this. We worked with industry to make sure that we get the best notification we can in terms of where they see potential drug shortages or where they see potential disruptions in supply.

We worked with the provinces and territories very specifically to deal with some of the areas that were raised in the motion and in the recommendations from this committee in terms of looking for how we work together and how we get the best clinical information on the use of therapeutic alternatives.

We worked very much with the provinces and territories to try to provide some of those alternatives, for example.

Ms. Libby Davies: Do you feel assured that we won't be facing shortages? For example, I know that Zarontin, which is an epilepsy drug, is no longer accessible, so there still are issues with certain drugs. Are you satisfied with the progress that is being made? It sounds like we've still got a big problem out there.

Ms. Glenda Yeates: Everyone in the field would acknowledge that this is going to be an ongoing issue that needs to be managed. That's why we need to bring the parties together.

We are satisfied that the parties are very much alerted to this. We are dealing with issues of sole sourcing. How do we ensure that we don't have—

The Chair: Thank you, Ms. Yeates. I'm sorry, but we're out of time.

Ms. Glenda Yeates: I think there will be ongoing challenges.

The Chair: Ms. Yeates, I'm sorry, I'm going to have to cut you off.

Ms. Block, you can continue along that vein if Ms. Yeates has something else she has to say, whatever you wish, but you're on now.

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): I'm going to carry on with some of my own questions, Madam Chair.

I did have a question for the minister, but I'm sure that you or any one of the other officials who are here today will be able to answer it as well.

First of all, I should say welcome. It's always good to see you, Ms. Yeates, and it's always good to have the minister here to speak to the estimates and other issues that are at the front of our minds as parliamentarians.

I did want to ask if you could comment on the supplementary estimates (B). One of the items is to maintain the provision of supplementary health benefits to eligible first nations and Inuit. Could you explain the background of the increase of $226.4 million and how this protects front line services?

● (1225)

Ms. Glenda Yeates: Yes, and thank you very much for this question on the supplementary estimates.

It is a significant sum. The background here is that this is a program for which we have a base budget that this committee would have seen in the main estimates, but in addition, we go through a process of determining the actual amount that it will take for the program. There are no changes in benefit levels, but we determine as we work through our estimations of, again, what new drugs have come on, and what new mechanisms have been put in place to control costs, as the minister mentioned, we refine the estimates.

In this year, for example, we have new clients who are covered with the implementation of the McIvor decision and the new Qalipu recipients, so we have new individuals who are coming on who are eligible for these benefits. As we refine those estimates, we then come back to Parliament as part of supplementary estimates (B) for the additional funds. That's what the $226 million that you see in the supplementary estimates relates to, which is for the main programs. Our biggest components here would be prescription drugs, medical transportation, dental benefits for eligible clients, as well as vision care, and some other smaller portions. This is for clients who are on and off reserve, first nations and Inuit clients.

That's the reason for the supplementary estimates. It's a continuation of the program. All told, when you combine it with the main estimates, it's a program where we would estimate expenditures to be in the $1.1 billion range this year.

Mrs. Kelly Block: Thank you. I'd like to ask another question in regard to the supplementary estimates.

I notice that under the Canadian Institutes of Health Research there is an item with respect to funding for patient-oriented research to improve health outcomes through evidence-informed care. I'm very interested in the strategic patient-oriented research initiative that the minister announced in 2011. I'm wondering if you could give us an update on that initiative and how it will have an impact on health care and on health outcomes in Canada.

Ms. Glenda Yeates: Madam Chair, I think I'll ask my colleague from the Canadian Institutes of Health Research, Mr. James Roberge, to answer the question.

Mr. James Roberge (Chief Financial Officer and Executive Vice-President, Resource Planning and Management Portfolio, Canadian Institutes of Health Research): Thank you. Dr. Beaudet sends his regrets.

The momentum around SPOR is really building. We are in negotiations with the provinces with regard to the first rollout of what are called support units. These are regional centres that will be established across the country, centres of excellence to find creative ways of integrating health research findings into the health care system for the benefit of Canadians.

We're also in discussions with various partners around the launch of research networks. These are national networks that are thematically based. The first one was with respect to mental health and was announced with the Graham Boeckh Foundation, a $25-million jointly funded research network. We've also launched the network on primary health care and we are in discussions with other partners, as I mentioned.

We're expecting over time to have six to eight of these networks with respect to SPOR.

Mrs. Kelly Block: As I have some time left, I'm going to pass on some of my time to my colleague, Mr. Lobb.

Mr. Ben Lobb: Thank you, Ms. Block.

There's a line item regarding Indian residential school settlements, and it's for $55.9 million. Could you tell the committee about that? Is that just in the supplementary estimates? Is it in the main estimates and the supplementary estimates? What exactly are those dollars for?

Ms. Glenda Yeates: Again, Madam Chair, I think this is an important and substantial part of Health Canada's supplementary estimates. As was noted, it's $56 million to continue the resolution health support program under the Indian Residential Schools Settlement Agreement.

Under that agreement, as individuals come forward through the process to identify themselves and to go through the support program, we very much understand that individuals and their families, through that process as these meetings are held across the country, need to have the kinds of mental health supports, whether they be access to mental health practitioners or access to elders and cultural supports. Those are very critical because these are very heartfelt and sometimes very challenging times for families, obviously.

● (1230)

Mr. Ben Lobb: What would the total expenditure be on the 2012-13 budget year?

Ms. Glenda Yeates: This was in the supplementary estimates. Again, this is one of the estimation challenges. We didn't initially know how many people would come forward or in what year they would come forward, so we didn't have a main estimates ongoing budget base for this. Now, there may have been some small amount in the base, and I'd have to check that for the member, but in general, as we understood the demand for the program and the need for our services, that's when we came forward and sought the supplementary estimates here.

Mr. Ben Lobb: That's fair enough.

You touched on mental health as one of the line items. Can you list some of the other line items that would go towards that nearly $60 million?

Ms. Glenda Yeates: Yes, and there was about $8.8 million remaining in our base budget, to which this $56.7 million is added. That's a total of $65.6 million for the IRS resolution health support programs in 2012-13.

Again, we have people who attend at the sessions and provide support to people. Individuals choose different kinds of supports, depending on what they or their families might need.

The Chair: Thank you, Ms. Yeates. I'm sorry, we're way over time.

When you're answering questions could you please try to keep your eye on the Chair, because I try not to go over too far. Thank you.

Dr. Fry.

Hon. Hedy Fry: There are a couple of things I want to have clarified.

On the whole idea of public health, the minister said that the role of the Public Health Agency was to protect Canadians. Can you tell me, therefore, what is happening with regard to trans fats and salt content in food, which we know adversely affect the health of Canadians?

The minister said this would be regulated by the industry, that it would be self-regulatory. She hasn't made any regulations of her own. Surely it is a job of the Public Health Agency of Canada to regulate these things when evidence shows very clearly that high levels of trans fats in foods and high levels of salt are contributing to the mortality of Canadians.

Ms. Glenda Yeates: Madam Chair, I'll try to keep my eyes on the right spot. I very much appreciate the question.

It is Health Canada's responsibility to regulate food. We have a substantial regulatory role there. Internationally, all countries are understanding and trying to find ways, as was mentioned by the honourable member, to reduce our intake of sodium and sugars and trans fats. We do this in a number of ways.

In some ways, it's partly the mechanism or the most effective way that is perhaps the source of some of the discussion. We provide consumer information. We've been working with some partners in the provinces and territories and with some of the industry partners to try to make sure that consumers have an awareness and can build an understanding of how to make healthy choices.

We also have seen—

Hon. Hedy Fry: Ms. Yeates, excuse me. I asked a specific question and I don't have a lot of time, so I'd like to get a specific answer. It was about actually regulating.

It was agreed in 2007 by the Minister of Health that there would be self-regulation and that it would be a trial process. It is my understanding that the Department of Health and the advisory committee on salt and trans fats has said it didn't work.

It's now five years later. The mandatory regulation must occur. I'm asking specifically about mandatory regulation, not about anything else, awareness, etc., but about mandatory regulation.

Ms. Glenda Yeates: I would say that governments have been very clear that a variety of voluntary approaches have been used, including guidance to industry setting benchmarks. We've released guidance benchmark levels. What we're seeing, for example, is that in a number of food categories, sodium levels are now down by about 10%. We are a third of the way to where we wanted to be by 2016.

The approach has always been to understand how and whether these mechanisms and tools we're using are working, and we have seen significant progress.

● (1235)

Hon. Hedy Fry: Thank you, Ms. Yeates.

I want to ask you one question, and it is specifically with regard to access to drugs. By access I mean the ability for Canadians, when they're chronically ill or terminally ill, to afford outside of a hospital setting the drugs they need to keep them healthy.

The 2004 health accord clearly talked about not only bulk buying, but also about working to “develop, assess and cost options for catastrophic pharmaceutical coverage”—I think that was one of the first things—and “establish a common national drug formulary for participating jurisdictions based on safety and cost effectiveness” and to “strengthen evaluation of real-world drug safety and effectiveness”.

None of this has happened. It was supposed to have been done. It was agreed upon. The minister said she was at the table and nobody agreed. It was agreed. It was signed in the accord that these things would happen and to report back by March 2006.

Can you give me some reason why this never occurred, especially when money had been put in specifically for it to happen?

Ms. Glenda Yeates: The question again of access to prescription drugs is a critical one and one which concerns many of us. The honourable member cited some of the aspects, such as a common formulary, and I mentioned the common drug review. In fact that was the response to having a common formulary. We have had a common drug review. In fact, we see many of those decisions being taken up in a common way across provinces.

Hon. Hedy Fry: Ms. Yeates, excuse me—

Ms. Glenda Yeates: We see the strength—

Hon. Hedy Fry: Ms. Yeates, excuse me. I have to focus. I'm sorry if I'm cutting your off; I don't mean to be rude. What about the piece that I read out that says, "develop, assess and cost options for catastrophic pharmaceutical coverage"? That specifically was never done. Why not?

Ms. Glenda Yeates: There was a great deal of work done at that time between the provinces and territories in the federal government. A great deal of policy work was done.

Hon. Hedy Fry: Is there such a plan?

Ms. Glenda Yeates: A great deal of work was done. Some of that has been implemented in various ways by individual jurisdictions, but it was not pursued as a collectivity.

Hon. Hedy Fry: It was meant to be nationally done.

Ms. Glenda Yeates: There was policy work, as I understand it, Madam Chair, that was done collectively. Some jurisdictions chose to pick that up individually, but there was no will among the group, as I understand it, to go forward together. I would say that there was an interest in 2004 in strengthening the evaluation and the real world safety and effectiveness. We have in fact created the Drug Safety and Effectiveness Network. Again, a number of the individual mechanisms have been followed up and many of them have been implemented.

Hon. Hedy Fry: I just wanted to say, Ms. Yeates, that the accord categorically said, and I am reading, "The strategy will include the following actions", and that piece on assessing, developing, and costing options for catastrophic pharmaceutical coverage was number one on the list. I still haven't had an answer as to why it wasn't done. It was signed in the accord and a report was to be made in March 2006. Why have we not seen that?

The Chair: Thank you, Dr. Fry.

Do you want to make a quick comment on that, Ms. Yeates?

Ms. Glenda Yeates: I would say two things. One, the policy work was done jointly and it was decided jointly not to take it up. Two, the accord did offer a wider range of things that could be done together, but there was no specific tying of the resources to individual pieces of that. Again, as provinces and territories have moved on, the policy work was done but there's been no priority put on collectively moving forward although various pieces, as I mentioned, have in fact moved forward and been implemented.

The Chair: Thank you.

Mr. Lizon.

Mr. Wladyslaw Lizon: Thank you very much, Madam Chair.

There's the small amount of $20,000 to Industry Canada for development of the global portal of the consumer product recall database.

Can you explain what that global portal is and how it will protect the health of Canadians?

● (1240)

Ms. Glenda Yeates: I think increasingly we're understanding the great protections we have in a post-market world. As we discussed earlier, there are many things we can do to ensure that products are safe before we introduce them to the market. Often we only get information on various products once they've been used in the real world and then we have the feedback and the understanding.

As we move towards working together, increasingly what we're doing across our regulatory responsibilities is pooling our information here in Canada with others. In fact, as we recall products, for example, we work within Canada to establish recall databases and other things. Again, Canadians can become aware of what's happening.

We work with the OECD as well, and if I'm not mistaken, it's a small charge for an ICT infrastructure so that Canada can participate in an international way to protect the health and safety of Canadians by having a web-based platform to inform Canadians of product recalls.

Again, we all know that the world is smaller and smaller in some ways, and as we get information somewhere else in the world, we want to see if we as Canada can be part of an international community sharing that information.

Mr. Wladyslaw Lizon: If I understand you correctly, that portal would have information on the recalls in Canada and all other countries participating in it? Is that correct?

Ms. Glenda Yeates: That's my understanding. I don't have a detailed knowledge of that portal here, but that is my understanding. We have a portal for Canada, and Canada participates in the OECD international work as well.

Mr. Wladyslaw Lizon: Thank you very much.

The second question I have is on the funding that is being allocated for the support of the development of new community-based integrated palliative care. Could you explain what these new care models are? How important are they for Canadians, and how do they work?

Ms. Glenda Yeates: What we see in the supplementary estimates is a re-profiling of some money.

There was an announcement in budget 2012 of money over three years to help support the development of some new community-based integrated palliative care models. I'm not able to describe the models because in a sense this is the money that is starting to do that work, and it's being given to the Canadian Hospice Palliative Care Association. They are doing some work so that we can develop some models that may be useful across the country on palliative care. We are re-profiling the money. They began their work last year. In fact, we've seen an increased amount this year as their work continues.

We're very mindful of the aging of the population and of the fact that palliative care and innovative ways of having palliative care done effectively in the community will be an important set of factors going forward. I think this organization is very well placed to do some of that development work, again, to be shared whether it's with a regional health authority, or a province, or anyone else who is interested in understanding the best practices in palliative care. The models are not yet finished, but this is the work that this money is supporting.

Mr. Wladyslaw Lizon: I will ask just one more question on this, because I know I will be asked about details in my riding.

When can we expect some of the results of the work that's being done? How would it be shared with the provinces or territories on the implementation side? How can they benefit from that? In Ontario we have a shortage of beds in long-term care facilities. This would be a very important program to address that shortage.

Ms. Glenda Yeates: Yes, and thank you very much for the question.

It is something that Ontario, and all provinces—I'm a former Saskatchewan deputy minister of health—are looking for to be able to support their work. It is a three-year commitment. It began last year and this is the second year. Once the research funding is finished, then we will presumably have the outcomes and they will be shared. There will be consultation with jurisdictions in advance of that, so there's consultation to make sure that the palliative care association engages with stakeholders as the work is ongoing. I don't think it will be to the end of three years before people are able to connect to the work.

● (1245)

Mr. Wladyslaw Lizon: Thank you very much.

Do I have any time left?

The Chair: You only have about half a minute left. There's really not enough time.

Mr. Wladyslaw Lizon: Maybe if Dr. Carrie—

The Chair: We've come to the end of this seven-minute slot. I want to ask the committee, we do have 15 minutes left, but there are two things. We have to vote on adopting and reporting the supplementary estimates, and then there are a couple of business issues that have come up that have to do with our trip to Montreal and a few other things.

I'm going to ask the will of the committee. Would you mind if we now went into a unanimous consent vote on the estimates, and I'll call them out, and then we'll go into committee business? Is that okay with the committee?

Let's have discussion on it first. We can continue the questioning if you absolutely want to, but that means we have to do business another day. I will have to stop to do the votes in 10 minutes anyway, so what is the will of the committee?

Ms. Libby Davies: Madam Chair, I think we should continue with questions because we do have the officials here. Two hours isn't a lot of time. I know we have to have a few minutes at the end for the estimates, but I think committee business wasn't on the agenda, so I would prefer that we wait and continue the questions.

The Chair: That's fine with me. We will stop at 12:55 p.m. to go through the votes.

We will continue on. Dr. Morin, go ahead.

[*Translation*]

Mr. Dany Morin: First, I would like to thank all our witnesses for being here today.

It is always a special time of the year when we can put questions to you or to the minister. I missed my opportunity to ask the minister questions today, but perhaps I will be able to do so next time.

I want to go back to the case of Ms. Lajoie. My colleague Mr. Lapointe brought the matter up; he is passionately involved in the case. Ms. Sellah spoke about it too. I am pleased that the minister was able to answer the question by stating categorically that she has no plans to create an ombudsman position, at least in the short term.

Could I get an answer from you, Ms. Yeates? When Mr. Lapointe and the minister were discussing the matter, they did not seem to be on the same wavelength in terms of the way the story unfolded. According to the information that my colleague has passed to me, Ms. Lajoie's oncologist did everything required under the rules, and nothing worked.

You can take a little time before you answer. I can even ask another question in the meantime, so that you can have a little more time to answer this one.

As my colleague and I understand it, everything was done according to the rules and yet the lady ended up not getting access to the health care she needed. I think that is the reason my colleague was suggesting the ombudsman position, to make sure that the situation will not happen again.

Perhaps it is too early for you to provide a report, but are there things that could be improved in the future, maybe by creating an ombudsman position or by anything else? Did everything go well in this case? Tell us what you think of Ms. Lajoie's story.

Ms. Glenda Yeates: Thank you for the question.

Because it is a little technical, I will answer in English.

[*English*]

I am not going to speak to the specifics of the case, but I would be very happy to take the committee through the process. There was a question asked, Madam Chair, about the process that would perhaps be helpful to understand.

Again, the vast majority of the drugs that we deal with are, in fact, drugs in this country that have gone through the clinical trial process and that have actually been reviewed and then approved by Health Canada for sale and use in this country.

We also understand there are instances where there are either emergencies or very unusual circumstances where practitioners feel that a product that is not approved, has not gone through the clinical trial process, and has not received a notice of compliance from Health Canada is appropriate. We therefore have the special access framework to deal with these situations.

Perhaps I could just mention the roles that individuals play here, as was mentioned. Practitioners are responsible for initiating the request of this program. We dealt with—the minister mentioned the numbers, but I'll mention them again—25,000 requests last year for over 500 different drug products for about 70,000 patients. We are talking about a substantial program. The practitioners make the request. They identify the particular drug from the particular source. They give a brief history of the patient's condition and the therapies that have been tried or considered. Basically, they then provide some data respecting what they are proposing to use. The program then takes that information, considers it, and evaluates the nature of the emergency and the drug. In many cases, these may be drugs that we are aware of from other requests and we may be able to look at that. We operate this program 24/7. We understand that in emergency situations there will be an urgent need.

Manufacturers also need to have some responsibility for deciding that they will provide the drug. Obviously, they are providing it in circumstances where there is not a notice of compliance and no Health Canada review. The manufacturers also have to be willing to provide the drug. We don't have any authority to compel the manufacturers to provide a drug. There can, in some cases, be circumstances where a manufacturer is willing to release a drug but Health Canada is not, and vice versa.

There are a very large number of these requests. Most of them are, as the minister mentioned, processed within 24 hours. Some do take longer to evaluate if they are new to the program. As I say, we work very hard to make sure that service is available on an ongoing and 24/7 basis.

● (1250)

Mr. Dany Morin: In that particular case, can you tell us if the request was not treated in a timely manner or was it denied?

Ms. Glenda Yeates: Again, we don't discuss individual cases for privacy reasons, but I think the minister has offered to brief technical —

Mr. Dany Morin: Okay.

The Chair: Thank you.

We'll now go to Mr. Brown. You have three minutes, Mr. Brown.

Mr. Patrick Brown: Thank you, Madam Chair.

I have a question, and Colin Carrie may have one too. I'll be brief.

This is for the CIHR. One thing this committee has taken an interest in is neurological disorders. What allocations are in the main estimates or the supplementary estimates for the government's efforts on neurological disorders? I remember there was a project of interest, which we were working on with the U.K. and France, for a greater study on Alzheimer's. I know there is interesting work being done on MS.

Maybe you could shed some light on how these supplementary estimates contribute to our ongoing focus on neurological disorders.

Mr. James Roberge: Thank you for the question.

There are no additional funds specifically in those domains in the supplementary estimates, but there are ongoing programs funded under what was provided through the main estimates. There is in fact funding with respect to Alzheimer's roughly of the order of $30 million per annum, including an international component, which you referred to. There are arrangements with international consortia looking at Alzheimer's disease in Europe, the United States, and now in Asia, a number of countries. With respect to SPOR as well, there is a component.

Again, until these research networks are selected, it is quite possibly components that would be involved. I mentioned the mental health research network funded with the Graham Boeckh Foundation. It's looking at youth and areas such as suicide, as an example. There is ongoing funding, but there are no additional moneys through supplementary estimates, other than for SPOR, as was mentioned.

Mr. Patrick Brown: Colin, do you have a quick question?

Mr. Colin Carrie: Yes, thank you, Patrick.

Madam Yeates, there has been talk in the news about narcotic abuse, specifically of OxyContin. It appears that the provinces have the tools to deal with prescription drug abuse in their jurisdiction. I know our government took a leadership role with first nations.

Could you outline more clearly what we have done at that level to work with the issue of prescription drug abuse?

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

Madam Chair, as the minister mentioned, the issue of prescription drug abuse is one for which there's a heightened awareness of its challenge for communities, including but certainly not limited to first nations communities.

Because we run the non-insured health benefits program, which provides financial assistance for first nations to access the drugs, the needed medications on our formulary program, we've been doing a number of things to try to find the balance, which I think all jurisdictions are trying to do, in order to make sure that needed pain medication is available but that we are putting appropriate checks and balances in place.

The kinds of checks and balances we've done in conjunction with our expert advisory committee include our working with them to understand what is appropriate. We have, for example, daily or monthly limits, so that there is some sense of how much pain medication of a certain type is appropriate. There are in some cases circumstances in which we will have flags that go up for the pharmacist, and therefore they can't fill the prescription until there's a check.

Particularly with regard to OxyContin, we've put it on what is called exception drug status. That means it's not on an open formulary basis; you have to have the approval of the program very specifically. That's the mechanism that we see has significantly impacted the use of OxyContin.

● (1255)

The Chair: Thank you very much, Ms. Yeates, and thank you, Dr. Carrie.

I want to thank all of our guests for coming today.

Before we go any further, I would like unanimous consent to call all the votes on the estimates together. I'll call them out. There are seven votes. If you want to do them one by one, we can do that too, but I don't think that's really necessary.

Do I have unanimous consent to call all the votes together?

Some hon. members: Agreed.

The Chair: I'm going to go through all of this in a block.

Shall votes 1b, 5b, 10b, 25b, 50b, 55b, and 60b under Health carry?

HEALTH

Department

Vote 1b—Operating expenditures.....$194,938,496

Vote 5b—Capital expenditures.....$1

Vote 10b—The grants listed in the Estimates and contributions, in the form of monetary payments or the provision of goods or services.....$42,150,191

Canadian Institutes of Health Research

Vote 25b—The grants listed in the Estimates.....$2,287,600

Public Health Agency of Canada

Vote 50b—Operating expenditures.....$1

Vote 55b—Capital expenditures.....$1

Vote 60b—The grants listed in the Estimates and contributions.....$1

(Votes lb, 5b, 10b, 25b, 50b, 55b, and 60b agreed to)

The Chair: Thank you.

Shall I report the supplementary estimates (B) to the House at the earliest possible time, which would be tomorrow afternoon?

Some hon. members: Agreed.

The Chair: Thank you.

With that, I want to thank our guests. We really appreciate all you do.

The meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

SPEAKER'S PERMISSION

Additional copies may be obtained from: Publishing and Depository Services
Public Works and Government Services Canada
Ottawa, Ontario K1A 0S5
Telephone: 613-941-5995 or 1-800-635-7943
Fax: 613-954-5779 or 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Also available on the Parliament of Canada Web Site at the following address: http://www.parl.gc.ca

Publié en conformité de l'autorité du Président de la Chambre des communes

PERMISSION DU PRÉSIDENT

On peut obtenir des copies supplémentaires en écrivant à : Les Éditions et Services de dépôt
Travaux publics et Services gouvernementaux Canada
Ottawa (Ontario) K1A 0S5
Téléphone : 613-941-5995 ou 1-800-635-7943
Télécopieur : 613-954-5779 ou 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante : http://www.parl.gc.ca