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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): I'll call the meeting to order.

I want to welcome everyone. We have a very special day today, with the Honourable Leona Aglukkaq, Minister of Health, joining us.

Welcome, Minister. You're at the best committee on the Hill, but of course you know that. We certainly welcome you here today.

Today, pursuant to Standing Order 81(4), we're doing main estimates for 2013-14, and of course, we do the votes. These were all referred to the health committee on February 25.

We will begin with the minister, and I'm sure you want to introduce your assistants with you, Minister.

Hon. Leona Aglukkaq (Minister of Health): Thank you.

Good afternoon, everyone.

Madam Chair and members of the committee, it's a pleasure to be back here to discuss the main estimates for the health portfolio. With me today are Glenda, Krista, Dr. Greg, and James. I believe this is the last appearance for James before this committee. He will be retiring on Friday.

Some hon. members: Hear, hear!

Hon. Leona Aglukkaq: I'm sure he's quite happy about that, so give him a good time today and don't be too hard on him.

Over the past year, the committee has discussed and considered many of this country's most important health issues. During my last appearance before the committee, in November, I highlighted our government's efforts to reduce the deficit, and our emphasis on protecting the front-line health care services within the health portfolio. I am pleased to report that we have honoured and continue to follow through on these commitments.

Madam Chair, we remain committed to sound financial management. Building on budget 2012 commitments, we are increasing effectiveness and efficiencies across the portfolio. We're reducing redundancies and aligning efforts, where possible. As well, we are focusing on core mandates to help us meet emerging demands and adapt to new realities.

The main estimates for the health portfolio represent a net decrease of $104.9 million over last year. This decrease is mainly due to the savings identified as part of our economic action plan 2012, and sunsetting programs. However, for a more complete picture of the future direction of the health portfolio, we also need to consider the government's investments in health, as outlined within the economic action plan 2013.

As highlighted in economic action plan 2013, our government invests over $2.4 billion annually for first nations and Inuit health, including primary health care for on-reserve communities, as well as non-insured health benefits. On top of this investment, economic action plan 2013 provides $52 million over the next two years to improve access to quality health services for first nations and Inuit. This funding will help expand electronic health services, including telehealth within the remote and isolated first nation communities, and it will expand the number of accredited health care facilities on reserves, as well as mental wellness teams.

The funding is on top of the $90 million in main estimates that will also be dedicated to the continued implementation of both the residential school settlement agreement and the first nations water and wastewater action plan. Once these funds are added in the future supplementary estimates, the health portfolio planned spending for 2013-14 will increase over the 2013 main estimates level.

Our government has once again confirmed that health remains a key federal priority. As confirmed in economic action plan 2013, this government will not balance the books on the backs of the provinces and the territories. We are on a sustainable, long-term track for health transfers to the provinces and the territories that will see funding reach a record high of $30.3 billion this year, and it will continue to grow. This will help ensure health care services are there for Canadian families, when needed.

Federal action on health doesn't stop at annual transfers. The federal government remains the largest single investor in Canadian health innovation, primarily through the grants made by the Canadian Institutes of Health Research. We are supporting ongoing health innovation with advanced research through an additional ongoing investment of $15 million per year for Canada's strategy for patient-oriented research. Again, this will help ensure patients are placed at the centre of care.

The federal role in health extends far beyond health care services. This week I delivered a keynote address about how our government is supporting Canadian families. I announced several important new initiatives that demonstrate how we are strengthening the safety of consumer products, food, and drugs.

Today, I would like to echo those remarks in the context of the estimates and our priorities moving forward.

● (1535)

Health Canada is always on the lookout for emerging threats to health. For example, it's clear that some products containing small powerful magnets pose a danger to children. These magnets are found in some novelty sets and some children's toys. If more than one magnet is swallowed in a short period of time, the results can be very serious or even fatal. Under the Canada Consumer Product Safety Act, Health Canada is taking actions to identify these dangerous products and contacting companies to have the products removed from the marketplace.

Our government wants to make sure that playpens remain safe, which is why Health Canada is proposing to strengthen regulations for playpens, including adding new requirements for playpen accessories, which will result in the application of even higher standards for their construction and safety features.

I also noted this week that the safety of our medication is also of vital importance to Canadians and their families, which is why we're improving safety standards. We're ensuring that hospitals have strong systems in place for reporting adverse drug reactions. We're working with industry to improve drug-naming practices to reduce the number of products that are confused because their names look or sound alike. This will help Canadians to better understand what they're taking and prevent dangerous mix-ups of drugs, particularly among our seniors.

With regard to natural health products, we have listened to the industry and consumers, and we have streamlined our approaches while maintaining safety as our top priority. This means that Canadians will benefit from access to over 60,000 authorized products.

Canadians need to know that the products they buy, use, and eat are subject to strict safety standards. They need to know that their government can detect and correct problems quickly, and they need to know that the information and labelling that they see are helpful and accurate. This is particularly true with food safety. For people with food allergies, for example, proper labelling is essential. Now when people shop for groceries, they will find more straightforward ingredient labels. These labels declare allergens and gluten sources that may not have been disclosed in the past. It's about helping Canadian families to get the information they need to make healthy, safe choices.

In terms of emergency preparedness, we continue to be prepared to respond to a range of public health issues. More recently we have been monitoring events in China related to the H7N9 virus. While the risk to Canadians remains low at this time, we continue to share information with the public, communicate with our public health experts in China, and work in close collaboration with our many partners.

I'm also proud to report that we're expanding our food-borne illness surveillance program, known as C-EnterNet, with a third surveillance site. This is one way we're able to track food-borne illnesses and their sources, and to help prevent diseases from occurring. Through close collaboration between the Public Health Agency, Health Canada, and all our food safety and surveillance partners, we are committed to providing Canadians with the best possible food safety protection.

We've also demonstrated our commitment to protecting families when and where they need it. In partnership with the Heart and Stroke Foundation, we're going where Canadians are, to help ensure safe environments that are both active and healthy. For example, earlier this year Prime Minister Harper announced a four-year initiative to support the installation of automated external defibrillators in hockey arenas across Canada. It's one way we're reaching Canadians in their communities. This is technology that we know works, is easy to use, and can help save lives.

We need to be there for Canadians when they want advice or guidance, and that's why our government is also tapping into the power and reach of social media. HealthyCanadians.gc.ca allows even the busiest parent to stay informed. The latest alert on unsafe products, information on food, and tips on nutrition or quitting smoking are all on the HealthyCanadians site, as a one-stop shop.

● (1540)

Madam Chair, families, and all Canadians, want their government to be that kind of a partner in their health—not to lecture them, not to interfere in their daily lives, but to be there when they need it, to make sound policy decisions based on solid research, and to provide practical and clear advice as the world around them changes.

Today I've outlined some of the ways we're partnering with families across the country. As we look to the year ahead, I'd like to thank all members for their hard work and their shared commitment to Canadians.

I would be happy to take your questions this afternoon.

Thank you, Madam Chair.

The Chair: Thank you very much, Minister, for those insightful comments. We're very pleased to have you here today.

We'll begin with our first round of seven minutes, beginning with Dr. Sellah.

[*Translation*]

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

I would like to begin by thanking the minister and her colleagues for appearing before us today.

I want to let the minister know that my questions will be short and to the point, and I would appreciate it if her answers were the same.

Minister, do you believe in the principles of the Canada Health Act?

[*English*]

Hon. Leona Aglukkaq: The Health Council of Canada was established under the accord. The 10 years will expire this coming year, and that will be the end of that council.

[*Translation*]

Mrs. Djaouida Sellah: Do you believe in those principles? Yes or no?

[*English*]

Hon. Leona Aglukkaq: Oh, the interpreter made a....

The Canada Health Act? Absolutely.

[*Translation*]

Mrs. Djaouida Sellah: Okay.

Do you think that the federal, provincial and territorial governments should be accountable to their citizens regarding their health care spending?

[*English*]

Hon. Leona Aglukkaq: The provinces and the territories deliver health care. Under the Canada Health Act, the federal government provides health transfers to the provinces and the territories. Each of these governments makes the determination in terms of its own priorities on where it wants to spend health care funding, based on its own needs.

[*Translation*]

Mrs. Djaouida Sellah: But you do believe that they should be accountable to their citizens?

[*English*]

Hon. Leona Aglukkaq: Madam Chair, that is a question for the provincial and territorial health ministers, in terms of how they deliver their health care.

In terms of our obligations under the Canada Health Act, we provide transfers to the jurisdictions. There are different provincial and territorial governments in place. They are elected, and they make their own determinations in terms of how and where they will spend their health care dollars, based on their own provincial or territorial needs.

[*Translation*]

Mrs. Djaouida Sellah: Why then, minister, are you abolishing the Health Council of Canada, an organization that allows Canadians to monitor your government's results—or rather the lack thereof—in the area of health accords?

[*English*]

Hon. Leona Aglukkaq: The Health Council's mandate is to monitor and to report health care renewal commitment under the health accord. The 2004 accord is ending in 2014. It was a 10-year accord.

It makes sense for the government to wind down its funding to the council over the next two years. The government will provide the council with sufficient funding for the completion of the council's mandate, including its final report on progress under the accord.

Thank you, Madam Chair.

● (1545)

The Chair: Dr. Sellah.

[*Translation*]

Mrs. Djaouida Sellah: How much time do I have left, Madam Chair?

[*English*]

The Chair: You have about three minutes.

[*Translation*]

Mrs. Djaouida Sellah: Okay.

Minister, can you explain to us how you plan to carry out your mandate if, between 2011 and 2016, your department is going to lose 20% of its funding and 10% of its staff? Sectors as important as food safety and nutrition will undergo a 20% cut. In the area of substance abuse, the reduction will be 35%. Meanwhile, you just launched a Canada-wide strategy on drug abuse. How will you manage to meet your mandate?

Could you also tell the committee whether or not you will continue to fund Health Infoway?

[*English*]

The Chair: Ms. Yeates, would you like to...?

Hon. Leona Aglukkaq: I'll start with Health Infoway, Madam Chair. Yes, we'll continue to fund Health Infoway.

I'll ask the deputy to respond to the internal funding allocations.

Ms. Glenda Yeates (Deputy Minister, Department of Health): The estimates this year are displayed somewhat differently, so they show actual expenditures and then main estimates to main estimates. In some cases, it does appear there are significant decreases, as was noted by the honourable member. In fact, what we see is that the 2011-12 expenditures include supplementary expenditures, so supplementary estimates (A), (B), and (C), which often come before this committee, are included in those figures.

Some of the reductions that appear between last year and the coming year are, in a sense, because there's a different basis of calculation. I would like to reassure members, though, that in terms of food safety, there is no diminution in our focus on this core mandate. There are some small changes as time goes on, but in the areas that are mentioned, some of the figures, I think, reflect the differences between the way the different figures are based.

The Chair: You have 45 seconds.

[*Translation*]

Mrs. Djaouida Sellah: Your department really mismanaged the Alysena 28 recall. You issued a voluntary recall before issuing a mandatory one, in response to pressure from health professionals.

Could you explain to us what happened and what you will do to ensure that it doesn't happen again? We know that women could have become pregnant without really wanting to.

[*English*]

The Chair: Minister?

Hon. Leona Aglukkaq: I'm not really clear in terms of which voluntary recall. Can you clarify further? Maybe it didn't come across through the translation.

The Chair: I'll give you an extra minute to explain what you mean, Doctor.

[*Translation*]

Mrs. Djaouida Sellah: Minister, I am talking about the recall of Alysena 28—a birth control pill.

[*English*]

Hon. Leona Aglukkaq: Thank you for that question.

Our government is committed to protecting the health and safety of Canadians, and I have instructed Health Canada's officials to look into the issue and to assess whether the processes were followed and were sufficient within the rules that we do have in place.

In this case, Apotex indicated the recall of one lot, prior to advising Health Canada, based on their own assessment of the health risks. We encourage this with industry, based on their assessments, to do recalls as well. Once Health Canada's risk assessment was conducted, Health Canada immediately posted this information to the Healthy Canadians website.

Thank you, Madam Chair.

● (1550)

The Chair: Thank you, Minister.

Now we'll go to Dr. Carrie.

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

I want to thank you, Minister, for being here again with your officials at the health committee. We always enjoy having you here and we do appreciate your forthright answers to our questions.

You're well aware of one of the things that I'm very interested in. As a chiropractor in Oshawa, before I got involved in politics, I had a practice full of people who were very wellness-oriented, preventive-care oriented, very much into personal responsibility for their health. Some of the things that I used in my practice were vitamins, minerals, herbs, and things along these lines.

Back in 2004, under the previous government, the Liberal government brought in these new regulations. Over the last several years I've heard from a lot of Canadian businesses and consumers who have expressed their discontent with regard to the bureaucratic backlog created when these regulations came into force.

I was wondering if you could provide an update for our committee on any progress we have made on this issue, because I think at one time there was a backlog of over 10,000 products. Would you be able to give us some insight?

Hon. Leona Aglukkaq: We're talking about the NHPs?

Mr. Colin Carrie: They're the natural health products.

Hon. Leona Aglukkaq: Okay.

Our government recognizes that Canadians want to be able to choose from a wide range of safe and effective natural health products, so we have introduced a new approach for NHPs, which enables more efficient processing of applications to increase consumer access to safe and effective products.

Review times for applications are now based on how much we know about each product, relying on the library of information collected from the licensing of over 60,000 natural health products. NHPs about which we know the most are reviewed in a shorter period of time than are those we don't know much about or those that are more complex. So the administrative burden for bringing lower-risk products to the market is reduced. Our target is now to have these applications reviewed in 30 days or less, with the majority of them being done in 10 days.

That means that our efforts can now be focused on the lesser known or more complex products. The target in that area is to have those reviews completed in 180 days or less. Ultimately the improvements have provided a stable and predictable approach to the industry, and these changes are having a very positive impact. The new approach played a key role in eliminating the backlog of over 10,000 NHPs, so we are making huge progress in processing those NHP applications in Health Canada.

Thank you.

Mr. Colin Carrie: Excellent.

I want to follow up with another question. Right now, as you know, the health committee is undertaking a study on technological innovation. We've had some of the most interesting witnesses we've ever had, and the potential we see is just huge.

I wonder if you could elaborate on how electronic health services will result in positive health outcomes. I know you've been very interested in Health Infoway and things along those lines, but could you specifically comment on how this will help change health care services, specifically in rural communities?

Hon. Leona Aglukkaq: Infoway and electronic health records are having a positive impact in many of the remote, isolated communities in Canada. I'm a big believer that we need to start looking at technology, e-health, or Infoway to address getting better services into our remote, isolated communities.

How can we use telehealth, for instance, to provide mental health counselling to individuals who require assistance or support that may not necessarily be there? There are examples of pilot programs out there through which psychiatrists can provide services to youth who require support. In isolated, remote communities, we're able to do assessments of X-rays and what not from the high Arctic with hospitals, etc.

Going forward, I think this technology has to be an integral part of our discussion in terms of how we are going to improve primary health care services, particularly in the most isolated communities in Canada.

That was a great question. Thank you.

● (1555)

Mr. Colin Carrie: How am I doing for time?

The Chair: You have about two and a half more minutes.

Mr. Colin Carrie: Thank you very much.

We recently heard our most recent budget, budget 2013, and I know there was some really good stuff in there for the health care community. I wonder if you could comment on some of the really good things that are in budget 2013 with regard to health.

Hon. Leona Aglukkaq: The good thing about this one, for us in Health, is that there is long-term stable funding for transfers to provinces and territories, first of all. The second is in our primary responsibility, which is first nations' health. We have the budget for long-term predictable funding in this area. We have resources to provide more innovative services to first nations within that—accreditation is an example. Those, I think, are the highlights for us—a long-term stable area.

Other areas relate to better integration of our own services within the Public Health Agency and Health Canada, and in how we can better collaborate and work with similar resources internally, cutting down some of the red tape to provide better services. We've been able to make some improvements in that—in reducing red tape in processing applications, as an example.

So there are a number of great investments in health care.

At the same time, I think it has been very well received by the provinces and territories that they have long-term, stable, predictable funding that allows each jurisdiction to provide their own investments in areas of their priorities.

The other area is research. We have research funding. CIHR is providing funding to more than 10,000 research projects in our communities. That will also be very helpful in addressing some of the challenges we have in health care, particularly around tuberculosis. As an example, the pathways to health equity program is to basically bridge the health gaps between aboriginal people and the rest of Canadians. That program focuses on areas such as obesity, diabetes, oral health, suicide, and mental health, as well as tuberculosis.

This is the first time research investments are being made in partnership with aboriginal people. One key element that has changed is that we're not approving research projects in which aboriginal people are being studied from afar. It requires a partnership of health care researchers partnering with aboriginal people on the ground, so that we can bridge between traditional knowledge and modern medicine in how we address some of those challenges.

That area is very exciting, and it's new. I look forward to making some announcements around some of the proposals that are coming forward.

Thank you.

The Chair: Thank you, Minister.

Now we'll go to Dr. Fry.

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

I'm going to ask my questions, but because I have only seven minutes I want to get very succinct answers, if I can, please.

I'm going to start by asking about some of the cuts in the budget and why they were done and how the Department of Health is going to be able to cope, given some of the cuts. For instance, we see that the whole health portfolio since 2012 has had $200.6 million cut from it, so its ability to do the work it has to do is very compromised. My question, then, is not just about that but about, for instance, health promotion and disease prevention.

We have seen the tobacco strategy eliminated, and we have seen cuts to substance abuse and addiction funding, etc.—cuts of 35% in tobacco alone. Given that six million Canadians still smoke, how is this going to decrease the burden on the health care system for cardiovascular disease, lung disease, etc., which is going to obviously cost the system at the other end?

Hon. Leona Aglukkaq: On the issue of tobacco, Canada is a world leader in tobacco control impact. According to recent reports by the Canadian Cancer Society, Canada's world ranking for cigarette package warnings rose to fourth in 2012.

When flavoured little cigars became increasingly popular, we took immediate action in the House of Commons by cracking down on tobacco marketing for children. We'll continue to do that—

Hon. Hedy Fry: Minister, excuse me. I asked you a specific question. May I have an answer to it?

The Chair: Order, please.

Dr. Fry, I will not have interruptions. Let the minister finish. Then you can ask your questions.

Hon. Hedy Fry: I'd like to get an answer to my question, Madam Chair. I have only seven minutes.

The Chair: No, I will stop right now, if you don't listen.

Hon. Hedy Fry: Yes, of course.

Thank you.

The Chair: Minister, would you continue? Then Dr. Fry can continue.

Hon. Leona Aglukkaq: The new tobacco regulations, which are also requiring health warning messages that are new as well, increase to 75%. This year there is also a pan-Canadian toll-free “quit line”, which we introduced in partnership with the provinces and the territories. Again, that was introduced in the last year.

Our government is quite proud of the record we have related to the rate of tobacco use in Canada, which is currently the lowest ever, at 17%. Only 8% of Canadian youth aged 15 to 17 smoke—another record low. Those are significant results from the investments we have been making.

Thank you.

● (1600)

Hon. Hedy Fry: Minister, I would like an answer to my question and not a sense of what went on in the past. I'm talking about the future and how you will meet the needs Canadians have.

For instance, the drug and substance abuse funding has been cut by almost 50%, and all of the community funding that will go to drugs and substance abuse is down by 16%.

Given that substance abuse and addiction is at an all-time high, given its cost to the health care system, given its damage to the ability of human beings to live meaningful lives, and given that this is high in Inuit and aboriginal communities, how is the minister going to meet the needs of these communities? It's obvious that a 50% cut is huge.

Hon. Leona Aglukkaq: Thank you.

One of the areas we are looking at focusing on relates to the abuse of prescription drugs. Prescription drugs pose a serious and very complex problem. We have seen some of the media information out there related to a single pill. This is why we have provided funding and support to the Canadian Centre on Substance Abuse so that it could develop a national strategy on prescription drug abuse. That report and its recommendations will no doubt help to advance work in this area.

As a service provider for first nations and Inuit, this government has shown leadership by cracking down on prescription drug abuse in areas within our own jurisdiction. These measures have resulted in a 50% reduction in the amount of long-acting oxycodone provided to Health Canada's non-insured health benefit program, without a significant shift in other long-term areas.

The provinces and the territories, as well as health care professionals, pharmacists, and doctors, also have key roles to play in addressing prescription drug abuse. I have committed to working with all the partners, the Canadian Centre on Substance Abuse as well as the provinces and territories, to address this very issue.

Thank you.

Hon. Hedy Fry: Minister, the Public Health Agency of Canada has seen a cut since 2011 that is about 14%, and specifically disconcerting is that the surveillance part of the Public Health Agency of Canada has been cut by 26%.

Now, the minister assured us that the health and safety of Canadians are going to be a priority for her. How are you able to ensure the health and security of Canadians when you are not going to be able to do surveillance, when you're not going to be able to keep an eye on population health, and at a time when pandemics around this world can happen at any moment?

You are diminishing your ability to respond to anything—most specifically to the health and safety of Canadians.

I'd like to have an answer to that, please.

Hon. Leona Aglukkaq: I'll pass it on to Krista, but the surveillance systems that we have with public health agencies through the microbiology labs are not impacted. In fact, we are also evaluating the rollout of the pandemic plans so that we can continue to make improvements to the way provinces, territories, and the federal government responded during the H1N1 outbreak. We continue to do that.

I also said in my opening remarks that we are opening another site to detect food-borne illnesses. In terms of surveillance, those systems remain in place.

As for the amounts, I'll ask Krista to identify the budgets within that area.

Thank you.

Mrs. Krista Outhwaite (Associate Deputy Minister, Public Health Agency of Canada): Thank you, Minister.

Thank you for the question.

The agency takes great care to protect its primary mandate, to which you were referring, in terms of emergency preparedness and response, leadership in health promotion, disease prevention and health protection, public health capacity, and science leadership. This includes things such as surveillance.

As we went about the exercise of looking at what efficiencies we could engender, we made sure that we protected our ability to do surveillance. We made sure that we protected our ability to do science in our three laboratories in the country, so that we could be ready and we will be ready when we next face a pandemic or other significant public health event.

This year the agency is facing a reduction of about $35.7 to $36 million, and 80% of those savings are coming from administrative efficiencies in the back office. So when we talk about surveillance, we are talking about our 55 surveillance programs not in terms of the data we collect or what we do, but in terms of how we do it in the back end.

Thank you.

● (1605)

The Chair: Thank you so much, Dr. Fry.

We'll go to Mr. Wilks, please.

Mr. David Wilks (Kootenay—Columbia, CPC): Thank you, Madam Chair.

Thank you, Minister, for being here today.

Aboriginals face many unique challenges when it comes to health care. The 2013 budget proposed investments to address these challenges. Can you please tell us how these investments will assist in improving health care services and outcomes for Canada's first nation and Inuit population?

Hon. Leona Aglukkaq: Thank you for that question.

As you know, improving the health of aboriginal people is a shared undertaking among all levels of government and aboriginal partners. The federal government is working with its partners to provide effective, sustainable, and culturally appropriate health programs and services.

As highlighted in budget 2013, we invest more than $2.4 billion annually for first nation and Inuit health, including primary health care on reserves as well as the non-insured health benefit program. We're also proposing an investment of $48 million to support the uptake of innovative technologies, such as electronic health services, within the remote and isolated first nation communities. Finally—and I spoke to this earlier on Dr. Carrie's question—budget 2013 also includes a proposed $4 million in investment over two years to increase the number of mental health wellness teams and specialized services available in first nation communities.

Mr. David Wilks: Thank you for that.

You mentioned electronic health services. Could you expand upon that and explain to this committee how they will bring positive health outcomes, specifically for rural communities?

Hon. Leona Aglukkaq: Thank you for that question.

One of the biggest challenges we have is making sure that we respond to situations quickly in communities. Many of the first nation reserves or Inuit communities have nursing stations; they don't have hospitals. One of the biggest cost factors we deal with, before we even provide services, is flying patients to hospitals from remote communities—northern Ontario to southern Ontario, Iqaluit to Ottawa, Rankin to Winnipeg, or what have you. We face a number of challenges in getting patients there.

One of the things we're doing is investing in telehealth in the north, so that physicians or nurse practitioners have access to specialists in southern hospital settings to provide advice or make decisions on whether a person requires hospital service or not. Another is investing in X-rays that we can be sending to hospitals immediately, rather than flying people down to the hospitals to be seen. That can sometimes take some time because of weather, flight schedules, and whatnot. These investments in some areas are reducing costs and dependency on transportation, which we can invest in other areas. We're looking at those types of initiatives.

But in everything we do, technology will become a more integral part of how we ensure, in primary health care settings, that patients have access to the services we see in city-centred areas, such as here in Ottawa. We're looking at these options to make sure that we have great services in our communities.

Mr. David Wilks: Thank you.

This proves that, just to take you back a bit, consultation and partnerships can be very helpful in improving the health of first nations.

Could you update us on the initiative taking place in British Columbia among the different levels of government?

Hon. Leona Aglukkaq: The work we're doing in British Columbia is historic and very innovative. The first nation communities and first nation leaders in that region, in partnership with Health Canada and the provincial government, have established a first nations health tripartite agreement. The first rollout of it will happen this summer, when the first nations authority will take responsibility for delivering health care, by first nations people for first nations people, in partnership with the provincial government.

The opportunity there is to break down the silos of delivering health care, with better partnerships and with collaboration with similar existing provincial programs. The provinces have partnered in this. This is the first of its kind in Canada—in a provincial setting, anyway—in which Health Canada direct delivery will be out. It will be a first nations health authority delivering programs.

Another exciting piece about this is that they'll have a great opportunity to better incorporate aboriginal knowledge into the delivery of their programs and to have a better design of community-based health care services incorporating traditional knowledge of aboriginal people in the medical practice, as an example.

It's the first of its kind, and we're quite excited about it. The first nation leadership in British Columbia has been fantastic, and it has been a great joy working with them. They're thinking outside the box, planning and prioritizing their areas based on their needs in their communities.

This summer and in the fall, the first nations health authority will be delivering that. This is really exciting.

I think we'll be able to share some of these types of models in other jurisdictions that may be interested in looking at how to break down some of the silos in a provincial, federal, and first nation health delivery system. This is one that has been in the works for over five years, and I commend the leadership of the first nations people in British Columbia.

● (1610)

Mr. David Wilks: Thank you very much.

The Chair: Thank you, Mr. Wilks.

We'll now go to our five-minute rounds.

Welcome to our committee, Ms. Crowder.

You have five minutes. We watch the clock carefully.

Ms. Jean Crowder (Nanaimo—Cowichan, NDP): Great. Thank you, Madam Chair.

Welcome to the minister and her staff.

It's always a challenge when we're dealing with estimates, because we have to deal with the facts and figures that are before us and not what could be coming in the supplementary estimates. When you look at the department's report on plans and priorities for Health Canada, it shows that there will be cuts of $140 million from first nations and Inuit primary health care in the next three years. It goes from $980 million to $850 million. When you just look at the year 2012-13 in comparison with 2013-14, Health Canada will be reducing its spending by $40.5 million.

In your opening remarks, Minister, I understood you to indicate that there will be additional funds coming through the supplementary estimates. Could you tell me exactly how much? Is it $52 million that will be in the supplementary estimates for additional spending?

● (1615)

Hon. Leona Aglukkaq: Do you want to take that?

Ms. Glenda Yeates: There are many documents before the committee. You mentioned the report on plans and priorities.

I can speak to the fact the allocations in budget 2013 include $48 million over two years, so $24 million a year. That will be apportioned according to these business lines. Of that $24 million, some of that will be in health infrastructure and some of it will be in primary care.

We have additional moneys coming through supplementary processes that will exceed these figures that we've given you today. They will appear in supplementary estimates (A) and (B).

In some of the programs, I'd say in both non-insured health benefits and in primary care, we tend to look year to year at the estimate of the need. It varies depending on the population and the usage. Then, if you look at the committee's historic records, we will have added money in primary care and in non-insured health benefits in some substantial figures during the year through supplementary estimates.

Ms. Jean Crowder: It's interesting that you talked about depending on the needs of the population. We know that first nations and Inuit are the fastest-growing youth populations in Canada and have some of the poorest outcomes in Canada. It would be surprising to see less money required.

You talked about the fact that there will be additional money in the supplementary estimates and that some of that money will be targeted towards primary care. Can you tell us specifically how much money will go into primary care, including chronic illness management and mental health? I know the minister did indicate that $4 million would be going to mental health over two years, but will there be additional money?

Hon. Leona Aglukkaq: First, just to clarify in terms of the services to Inuit, those are through the Canada health transfers. Nunavut delivers their health care, as an example; Northwest Territories delivers their care; Quebec, northern Quebec, Labrador, and whatnot. The services here are for first nation reserves for primary care.

Thank you.

Ms. Glenda Yeates: There is new money in the budget, as the minister mentioned, for the mental health teams, and that will be added to the primary care portions. But in addition to those figures that are specifically outlined in budget 2013, there will be additional funding, essentially program integrity funding, that we will be applying for and expect to see coming in the supplementary estimates.

What I can say to the committee, just as we've said in past years, is that there are no program changes here. There are no reductions in the programming. We will get the money that will live up to the needs of the same level of programming for non-insured health benefits and for primary care services for 2013-14.

Ms. Jean Crowder: Just in terms of the electronic health services, has the department done an assessment on Internet accessibility in rural and remote communities? When I was on the human resources committee, we were hearing that there were some challenges in some communities. Have you actually done that assessment?

Ms. Glenda Yeates: Thank you for the question.

We are continuing to expand the supports that we have in first nation communities. We have a number of communities that are connected now with the additional funds that are available to us with this $24 million. We expect that $20 million of it, for example, will be focused on, in some cases, adding communities to the number that are connected. But in other cases, as the technology changes, we're actually broadening the broadband. We are actually adding additional connectivity to communities that are already connected but perhaps don't have the bandwidth to deal with the latest technology.

So it's some of each.

The Chair: Thank you, Ms. Yeates.

Welcome to our committee, Mr. Gill. It's good to see you.

You have five minutes.

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

Thank you to the honourable minister and her officials for being here.

I'm no longer a regular on this committee. I'm just filling in for my colleague. It's wonderful to be here and to be able to join in this meeting.

Minister, my question is related to neurological disease. Neurological disease disorders and injuries represent one of the leading causes of disability in the Canadian population. They produce a range of symptoms and functional limitations that pose daily challenges to individuals and their families.

Can you please tell us what our government is doing to assist those suffering from this serious disease and the families who care for them?

Hon. Leona Aglukkaq: Thank you for that question.

The Government of Canada has invested $15 million, in partnership with neurological health charities across Canada, to carry out Canada's first national population health study of neurological conditions. The study results will provide reliable information on the extent of neurological conditions and their effects on Canadians. The study will be completed this year, and a full report will be available in 2015. This information will help to inform the future program and policy decisions we make.

The government launched the development of the Canadian MS monitoring system in March 2011 to support efforts to improve the care and quality of life of Canadians who are suffering from MS. That system will increase our understanding of MS in Canada and its treatment.

There is much to learn about the prevention, diagnosis, and treatment of neurological conditions. A total of $255 million has been invested by the Canadian Institutes of Health Research into neuroscience research since 2010. In addition, the 2011 budget committed $100 million to establish the Canada brain research fund in partnership with Brain Canada. This fund will support the very best Canadian neuroscientists and help accelerate discoveries to improve the health and quality of the lives of Canadians with neurological conditions.

Thank you.

Mr. Parm Gill: Thank you.

I'd like to share the rest of my time with my colleague, Mr. Lobb, please.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you, Mr. Gill. That's very generous, if I might say.

Minister, you've been the minister now for four and a half years, and you've been through this main estimates process five times. What amazes me from the opposition—for the last five estimates, five years in a row, not only in this committee but also on my veterans affairs committee—is that they ask the very same question, every time, about main estimates. Then on supplemental estimates they ask the same question.

What can we do to help the opposition better understand the process of main estimates and supplemental estimates so that we can get beyond their questions and into more detail about the actual content of main estimates? Do you have any ideas on what we can do to help these people out?

● (1620)

Hon. Leona Aglukkaq: That's a challenge.

In terms of any new programming we have in the budgets, we're making a lot of great investments through Health Canada and the Public Health Agency of Canada. In terms of the process of developing main estimates and whatnot, the members have been here for a long time, and I think they know that process, so I won't go into it.

We are making a lot of good investments, and we do try to highlight the great investments being made, whether they be in technology or the increased transfers or prevention initiatives that we're doing in responding to research, and what have you. We'll continue to do our part to respond to the needs of Canadians through the main estimates process.

Thank you.

Mr. Ben Lobb: The other thing I'd like to add is with regard to a point that Ms. Outhwaite made and that I'd like to commend your department on, namely, the fact that you've been able to find savings inside your department and you've been able to find efficiencies while still maintaining and probably improving the services you provide to Canadians.

Business does this all the time. We're asking Canadians at home, and Canadians have taken it upon themselves, to find savings in their own household budgets. I'm impressed and happy that you've been able to do this. I think it's a healthy cycle to go through, to actually kick the tires and find improvements. So thank you for that.

Do I have any time left, Madam Chair?

The Chair: Actually, no—

Mr. Ben Lobb: Am I over my time?

Well, I just wanted to let you know that, because I think what you're doing is important.

The Chair: Thank you.

Dr. Morin.

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you very much.

All my questions are directed to the minister. Please keep your answers short and under one minute. Otherwise, I am going to interrupt you, and I don't want to do that.

Your ministry is participating in the road map for Canada's official languages. Although it was renewed this year, the financing has decreased by $16 million. Can you guarantee that the financing of the local organizations on the ground will not be affected?

Ms. Glenda Yeates: As was noted, the main estimates do not include the renewal of the official minority languages funding, but budget 2013, which came after these were put together, did announce that there would be a renewal. Health Canada, which has had a strong program of supporting official minority language communities, does have the same level of funding. We will be making announcements in the near future about how that will be supportive of official minority language communities, but it's the same level of funding.

Mr. Dany Morin: Okay. That is quite problematic, not in the fact that it's the same level of funding, but because you have missed the deadline for the next year and those local organizations on the ground will not have their money. Your ministry knew that the program ended at the end of March of this year, and because you did not renew it in time, those organizations on the ground will have to wait until January or February of next year. They will spend pretty much all year without any new funds to fund those minority language services. What do you have to say to that?

Ms. Glenda Yeates: We'll certainly be—

Oh, sorry, Minister.

Hon. Leona Aglukkaq: In terms of the budget cycles in the House of Commons, we can't change that. Budgets are announced and we go through the vote process and so on, so that's the process in itself. I encourage you to vote for the budget very quickly so that we can get the funding rolling.

But in the interim, I'll get Glenda to—

Ms. Glenda Yeates: Yes, and we will continue to work with our partner organizations and remount the program. As these sunsetting programs are reviewed periodically, go through an evaluation and a review, and are renewed, there is sometimes this process, but we'll work with the communities and the....

● (1625)

Mr. Dany Morin: Okay. I'm going to change topics, but I just want to say that you have known for a couple of years that this would end at the end of March of this year, so you cannot just pretend that you have to follow the normal cycles in the House of Commons. You knew before, and you could have prevented it and renewed it in time for those local organizations to have the money. They will not have the money for the next year, and that is unfortunate.

My next question is in regard to the sweeping changes proposed in the marijuana for medical purposes regulations. Through these new regulations, medical marijuana users will be forced to access medical marijuana through expensive commercial growers. Your own department has submitted that a new cost will be $8.80 per gram, up from its current rate of $1.80 per gram.

Many medical marijuana patients grow their own supplies or buy medical marijuana from the local compassion clubs because they are on a limited income due to their illness, or because they have a disability that prevents them from having a higher income. Why are medical marijuana patients being forced to buy their own supplies from expensive commercial growers? How are they expected to afford this medical treatment?

Hon. Leona Aglukkaq: Thank you.

I don't think many Canadians know that they're heavily subsidizing people who are on medical marijuana. Canadians do pay for the current program on behalf of the users. While the courts have said that there must be reasonable access, we also have heard a lot of concerns from law enforcement officials, the fire departments, and the mayors. This is why—

Mr. Dany Morin: I'm cutting you off. I have only a few seconds.

Hon. Leona Aglukkaq: —the changes are going forward. This is why we're going forward with the Gazette. It is because of the—

Mr. Dany Morin: Are you honestly telling us that the price will increase because you are appalled that taxpayers are paying for patients who have terminal cancer and the price right now is too low so you want to increase it and make it less affordable for those cancer patients to have their medical marijuana?

Hon. Leona Aglukkaq: That's not what I said at all. That's what you said.

Mr. Dany Morin: You started by saying you heard from taxpayers who were thinking that—

Hon. Leona Aglukkaq: Canadians pay right now over $15 million to subsidize medical marijuana for patients.

The Chair: Doctor, you're finished.

Hon. Leona Aglukkaq: That's a fact, so in terms of going forward to reform this program, there was widespread abuse and a lot of concerns from fire departments, police enforcement officers, neighbourhoods, mayors, and what not. We've been consulting for the last two years, and we are moving forward and making changes to reform the program to mitigate the abuse we see on our streets.

The revised changes will be that individuals will not be able to grow their own marijuana, and they will be able to purchase their marijuana from a warehouse. The dispensing of that product will be from the warehouse to the patient. But we are removing personal grow ops for marijuana because there is widespread criminal activity related to them.

Thank you, Madam Chair.

The Chair: Thank you, Minister.

That brings us to an end. We don't have time to go into anything else. We have only two minutes left, and I need to suspend to bring the officials on.

Minister, I'd like to thank you very much for coming. I think the questions and answers moved along very quickly, and we got the majority of questions and answers in for the time allotted. So thank you so much for coming out today.

Thank you, committee, for your insightful questions.

We will suspend for two minutes. The officials can come forward.

● (1625)

(Pause)

● (1630)

The Chair: Can we continue, please, committee? Thank you so much.

Just keep in mind that we have to have our votes, so at maybe 5:13 we will stop and thank our officials, and then we will go into the votes and get that done.

We're going to start again. I think we'll continue on from where we were.

Mr. Lizon, we're going to finish our five-minute round so I'll begin with you. You may begin now.

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

Welcome, everybody.

For my first question, I note there are consultations taking place with first responders, including firefighters, on the update of Canada's pandemic influenza plan.

Can you update us on how those are going?

Mrs. Krista Outhwaite: Thank you for the question. I'd be delighted to update you on this.

As you know, Canada has a pandemic preparedness plan for pandemics and influenza. Building on our experience from the H1N1 pandemic, we of course wanted to revise and update that plan in terms of lessons learned.

Among many stakeholders who have an interest in the pandemic plan, we also have first responders, including firefighters. We are commencing an eight-to-ten-week consultation process with all of our stakeholders. We're going to extend invitations to health professional associations and other organizations. We will also provide two complementary processes for emergency service workers including firefighters, as well as aboriginal populations, and we're also going to run a number of webinars. So there will be lots of opportunity for people to give input, particularly these emergency responders.

We know they take great interest in the pandemic plan. They were affected by it. They were a critical part of the last pandemic, and we're eager to hear from them.

We expect to conclude our consultations by the end of June this year. Then we'll move on with that input to revise the plan in concert with provinces and territories.

● (1635)

Mr. Wladyslaw Lizon: Thank you very much.

The next one will be more on the budget. In Canada we're experiencing the aging of the baby boomer generation. Of course, as a result, there will be pressure on the labour market of health care professionals.

My question is whether budget 2013 has any proposals for palliative and end-of-life care.

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

I think there is real and growing interest in the country on the issue of palliative care and end-of-life care. We recognize it as an area where many families, many communities and facilities, all face a sense of the challenge in doing this as best we can for Canadians.

Budget 2013 did make an announcement of funding for some research into how best to do end-of-life care, with $3 million over three years to the Pallium Foundation of Canada. This organization has a national scope, providing professional development and modules for family care providers—family physicians, for example, or nurse practitioners—and developing interdisciplinary palliative care training modules and education. They have already educated over 500 health professionals through a number of learning projects.

There are funds in this budget over the next three years for them to have continued support to increase this development. We see it as a key area, and one where we think the federal government can play a role, not in delivering the service but in helping to support the improvement by providing these resources.

Mr. Wladyslaw Lizon: Regarding current service providers, we can look at an example from Ontario. I know from my own experience, on the board of directors of a seniors residence, that a lot of services have been downloaded by the province, unfortunately to the regions. Therefore, there's a challenge there as well, so maybe in the new health accord, or in the budget....

There are no provisions in the budget, I suppose, for direct financial help to the providers of long-term care.

Ms. Glenda Yeates: As the minister mentioned, the Canada health transfer to the provinces is obviously the significant financial support for the delivery of health services. There is provision through Health Canada to try to support some of the areas where doing something once in the country makes some sense.

So we do some work on health human resources planning and—

The Chair: I'm sorry, Ms. Yeates. I hate to interrupt you, but would you be so kind as to watch the chair so that I can tell you when your time is up? And your time is up, I'm sorry.

We'll now go to Mr. Kellway.

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

To the officials, thank you for staying with us.

Congratulations to you, Mr. Roberge, on your happy news there.

I'd like to say how unfortunate it is that the minister only saw fit to spend an hour with the committee.

I would also say it's unfortunate, Madam Chair, that you let Mr. Lobb waste his time and our time trying to prove he's the smartest guy in the room, instead of making constructive use of the minister's time.

The Chair: Do you have a question, Mr. Kellway?

Mr. Matthew Kellway: I do, Madam Chair, and I'm using my time as I see fit. If you're going to start counselling members, you should have counselled Mr. Lobb on a losing gambit there.

The Chair: Would you like to ask a question, Mr. Kellway?

Mr. Matthew Kellway: Yes, I would, Madam Chair.

I'd like to pick up where Mr. Lizon left off, with the issue of long-term care, and particularly home care and palliative care. I note that we've all been aware for years and years, of course, of the demographic bubble and the aging population. It's no surprise to anybody that there are health care implications flowing from that. But all I see in budget 2013 to help with the issue of personal home care services is a GST/HST tax exemption.

I know you guys aren't the.... You're the policy people, and you're not there, but perhaps you could please explain what your understanding is of why we've adopted a policy that doesn't put more effort and funding into what are obvious needs and desires for Canadians in their health care system, the palliative care and long-term home care.

● (1640)

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

I'll try to keep my eye firmly on the chair, as I was instructed to. I apologize for sometimes missing the chair's signals.

I think there's a strong desire...and in fact we've seen in the data that there are actually strong increases in home care that the provinces and territories, as the direct deliverers of care, are providing across the country. But I think as the minister outlined, the fact that the federal government puts its increases in funding to the provinces and territories through the Canada health transfer allows them essentially to determine where their greatest areas of need are.

Some provinces are still working on their drug coverage. Other provinces have younger populations; others have older populations. But we do see in the country that most, I think, if not all of the provinces are making increasing investments in home care and long-term care.

Mr. Matthew Kellway: Where there are levers, though, for the federal government—and I look to, for example, EI compassionate care benefits and stuff like that—those could have been used at least to support what we all know is a legion of volunteer helpers, loved ones and friends, who help seniors who need home care services in this country. Why not pick up on something like that, for example?

Ms. Glenda Yeates: As I said, I know that is an HRSDC program, so they do have that program. But again, the health department's role here is largely to support some of the infrastructure needs, hence our support for some of the information or for Canada Health Infoway and the funding that allows provinces and territories to focus on the areas where they feel the needs are greater.

Mr. Matthew Kellway: As a last question, on this issue of blood for profit, can I very briefly read from the very first sentence of Justice Krever's report? He says it's his "account...of a public health disaster that was unprecedented in Canada and, if we have learned from it, one that will never occur again".

That disaster involved 20,000 lives lost and $5 billion in compensation. Yet I got news this morning regarding the construction of a third blood-for-profit shop being built in Ontario. I'm very concerned that this government is not doing something to stop the undermining of our current volunteer blood services system in this country.

Ms. Glenda Yeates: I appreciate the question. This is something that I think is of critical importance to Canadians. Canada has one of the safest—if not the safest, according to some sources—blood systems in the world. There has been no change in the government's policy on blood donations. Blood used for transfusion is collected only from volunteer donors in Canada.

The manufacturing of plasma products is not a new practice. In some cases, that is the situation that is currently being discussed in Canada.

The Chair: Thank you, Ms. Yeates.

We'll now go to Dr. Carrie.

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

I want to thank Ms. Yeates for clearing up the misinformation that's out there on blood products.

I want to take this opportunity as well to congratulate Mr. Roberge. I know about all the work you've done over the years, and your retirement is certainly well earned. Thank you very much for all the work you've done for Canadians.

I wanted to ask a question about SPOR, because at the end of the day, it's about the Canadian patient. I realize that Health Canada is taking a significant leadership role. In committee this week, we heard from somebody from Oshawa, Dr. Carolyn McGregor, who mentioned the work being done through the strategy for patient-oriented research, SPOR, and the benefit it provides to the Canadian health care system. I was wondering if you could discuss SPOR in budget 2013 and any proposed funding that is going to be allocated to SPOR, because we're hearing some great feedback on that.

● (1645)

Mr. James Roberge (Chief Financial Officer and Executive Vice-President, Resource Planning and Management Portfolio, Canadian Institutes of Health Research): Thank you very much for the question.

Yes, indeed, there is incremental funding again for SPOR. This is the third consecutive year. There's a total of $45 million cumulatively; $15 million from this budget. SPOR is a very overarching strategy with the view of trying to bring the fruits of research directly to benefit patients. A lot of the effort is dealing with bridging the gap between research findings and the impediments of putting them into use. That involves research into how to apply certain interventions effectively. It also involves research into whether certain treatments are effective or not, or cost effective. Research can contribute to that and directly benefit patients as a result.

Mr. Colin Carrie: We've heard over and over from witnesses in front of committee that it's also about best practices. Would you be able to give some examples to the committee about some of the research that is being done with SPOR right now and some of the projects that are already on the go or have been announced?

Mr. James Roberge: Thank you for the question.

One area we've been focusing on, in which research is starting to show quite dramatic results, is the efficacy of certain tests. Tests are widely used in this system. There's evidence that they're overused and that they're frequently not effective and are very costly. So understanding which tests are required and under what circumstances is extremely important. Personalized medicine, which is really about tailoring the application of medical interventions to the individual's particular circumstances—their genetics as an example—again is a way of making sure that the interventions are targeted, effective, and not wasteful.

Mr. Colin Carrie: Are we finding any instances where we're doing research on multidisciplinary types of clinics? How is that working? We have heard from the more remote rural communities and first nation communities that sometimes there's difficulty with human health resources and getting people to go to these areas to serve the public. Do we have some examples of multidisciplinary research projects?

Mr. James Roberge: Science is converging in many ways. The disciplines are working together more and more. As an example, we see it through the work we do with the Natural Sciences and Engineering Research Council in bringing engineers and medical researchers together to develop more effective medical devices. As an example, these could be prostheses for people who have had limbs amputated.

It's that kind of convergence, where the disciplines work together, that really can benefit in ways that siloed researchers cannot. Much of our work on SPOR, for example, is about putting networks of people together, and they're often people who have not worked closely together previously because they were from different disciplines.

Mr. Colin Carrie: Is there an uptake from the provinces in regard to the information that the federal government is finding out through these different projects? How do the provinces and territories partner with the federal government on these? Is there a partnership there? Or do they just take a look, see what we've done, and decide what they'd like to utilize or not utilize?

Mr. James Roberge: Again, thank you very much for the question.

SPOR was constructed on a premise that we would cost-share 50-50 with our partners. No SPOR expenditures will occur unless matching funding is available. For example, on the support units, the national set of research centres being established across the country, the provinces are coming forward and they are paying their 50%.

Thank you.

The Chair: Thank you very much.

We'll now go to Mr. Wilks for five minutes.

Mr. David Wilks: I'd like to carry on with what Dr. Morin was speaking to with regard to the medical marijuana. My expertise and background are as a retired member of the RCMP, and I did a number of years of drug work. I applaud the ministry for the initiatives they've taken on revamping the regulations with regard to the medical marijuana initiative.

I do believe that everyone in this room would concur that for some cases medical marijuana has been found to be a very good source of pain relief, as well as other opportunities that are available, but there was rampant abuse in the old system. I wonder if you could provide to this committee some of the improvements in the new regulations that will better satisfy not only those who will be able to have marijuana for medicinal use but also those who were concerned about its rampant abuse.

● (1650)

Ms. Glenda Yeates: Thank you very much.

I'm very pleased, Madam Chair, to respond to this question.

As the committee has reflected in the past, or discussed in the past, the courts have been clear that what we need to maintain in the country is reasonable access to marijuana for medical purposes, but there have been challenges with the way the system has been structured.

The go-forward plan is to treat marijuana as much as possible like other narcotics that are used for medical purposes. We want to create the conditions for a new industry that would be responsible for its production and distribution, where the quality is controlled.

Therefore, under that system, Health Canada would no longer receive applications from program participants, but rather, a new supply and distribution system based on licensed producers, who would be audited and inspected by Health Canada, would be established. The production of marijuana in homes and in communities would be phased out, so as I said, it would treat this medication, which is very helpful when used for medical purposes for some individuals, as was noted, more like other substances—controlled through licensed producers, and as prescribed by medical practitioners, shipped to patients directly.

Mr. David Wilks: Further to that, Madam Chair, one of the concerns I've heard from patients is that the THC levels, or tetrahydrocannabinol levels, will be vastly changed so that they will not receive the THC level they are expecting, and different strains will provide different medicinal properties to them.

I wonder if you could speak to that a bit from the perspective that the new program will potentially regulate the types of strains that will be available to patients.

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

We are doing the consulting now. We are in the phase of putting out the proposals and getting the feedback.

One thing we have done is to put out information to potential licensed producers. We are in dialogue with them, asking them to think about what the seed strains might be. A variety of strains might then be available, for example, and some people might find more pain relief from certain strains than others.

Again, in a more highly regulated, regularized environment, we would be able to have several strains that licensed producers would develop. At this stage, that's still in development, as we are in the transition mode.

Mr. David Wilks: I suspect, and do concur, that removing this from the dwelling-house and outdoor grows to a viable commercial facility will also assist those who are in the market of growing medicinal marijuana in their ability to provide a reasonable product at a reasonable price. Is that correct?

The Chair: Please give a very short answer.

Ms. Glenda Yeates: Yes, our assumption is that for licensed producers, it may well be a very competitive market. We'll audit for quality, and our assumption is that they will work hard to provide the best possible price.

The Chair: Thank you very much.

Dr. Fry.

Hon. Hedy Fry: Thank you very much, Madam Chair.

Thank you again for staying.

I have a few questions I'd like to ask. One of them is about CIHR.

As you know, CIHR has had a 30% reduction in its scholarships. That seems not to be actually in keeping with the government's agenda, which is to help train highly skilled workers, especially in certain biomedical and other technologies. I wondered how that would affect it.

There's also another part about CIHR I wanted to ask. As you know, CIHR is transferring $510,000 to commercialization efforts. Is that coming out of the reduced budget—as we know, the budget's reduced by about $45 million—or is that new money that is going to be given CIHR to do that?

Those are the two questions, Mr. Roberge: scholarships and the money for commercialization.

● (1655)

Mr. James Roberge: Thank you very much for the questions.

With respect to the scholarships, there is no change in the levels of scholarships being provided, so I'm not aware of the percentage reduction you're referring to. Our existing programs, the Vanier, the Banting, the Canada graduate scholarship programs, are all functioning at their steady-state levels. There is no change in those programs.

With respect to the additional money, the $500,000, comparing these main estimates to the previous main estimates, it's about a $43-million envelope, so it's a relatively small variation. Once again, this is not incremental funding as a result of budget 2013. That money is aimed at SPOR, so it's not impacting that particular line object in the budget. It would be smaller adjustments, which I really can't explain here and now but would be happy to provide additional detail on.

Hon. Hedy Fry: Thank you.

I notice that contributions went down in terms of the infrastructure for first nations and Inuit by about $93 million. This is a community that has had third world health statistics that are not getting any better. How will that reduction address the need to deal with high suicide rates, high obesity, high diabetes, and an explosion 185 times the non-aboriginal rates of TB in Canada? As you know, it's no longer ordinary TB. It's drug-resistant TB that we might be seeing here soon.

How will that deal with those major problems that are coming up?

Ms. Glenda Yeates: Thank you very much for the question, Madam Chair. I'm happy to answer it.

Because we're comparing all-year funding with supplementary estimates (A), (B), and (C) in the previous year to the main estimates in this year, the funding looks very significant, as was noted, but I can certainly flag for the members the reasons for that.

The first is that the innovation fund that we spoke of—the infrastructure on telehealth and on accreditation, which was noted—has been renewed and has been announced in the budget, so you as a committee will see that come forward in the supplementary estimates. That was an infrastructure program so it is not reflected in the main estimates, but it will come before your committee.

Another significant area was that we provided upfront money to the First Nations Health Authority. Obviously, there's a huge undertaking to do this very important transfer that we're doing in British Columbia, so there was one-time money provided to the First Nations Health Authority for readiness. What we will see in 2013-14 will be the transfer of the whole of the money. That's just one of the things that come out of the fund.

There was a coding change, I was told, and there is some reduction in non-service delivery organizations, which I think we spoke about last time before the committee. So there was the elimination of funding to NAHO, for example. We had some funds that were for front-line delivery, which we've protected, but some of those non-service delivery reductions occurred here as well.

Hon. Hedy Fry: Ms. Yeates, will the new money that goes into the budget be the equivalent of the $93 million that's been cut?

Ms. Glenda Yeates: The combination of those four items I mentioned is the difference in total.

Hon. Hedy Fry: Okay, thanks.

I noticed that in your estimates the Business-Led Networks of Centres of Excellence are being cut by an extraordinary amount. What's going to replace those?

Ms. Glenda Yeates: I'm sorry, Madam Chair, I missed the title.

A voice: It's for the CIHR.

Ms. Glenda Yeates: Thank you.

Mr. James Roberge: Thank you for the question.

This program is a tri-council program, so it's administered by the three granting councils. A national competition is run. The results of that competition determine the relative share of each council. The competition is yet to be run. The money is in the fiscal framework and is available. Once the results are known, and if health researchers are as competitive as they always are, we would expect to again have comparable funding. But, again, we don't know the results of that yet. It's not a cut.

● (1700)

The Chair: Thank you, Dr. Roberge.

Thank you, Dr. Fry.

We'll now go to Dr. Sellah.

[*Translation*]

Mrs. Djaouida Sellah: Thank you, Madam Chair.

I want to thank the minister's assistants for staying with us.

I would also like to wish Mr. Roberge a happy retirement.

In the report on plans and priorities, under the priority titled "Promote Health System Innovation", the following is stated:

> Work with provinces, territories and other health care partners on health system renewal, innovation and sustainability.

Does this mean that Health Canada will participate in the Council of the Federation's working group?

If so, could you tell us more about that?

Ms. Glenda Yeates: Thank you, Madam Chair.

Working with the provinces and territories is among our objectives. However, the issues we deal with can change. For instance, a few years ago, we focused on the waiting list issue. We talked about health human resources. For the time being,

[*English*]

the Council of the Federation is a council of the premiers of the provinces, and at this time the federal government has not been invited to that particular group of discussions.

[*Translation*]

Mrs. Djaouida Sellah: Okay.

Madam Chair, do I have any time left?

[*English*]

The Chair: Yes.

[*Translation*]

Mrs. Djaouida Sellah: This week, in the House, the minister answered questions on incorrect chemotherapy doses.

Could you please give us additional information on the next steps, from a more technical perspective?

Madam Chair, just so you know, I will share my time with my colleague Matthew Kellway.

[*English*]

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

I understand the question to be about the chemotherapy situation currently in Ontario. Is that correct?

Mrs. Djaouida Sellah: Yes.

Ms. Glenda Yeates: It's obviously a very important issue. I think we have all been working very closely together with the Province of Ontario, with provincial officials, and with the Ontario College of Pharmacists to address the situation.

We understand there's a situation in which compounds that were—or in some cases still are—mixed in the hospital pharmacy for chemotherapy have, in the case of these particular hospitals, moved outside the hospital through a contract to an outside company. We are working very closely with Ontario to understand what is happening and to assure ourselves, and obviously Ontario, that we are providing whatever assistance we can to them to make sure there is proper oversight of this situation.

It is a changing and evolving one, as we are learning. That's why we are working closely with our partners in Ontario. We will obviously want to work across the country as well.

The Chair: Thank you.

Mr. Kellway.

Mr. Matthew Kellway: Thank you.

Ms. Yeates, we left off with you saying there'd be no change in the department's policy with respect to the blood scheme. But something has changed in the context, which is a $6 million private sector investment in this blood-for-profit scheme, which is, frankly, both predatory and exploitive. These shops are being set up cheek by jowl with homeless shelters and methadone clinics.

Can you tell me what the department is going to do about it, or if that's unclear at this point in time, at least what options you're assessing?

Ms. Glenda Yeates: Thank you again for the opportunity to continue the dialogue on this very important question.

As I said, there's no change. Blood used for transfusion by both the Canadian Blood Services and Héma-Québec is collected only from volunteer donors. Plasma is also collected from donors and used in the manufacturing of pharmaceutical products, blood products that are very necessary, and there is an increasing demand for those products.

Historically, in Canada, 70% of those products have, in fact, been sourced from compensated plasma donors. Many of them come from the U.S., because Canada is, in fact, not self-sufficient. But also in Canada...there is one long-standing instance in Manitoba. There's a Canadian company that has, in fact, manufactured a plasma product for compensation.

● (1705)

Mr. Matthew Kellway: You don't see a change here, in that you're not proposing to deal with the issue?

Ms. Glenda Yeates: If I might continue, Madam Chair, I should be clear here about the role. Health Canada is very concerned about the strict screening and the safety, because we are the regulator. We are very concerned about the safety of these products. That is our role, to make sure nothing in any process or any part of the process will affect the safety of the products.

Provincial and territorial governments have the authority to deal with the question of compensation, whether it is for blood, cells, tissues, or organs. We know that some jurisdictions, notably Quebec, have made a provision that they are not compensating for any of these. Other provinces—and I mentioned that this is a long-standing practice in at least one jurisdiction in Canada. This is, therefore, something we are in dialogue, again, with our provincial and territorial colleagues about, as the payment question is one in their jurisdiction.

The Canadian Blood Services and Héma-Québec are also involved. Obviously, patients who rely on these products.... We held an initial consultation with groups that are very reliant on some of these specialist products. But as I say, currently 70% of them are sourced from plasma from paid donors, so this group of people also has a voice and an interest in this topic.

We are working with our provincial and territorial colleagues. We have the safety mandate; they have the payment question.

The Chair: I'm sorry, Mr. Kellway, you've already had a little extra time. Thank you so much.

Thank you, Ms. Yeates, for your answer.

Mr. Gill, I understand you and I are sharing a question. So you begin and just leave off when you finish, if there is time. How's that?

Mr. Parm Gill: I have two quick questions, Madam Chair, and then I'll pass the time on to you.

A few months ago, the committee heard about the importance of genomic research and the possibilities it presents for the future of health care. Does budget 2013 have any proposed funding to support this emerging technology?

Ms. Glenda Yeates: I'll start with the answer, Madam Chair, and it may be that my colleague from CIHR will continue.

There is an announcement in budget 2013—I'm just looking for my notes on this—of a renewal of funding for Genome Canada. That is an organization outside the Health portfolio but obviously one of interest to us, with our science interest and our health interest.

The budget did in fact announce the renewal of funding for a Canadian research capacity in genomics.

Mr. Parm Gill: Thank you.

My second question is regarding medical isotopes, which are very helpful in the detection and treatment of some cancers. Unfortunately, in recent years the global community has experienced shortages.

Does budget 2013 have any proposed funds to ensure a secure supply of these medical isotopes?

Ms. Glenda Yeates: I think there has been really heightened awareness of the importance of these substances in our health system as a result of recent years. Budget 2013 does provide $141 million over two years to secure a supply of medical isotopes, and maintain safe and reliable operations at Atomic Energy of Canada Limited's Chalk River Laboratories. That, as you know, has been one of the....

As there's a shift and a change happening here, the budget does provide funding for that lab at Chalk River.

● (1710)

Mr. Parm Gill: Thank you.

You can take over, Madam Chair.

The Chair: Thank you, Mr. Gill.

The clerk is going to keep me on time, so I'll be within my time as well. Thank you for the opportunity.

Ms. Yeates and officials, according to the 2013-14 report on plans and priorities, Health Canada will be investing in e-health tools for first nation and for Inuit communities. Can you tell me how these investments will result in cost savings in terms of medical travel? Medical travel seems to be a huge issue. It comes up here at committee every time we have people who are in rural areas.

Second, will these investments in e-health tools be used on such innovations as Rosie the robot, as used in Nain, Labrador? That has been a very successful initiative. We feel we know Rosie personally.

Can you please answer those two things?

Ms. Glenda Yeates: Thank you, Madam Chair, for the questions.

In terms of cost savings, we have made significant investments in e-health, and we have seen that it can reduce travel in two ways. First, and perhaps most importantly, for patients, if we can connect them to health providers through telehealth, it may avoid a trip that may have been an overnight and certainly very disruptive for patients, but also very costly. We've looked at that in Manitoba, where we've made significant investments and we've done a bit of a study. There was also an external study done in northern Ontario, and there were significant savings.

There's a second way in which there are savings. Nurses, our staff in the communities, also need to keep their skills up. They want professional development and training. We can provide much more of that professional education and training to our staff through telehealth as well. So there are also savings in that important respect for our nurses.

With regard to Rosie the robot, I will say that the plans for this time are in fact to concentrate on things that perhaps are not quite as well known to the committee as Rosie, things that are in fact a bit less flashy, perhaps I can say. These are things like connectivity. We're looking to connect the next number of 35 new communities and provide them with clinical telehealth services. We're looking to increase the bandwidth in over 120 communities. We're looking to increase the use of mobile health technologies.

So there is this very interesting pilot with the robot, but that is at this point not planned for replication. It is a costly thing, and we have communities saying they need some of these very basic connected pieces.

The Chair: Thank you very much.

I've finished my questions and we have a little bit of time.

Dr. Fry, I was going to suspend at 5:15, but for your benefit, you could ask one question that's near and dear to your heart, and then we'll suspend.

Hon. Hedy Fry: Thank you very much, Madam Chair.

There is something that I want to ask you about. The Patented Medicine Prices Review Board is having a cut of about 7.5%.

It would seem to me to be logical that they should get an increase, because they certainly need more resources to deal with the fact that the Auditor General has repeatedly said that the whole issue of adverse drug reporting is not timely and that more resources need to be added to it. I just want some sort of explanation as to why there's a cut in such an important area.

Thank you.

Ms. Glenda Yeates: Thank you again for question.

Madam Chair, I certainly would agree that the Patented Medicine Prices Review Board is a very critical and important institution. I would characterize the reduction in two ways.

One is that there are some administrative savings that they have found and that I think they feel they can manage with no impact, certainly, on their services.

They also were able to reduce funding they had set aside for hearings. Hearings are quite costly in their case, and again, there can be a number of years in which they hold a number of hearings. Their budget is increased to consolidate that. They've found that in recent years they simply weren't spending this money because they didn't need it. The hearings weren't required. They have indicated to us that they feel there will be no impact on their ability to fulfill their functions, because at current levels they were not needing those funds.

Thank you.

● (1715)

The Chair: Thank you, Dr. Fry.

Now I'm going to thank our guests for coming and giving us their very insightful and knowledgeable comments.

Mr. Roberge, we would have brought a cake had we known that you were going to retire. We're very happy for you and wish you well. We have retirement envy all across the way here.

We'll suspend for one minute, and only one minute, because we have to go into votes and some people are catching planes.

Thank you.

● (1715)

(Pause)

● (1715)

The Chair: I would like to have the committee resume, please. Could you please take your seats?

I'm just trying to be considerate of the people who have to catch airplanes shortly after this meeting. Their schedule is very tight to get back to their ridings, so I want to be mindful about that.

We have to do the votes. I must have unanimous consent so that I can call all the votes together. Do I have unanimous consent to do that rather than going through them one by one?

Some hon. members: Agreed.

[*Translation*]

Mrs. Djaouida Sellah: Yes, Madam Chair.

[*English*]

The Chair: Okay. I do have unanimous consent, so let's go right into it.

Shall votes 1, 5, 10, 15, 20, 35, 40, 45, 50, and 55 under Health carry?

HEALTH

Department

Vote 1—Operating expenditures.....$1,716,556,576

Vote 5—Capital expenditures.....$28,640,700

Vote 10—Grants and contributions.....$1,420,761,830

Canadian Institutes of Health Research

Vote 15—Operating expenditures.....$46,367,765

Vote 20—Grants.....$915,350,465

Hazardous Materials Information Review Commission

Vote 35—Program expenditures.....$3,243,543

Patented Medicine Prices Review Board

Vote 40—Program expenditures.....$9,918,440

Public Health Agency of Canada

Vote 45—Operating expenditures.....$329,555,178

Vote 50—Capital expenditures.....$7,217,054

Vote 55—Grants and contributions.....$210,343,452

The Chair: Do you want a recorded vote?

[*Translation*]

Mrs. Djaouida Sellah: Yes, Madam Chair.

[*English*]

The Chair: We will have a recorded vote.

(Votes 1, 5, 10, 15, 20, 35, 40, 45, 50, and 55 agreed to: yeas 6; nays 5)

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

Some hon. members: Agreed.

The Chair: I will do that, and I will do it on Monday.

For those of you travelling back to your constituency, I wish you a good weekend. For those of you on House duty tomorrow, enjoy.

The committee is dismissed. The meeting is adjourned.