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## Monday, November 25, 2013

Chair

Mr. Ben Lobb

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● (1530)

[*English*]

**The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)):** Good afternoon, ladies and gentlemen. Welcome to our health committee, meeting number six.

This afternoon we are honoured to have the Minister of Health here, Minister Ambrose. She's agreed to be here for an hour to go over the supplementary estimates. She has some of her colleagues from the department here as well.

Minister, you have some opening comments, and then you know the routine as far as questions and answers go. After the minister is done, we'll suspend for two minutes, and then we'll continue with our questions and answers from other people within the department. The last ten minutes we'll allocate to voting on the estimates.

Thanks, everybody, for being here. And thank you to the clerk for arranging to pull a few strings to get this large meeting room, so we can fit everybody in.

Without any further ado, Minister Ambrose, it's your time.

**Hon. Rona Ambrose (Minister of Health):** Thank you, Mr. Chair and members of the committee. Thank you for the invitation to discuss supplementary estimates (B) for the health portfolio.

I'd also like to congratulate you, Mr. Chair. I know you have taken over this position recently. Thank you for that. I wanted to say a big thank you to Joy Smith, who I know chaired this committee with great success for quite a long time. I know you'll be working hard to build on her strong record.

I have with me some members of a couple of departments. Of course, we have the deputy minister of Health Canada, George Da Pont; our associate deputy minister from the Public Health Agency of Canada, Krista Outhwaite; and Dr. Bruce Archibald from the Canadian Food Inspection Agency. Thérèse Roy is here as well, the CFO from the Canadian Institutes of Health Research, on behalf of Dr. Alain Beaudet.

I've also brought with me today, for interest's sake, something we just announced recently. I'll allow the clerk to pass it out. It's our new healthy and safe food for Canadians framework. This is the culmination of a lot of work, bringing CFIA under the health portfolio, as you know.

I understand also that the committee is undertaking a very important study on the growing problem of prescription drug abuse. I'd like to thank you for this work and say to you that after the meetings I've had with provinces and territories, this is not only an emerging issue, I think it's a pressing issue. I very much look forward to reviewing the report.

Do you need me to say I'm tabling this?

**The Chair:** That'll be fine. The clerk will get it and distribute it.

**Hon. Rona Ambrose:** As you know, members, in the recent Speech from the Throne, our government committed to expanding the national anti-drug strategy to address this very issue of prescription drug abuse. And I know that your work here at committee will provide much needed information on this important topic.

[*Translation*]

This is my first appearance before the committee as Minister of Health, so I would like to take a few moments to discuss how I will be approaching my role in general, before getting into some priority areas.

[*English*]

As evidenced in budget 2013 and also reiterated in the recent Speech from the Throne, health is a key priority for the government. In my opinion, one of the keys to success is finding new and better ways of working together. I can assure the committee that fostering partnerships and building relationships with the provinces and territories, with medical associations and health professionals, will be fundamental tenets of my time as health minister. This is noteworthy because we know there is nothing more important than good health.

Federally, we play a vital role when it comes to promoting healthy living, preventing chronic diseases, protecting Canadians from harm, innovating through research, and providing leadership on national health issues. But of course we can't do any of this alone. We all have a role to play when it comes to improving the health of Canadians.

A key achievement of our government has been to increase health transfers to the provinces and territories to unprecedented levels. Our record funding will reach $40 billion by the end of the decade, providing stability and predictability to the system. These transfer dollars support the provinces and territories in addressing the health concerns of their residents and allow all jurisdictions to focus on innovative solutions to their health care needs. As the new federal health minister, I take that responsibility very seriously, and I'm committed to each aspect of the portfolio. However, today I'd like an opportunity to highlight four key areas of interest before getting into the details of the portfolio's supplementary estimates. These include addressing family violence, fostering innovation in health care, working with partners on healthy living and injury prevention, and providing Canadians with healthy and safe food.

As I have in the past, I will continue to shine a spotlight on family violence, an important issue, and encourage Canadians to be part of the solution. Family violence, as you know, can wreak physical and emotional havoc on individuals, families, and communities. Violence in any form reverberates across our society, and of course across the economy as well. According to Justice Canada, spousal violence alone costs society at least $7.4 billion annually. Of that, approximately $6 billion was spent on medical treatment and psychological services alone.

● (1535)

[*Translation*]

From my perspective, family violence is a health matter—just as much as a criminal one.

[*English*]

To help address it, as you know, we have the federal family violence initiative that connects the work of 15 federal departments and agencies. The Public Health Agency of Canada is leading this work to make sure this initiative is focused on priorities that make a difference to Canadians.

Another focal point I'd like to touch on centres around innovation, technology, and research, all of which are obviously linked. At the federal-provincial-territorial health ministers meeting in early October in Toronto, I was very encouraged to hear from my colleagues that they've expressed their desire to make health care innovation our top priority in working together. It was also obviously well received at the annual meeting of the Canadian Medical Association as a priority for physicians. Federally, our government supports research and innovation through a range of initiatives. Most notably, of course, is the fact that we are the single largest investor in Canadian health innovation.

On any given day, thousands of federally funded research projects are under way involving more than 13,000 Canadian researchers. These researchers are developing cutting-edge technologies designed to help improve our health care system. We will continue to invest in research and innovation so that together with the provinces and territories we can continue to improve the quality, accessibility, and sustainability of our system so that it's there for Canadians when and where they need it.

On another note, ensuring that Canadian children and youth get the healthiest start in life is a key priority for our government. One in three children in Canada right now are overweight or obese. On average, only 12% of Canadian children take part in enough physical activity on a daily basis. These are truly alarming statistics. In the recent Speech from the Throne, our government committed to working with our provincial and territorial counterparts, as well as the private and not-for-profit sector, to support Canadian children and youth in leading healthy active lifestyles.

[*Translation*]

Awareness and momentum are growing. We are seeing strong leadership across the country to work towards the common objective.

[*English*]

Through the Public Health Agency of Canada, we are now mobilizing with groups like Canadian Tire, Right to Play, Maple Leaf Sports and Entertainment, Air Miles, and the YMCA. By leveraging our resources and theirs and ideas across sectors, we're laying a foundation for sustainable change.

Another area of interest and focus that I have, and the department is working on, revolves around injury prevention, a topic of such importance that it was also specifically highlighted in the recent Speech from the Throne. Unfortunately, preventable injury is the leading cause of death for Canadians aged 1 to 44 years. Often considered accidents, preventable injuries are far more common than people think, and of course all are most often predictable and most often preventable. Preventable injury is also a concern from a health equity perspective.

An injury can happen to anyone at any time, but children, youth, seniors, aboriginal people, and those of low socio-economic status carry a higher burden of injury than other Canadians. By working together and leveraging our resources, we can reduce the number of preventable injuries in this country and make a real, tangible difference in the lives of Canadians. Going forward, we will continue to build on new partnerships, raise awareness about injury prevention, and give Canadians the tools they need to live safer, healthier lives.

I also want to touch upon the issue of healthy and safe food for Canadians and why this is such a focus for our government. As committee members know, Canadians are fortunate to have a world-class food safety system. But that said, we must always be looking for ways to improve it.

Earlier this fall our government moved the Canadian Food Inspection Agency into the broader health portfolio. This decision takes the three federal authorities responsible for food safety—the CFIA, the Public Health Agency of Canada, and Health Canada—and places them under one umbrella. We did this because food safety is not only a top priority for our government, but we do feel that by better connecting these three entities, we are improving the way we manage food safety, as well as regulating, sharing information, and communicating with Canadians about food safety.

One of the accomplishments stemming from that reorganization was the recent release of the document I just shared with you: the healthy and safe foods for Canadians framework. This framework outlines the portfolio's work on food safety as it pertains to three key pillars: promotion, prevention, and protection. With this in place, Canadians can have greater confidence in the food they buy and eat.

We're also improving food recall warnings by making important information easier to understand and more accessible by tapping into such things as social media. Whether it's Facebook, Twitter, or other tools, we are also trying to provide Canadians with essential, easy to understand information whenever and wherever they need it.

Now, under the healthy and safe foods for Canadians framework, we have all the researchers, inspectors, scientists, and public health officers working together with a common goal.

As outlined in the recent Speech from the Throne, we will continue and we are committed to strengthening Canada's food inspection regimes and ensuring that our food safety and recall system remains one of the best in the world.

As l've mentioned, with respect to this appearance, the agency is seeking an additional $39.9 million to further enhance its ability to maintain increased frequency of food inspections in meat processing establishments, improve online service delivery, and fund inspection verification teams.

To conclude, Mr. Chair, l'm proud of the vital role our government plays in health care in this country.

As Minister of Health, l'm committed to investing in health promotion by working with provinces, territories, and other partners, of course, on delivery of high-quality, cost-effective health care, by promoting innovation and health research, and by providing federal leadership on the areas that matter a great deal to Canadians.

Once again, thank you for inviting me to speak with you today.

My officials and I are pleased to take any questions you may have.

Thank you.

● (1540)

**The Chair:** Thank you very much, Minister.

As you well know, we'll do our best to do our two rounds today.

On the first round, there are four MPs for seven minutes; the rest are for five minutes.

I would just like to remind my colleagues that usually in committee we're a little bit loose for time as far as the length of questioning goes, but seeing that the minister is here today, we're going to keep it as close as we can to seven minutes. If I have to cut you off, I apologize in advance.

The first round is seven minutes.

Ms. Davies, go ahead.

**Ms. Libby Davies (Vancouver East, NDP):** Thank you very much, Chairperson. Maybe you could give me a heads up when I have about three minutes left.

First of all, thank you, Minister Ambrose, for appearing before the committee today, your first appearance as health minister. Welcome. It's a pleasure to see you.

I listened very carefully to your presentation and noted that an issue you actually didn't address, which I think is a very serious concern for Canadians, is the question of drug safety. In actual fact, Health Canada doesn't have the power to recall prescription medications. To us, that's another example on a long list of drug safety issues that have plagued your department for years. You're obviously a newcomer to it, but this is definitely not a new issue.

We've had numerous Health Canada warnings about safety and effectiveness for birth control, antibiotic, and blood pressure medications, but the concern is that there isn't actually a recall provision that exists. In addition, Health Canada doesn't follow up on adverse drug reaction reports, even when they're filed by family members when people feel that someone has died or have had a terrible reaction to a drug. There's been a lot of coverage about this issue. Some of the media have done extensive research on it, and it certainly does seem to be a major shortcoming.

My question, therefore, is when will Health Canada upgrade its drug safety protocols to ensure that medications Canadians are taking are safe, and that unsafe medications can be removed from the market immediately?

I do have one other question for you as well.

**Hon. Rona Ambrose:** I will try to be quick then.

I appreciate that, and I understand the concerns that Canadian families have experienced over adverse drug reactions. Of course, you probably know one of our members of Parliament is here, elected for that very reason, and we work closely with him on this issue.

We introduced in our Speech from the Throne a commitment to moving forward with patient safety legislation. I can't get into the details of the legislation, but I want to reassure you that we are working closely with multiple stakeholders, including patient safety advocates, to ensure that we do get this right. We'll have a chance as well for that legislation to come before committee.

I have also recently asked Health Canada to begin to publish more transparently their drug reviews. I think that's important information that regular Canadians should have access to. Some of it is difficult to understand, but I don't think that should be a reason to not make it available to Canadians, and of course to researchers and physicians who would like to have that level of information. I hope to see a template from Health Canada soon on what that would look like, so we can ensure that we do publish that data more transparently when it comes to drug reviews. Of course, when it comes to adverse drug reactions, that's something we also hope to address in the patient safety legislation.

● (1545)

**Ms. Libby Davies:** We certainly look forward to seeing that information, because there's no question that when you analyze this issue, we're lagging far behind the drug safety measures in, for example, the U.S. and Europe.

I'd now like to ask you a second question concerning your recent decision to intervene and, in effect, ignore the experts in your own department who had given approval under the special access program for the SALOME trial in Vancouver. One of the things that really bothered me about this is that both you as minister and your office publicly said on a number of occasions that the SAP is for rare diseases or terminal illnesses. According to your own website, "... practitioners treating patients with serious or life-threatening conditions when conventional therapies have failed, are unsuitable, or unavailable." Now, that's clearly within the realm of what the SALOME trial was about.

It was also very disturbing that you repeatedly referred to illicit drugs, when in actual fact, diacetylmorphine is actually a clinically produced medication. I'm aware that Health Canada, before coming to its decision under SAP, sought the advice of Michael Lester, an independent expert who has specialized in opiate dependence treatment for nearly 20 years. In fact, in a recent report in 2013 that he did for Health Canada, he called prescription heroin "a promising treatment of last resort" for this population, noting that there is no other next step for people who have failed multiple treatment attempts with methadone.

It is all very disturbing that this intervention was made at a political level, particularly in light of the information I've given you. So I guess my question is, why have you allowed politics to trump evidence-based medicine when the process was in place? Clearly, a decision was made based on expert evaluation, and as a result, because of your political intervention, I would say that people's lives are at risk and a very vulnerable population is left hanging out there with basically a political decision made by yourself. Maybe you can answer for that.

**Hon. Rona Ambrose:** First of all, in regard to the SALOME trial, these requests under the SAP are not, as you know, the SALOME trial. The SALOME trial is separate. That research is ongoing and was actually approved by our government.

In terms of the physicians who made this request, you should know that in the past when a request like this was made, it was denied. Under the special access program, as you know, Health Canada can approve emergency access to certain medicines for Canadians with rare diseases or terminal illnesses. The intent of that program was not—

**Ms. Libby Davies:** That's actually not the case. It's life-threatening conditions.

**Hon. Rona Ambrose:** I appreciate that. I know you quoted one person with 20 years' experience in the addictions world. I'll quote another.

**Ms. Libby Davies:** That's from your website, actually.

**Hon. Rona Ambrose:** I've read it.

I'll also quote another addiction specialist, who's been researching in this field for 20 years, who says, "Heroin treatment is unsafe and... does not address the treatment needs...."

For this very small, vulnerable group of people I support treatment, I support intervention, and I support recovery programs. We know that these kinds of addictive drugs are very dangerous. I believe that drug treatment should be focused on ending drug use, not on maintaining drug use, and supporting these people to recover and lead a drug-free life.

As well, you also know, as do many physicians, that there are safe alternatives available to giving heroin to someone who's addicted to heroin. If I had a request to give cocaine to someone addicted to cocaine through the special access program, or LSD.... I could go through the whole list—that is the list of substances that we have now disallowed under the special access program. But I can tell you, as far as I know, we've never received any requests for that. In the past, any request for this substance was denied.

**The Chair:** Thank you.

Thank you, Ms. Davies, for your questions.

For the next seven minutes, Ms. Adams, go ahead.

**Ms. Eve Adams (Mississauga—Brampton South, CPC):** Thank you.

Thank you very much, Minister, for joining us here today to review the supplementary estimates with our committee.

As you kindly noted, our committee is currently undertaking a study of prescription drug abuse. In the last few weeks, we've heard quite a bit of testimony about the scope of this problem and some of the challenges that lie ahead in addressing this very serious issue.

Our Conservative government has a very strong, proven track record when it comes to illicit drug use, addressing that through our national anti-drug strategy. I'm hoping that through the study we'll be able to look at some promising strategies on how we can best address prescription drug abuse.

Would you be kind enough to comment on what our government has done to date as it relates to prescription drug abuse and where you think the future lies in addressing this issue?

● (1550)

**Hon. Rona Ambrose:** Thank you very much for the question. I'm very encouraged that the committee is engaged on this issue, because I think it is a very serious one.

As you've probably seen from some of the statistics, Canada is now, I think, number two in the world in prescription drug abuse. While a lot of the work lies at the provincial level, we're working cooperatively with the provinces and territories on what we can do together to address this problem. We have levers, obviously, at the federal level as well.

The abuse of certain prescription drugs I think represents a very serious health and safety issue in Canada, and one that we committed to addressing, as you know, in the Speech from the Throne. I, myself, and probably many people in this room, have seen and heard the heartbreaking stories of people who have become addicted to prescription drugs, starting with a prescription they needed for back pain, and it has literally ruined their lives. Unfortunately, we haven't had enough focus on this area, given its seriousness. I know it's a growing problem, and we are working very diligently with the provinces and territories to address it.

We do have to cooperate with them, obviously. We've committed in the Speech from the Throne to expanding our national anti-drug strategy to include prescription drug abuse, and not just illicit drug abuse, which I think is important. This action will help build on the work we've already done to tighten such things as licensing rules around drugs such as OxyContin to prevent their being illegally distributed. These include tightened controls on companies that produce drugs like OxyContin to ensure that proper care is taken when they're manufactured, but also when they are distributed.

In terms of our own policy levers within Health Canada, we've also used our public drug plan, which is run by Health Canada. We now have maximum monthly and daily drug limits, we monitor the use of certain drugs to address potential misuse, and we also have real-time warning messages to pharmacists at the point of sale when we see issues.

On top of the good and very helpful and cooperative work that we're doing with partners, I also encourage provinces, territories, and medical professionals to develop their own complementary strategies, and some of them are doing this. We all have a responsibility to fight this issue.

This includes sharing of information that demonstrates that we know—obviously I don't know the extent of the issue—that there is some evidence that some people are doctor shopping and that doctors are prescribing too much. Too much ends up in someone's medicine cabinet and sits there for months. Unfortunately, sometimes kids get their hands on it, take it to school, and sell it. We really need to raise more awareness around this.

But there also have to be measures in place to make sure that doctors are also accountable for some of the misuse. If information is known about this happening, then Health Canada needs to be informed, and if we are informed, then we can take the necessary steps to stop these irresponsible practices.

There are obviously a number of stakeholders involved here. We are working with all of them. We very recently met with a number of them to bring them together in what will be, when we move forward, the first time that all of these stakeholders will be addressing this issue together. I think that's a really good first step, and there will be great information coming out of this committee to build on that work.

**Ms. Eve Adams:** Thank you.

Let me move to innovation. You noted in your opening comments that our federal government is the nation's largest investor of research and innovation in the country. That is a very proud legacy to have. I'm particularly focused on the results of those types of investments. Perhaps you could highlight for us some of the outstanding results that you've seen to date.

● (1555)

**Hon. Rona Ambrose:** The Canadian Institutes of Health Research is really an amazing research organization, and the support they're giving to Canadian researchers across the country is phenomenal.

In my short time as health minister I've had an opportunity to see that. I'm sure you've heard on this committee from many of those innovative health researchers. It's close to 13,000 presently, and at times it has been higher. So whether it's investing in research in diabetes, personalized medicine, aboriginal health, mental health—of course, the list goes on. We've invested recently $100 million in Brain Canada for neuroscience, and we've also created the pathways to health equity for aboriginal peoples.

We have recently, not that long ago, launched the strategy for patient-oriented research, which is a great initiative, working closely with the provinces and territories, which sees additional money going to the territories to support their particular specific innovation priorities. So it's a great opportunity for the federal government to use our research capacity to support the provinces in the areas where they need help, making sure patients are getting the right kind of treatment at the right time. It also focuses on including patients in the research itself, which has been obviously welcomed by patients' advocates. I think it really helps bridge the gap between research evidence and health care practice, which has been very well received across the country. We just launched the first initiative of this kind in Alberta, and there are a number more that will follow.

Obviously, Canada has been a leader on research on HIV. Whether it's new ways to prevent chronic diseases...our support has been providing the resources needed for that work as well.

The deputy wants me to tell you that we've also invested $2.1 billion today for electronic health records. Obviously that's a huge issue for the provinces and territories because they're delivering health services on the ground, and that is a huge undertaking that has seen great success. We know that there have been a lot of challenges in different jurisdictions on electronic records, but Infoway has an impeccable record, not only from the Auditor General, but recently they just won an international award for project management. So we're glad to see the $2 billion investment actually helping people, helping those who deliver health services on the ground do it better and in a more sustainable way.

**Ms. Eve Adams:** Thank you.

**The Chair:** Thank you very much.

For the next seven minutes, Ms. Fry, please go ahead.

**Hon. Hedy Fry (Vancouver Centre, Lib.):** Thank you very much. Welcome, Minister.

There were some questions asked by my colleague Ms. Davies that I wanted to expand on.

The first one had to do with the SAP and the removal of the decision by the department to allow for diacetylmorphine to be used with certain patients, These patients are a very select group. They do not respond to methadone or to suboxone or to any of those other things, and they actually only seem to respond to heroin. This comes from the NAOMI trials and other trials, as well as SALOME.

Now, if these patients cannot get this, what they do is go back to heroin, which at the moment is only available on the street. So the question is, is withholding this heroin from them a good approach? It's a start to treatment and to getting them off and getting them on lower doses, which has been shown to work in Europe and in Australia and across the world for quite a long time now. This would help these people to get off the drug eventually and save their lives, because if they go back on the street, they're back to petty crime and to injections of heroin that can kill them.

This is a life-threatening problem. Can you quickly tell me about that? That's my first question.

I want to allow you to answer them all, so I'm just going to give them to you. The second one has to do with research on HIV. I think it's interesting to note that you're spending a great deal of money on research on HIV, but I wondered if you have met with and have decided that it is a good time to look at the highly active antiretroviral program going on in British Columbia, which has now been adopted by China, by Brazil, by the United Kingdom, and by France. With this program, people who are deemed to be HIV-positive are given a drug whose effect is that by the end of the first two doses they no longer create enough virus to infect others. It's known, therefore, as treatment as prevention. I know that the Canadian government has never paid any interest to this, which is kind of sad since we should be really proud of it. This is Banting and Best work that is being done. That's my second question.

My final question is this: you're taking on the food inspection agency, which I think is a good idea. I've always believed that it should be in one place and that PHAC should in fact be in charge of this. So I think it's fine, but I wondered, when you do so, are you going to look at some of the recommendations that came out of the report that the United States had asked that Canada do? This is about prevention strategies and oversight and technical training and better-trained inspectors and looking at research on preharvest ways of dealing with things. Are you going to look at how we get a faster way of getting the information to the public and collaborating with stakeholders? Those were four big areas that the recommendations addressed, and I wonder if you're going to address this when we get there, because this is a really severe problem. People could die. Fortunately, people only got sick, but people could die from E. coli or listeriosis or salmonella, any one of the things that we can find in foods. Now that it's turned over to Health Canada, we should be better able to deal with this in an appropriate and effective manner.

Can you tell me whether you are going to look at those recommendations or not?

● (1600)

**Hon. Rona Ambrose:** That's a lot of questions.

First, on the SAP program, I'll reiterate my view that the intent of the special access program is not to provide addictive drugs to those who are addicted. I will continue to focus on intervention, safe intervention, safe alternatives, treatments, and recovery for those who are addicted.

As for the HIV, you're right. We are a leader in HIV spending. We have spent half a billion dollars to address HIV/AIDS since 2006, and the Public Health Agency has done incredible work in that area. There's also the HIV vaccine initiative with Bill and Melinda Gates that we have funded.

I'm going to ask Krista to say a few words about that. But before I do, I would just touch on the healthy and safe food for Canadians framework. I think it was a very good public policy decision to bring CFIA under the Health portfolio. Already, we have interaction between CFIA and public health officers at the provincial level. So you hit the nail on the head. It's all about information-sharing and making sure that it's not just about agriculture but also about public health. We're seeing a great response from the provinces and territories. We recently launched another part of our FoodNet Canada set-up in Alberta. We now have them in B.C., Alberta, and Ontario, and we hope to have more. It is all about collaboration and information sharing. The sooner we can get that information to the public health officers from the inspectors, the better. That's exactly why we've done this. We see a great collaboration.

I'll ask Krista to speak.

**Hon. Hedy Fry:** Thank you.

Mr. Chair, through you, when Ms. Outhwaite answers my questions.... I specifically asked about HAART. I don't want to know what you're spending money on. I want to know why we haven't looked at HAART, which is so successful in British Columbia and has been adopted around the world.

I also wanted to get, if possible, an answer from someone about the fact that diacetylmorphine and hydromorphone are two substitution products. They are pharmaceutical products, so why have they been taken off the SAP?

Maybe you can answer that. Other than the political answer, I'd like to get the scientific answer, because it hasn't followed the evidence base at all.

**Mrs. Krista Outhwaite (Associate Deputy Minister, Public Health Agency of Canada):** Perhaps, Chair, I'll start with the question with respect to the work of Dr. Montaner and the Province of British Columbia in treatment as prevention in the field of HIV/AIDS research and research into interventions. It's very interesting work, and in fact the Public Health Agency of Canada has been following it very closely. Our director general of infectious diseases, Dr. Howard Njoo, has actually travelled to British Columbia to meet with Dr. Montaner to participate in information sharing, research-findings sharing exercises to determine how this fits into the overall spectrum of responses to HIV/AIDS in this particular country. It was also an interesting topic that came up at the international AIDS conference in Washington in 2012.

You're quite right in pointing to this as a potentially promising area, certainly of great interest, in British Columbia. As you know, the Public Health Agency looks at a variety of responses to HIV/AIDS, certainly surveillance, certainly research into the best interventions, etc., and this may form part of the response to that more generally.

● (1605)

**Hon. Hedy Fry:** I just wanted to know why, if other countries are taking this and if the World Health Organization said okay, it isn't happening.

**The Chair:** Thank you, Ms. Fry. We're just over time.

**Hon. Hedy Fry:** We're finished, okay. Sorry about that.

**The Chair:** Thank you.

Next is Mr. Hawn for seven minutes.

**Hon. Laurie Hawn (Edmonton Centre, CPC):** Thank you very much, Mr. Chair.

Thank you, Minister Ambrose and all your officials, for being here. Apparently I do mean “all your officials”. That's quite a crowd.

Everybody here has been touched by mental health in one way or another, whether it's depression or Alzheimer's. I lost an aunt to Alzheimer's, and I know other people who have been touched by it. With one in five Canadians suffering some form of mental health.... Obviously, it has serious effects on all of our lives, whether it's us personally or people we know and love. There has been some good work going on by our government to support mental health research, and funding through your portfolio, and these dollars have gone a long way toward developing resources needed to tackle those issues.

Can you talk about some of those mental health research programs that we've undertaken and some we might be planning in the future?

**Hon. Rona Ambrose:** Sure, I would be happy to do that.

You're right in saying mental health affects everyone. I think the more we know about it, the more we recognize that it is part of every aspect of health care. It really is, and it's an area where research grows, and the more research we have, I think the better interventions we see, which is great.

Obviously we've made significant investments in mental health, both on the research side and the promotion side. We created, of course, the Mental Health Commission of Canada, which has developed a national strategy for ensuring best practices across the country.

I would say that Alzheimer's is one of the foremost challenges to mental health today, and it's been a key investment target for our government through the Canadian Institutes of Health Research. We've invested more than $146 million now in research specific to Alzheimer's disease and related dementias, including nearly $27 million in one year alone, in 2011-12.

We have also created the Canadian Consortium on Neurodegeneration in Aging, which was launched in March of this year. This particular initiative brings together all of the relevant Canadian expertise and acts basically as a research hub for all aspects of neurodegenerative processes affecting cognition, including Alzheimer's.

We are also active at the international level. CIHR is very active in supporting research through what's called the international collaborative research strategy for Alzheimer's disease. This particular strategy's goal is to prevent or delay the onset of Alzheimer's through early intervention and diagnosis. It's also focused on improving the quality of life for those who are afflicted and for their caregivers, which is interesting. As you well know, caregivers are deeply affected when their loved ones develop dementia and Alzheimer's. It also improves access to quality care and enables our health system to deal more efficiently with the rising number of affected individuals.

It seems to me, from what I've seen, that it's working. To date, we've been able to leverage an initial $13.4 million to over almost double that—actually more than double that—through international partnerships, so it helps us to partner with other countries and other organizations.

Through our federal responsibilities, which is in aboriginal communities, of course, we have also invested significantly. We've committed over $260 million annually now to target mental health issues in aboriginal communities, and our budget last year announced an additional $4 million specifically for mental health services for first nations.

So all of this, I think, plays a big part in dealing with mental health issues. These investments obviously ensure not only that our health researchers have the resources they need, but that then, of course, corresponds with innovative strategies and also on-the-ground support for those who are practitioners and physicians.

**Hon. Laurie Hawn:** Thank you.

PTSD is not just an affliction of the military but of any first responder and other people throughout society. Can you talk a little bit about the coordination between Health Canada and DND, particularly on dealing with mental health issues that DND is concerned about, and PTSD writ larger?

**Hon. Rona Ambrose:** I'll let Krista say a few words more specifically, but just recently I was really thrilled—if that's the word—to see that the Canadian Institutes of Health Research is funding research projects dealing with those who have experienced IED explosions and other explosive-type environments, to study how that affects our soldiers returning from battle, and that's very promising. The more research we have, the better information to actually deal with those who are suffering from PTSD.

Would you like to say a few more words on the work that we do at DND, Krista?

● (1610)

**Mrs. Krista Outhwaite:** Yes, thank you. I'd be delighted to.

As you know, the Public Health Agency of Canada is busy these days working on the implementation of bill C-300, An Act respecting a Federal Framework for Suicide Prevention. This is where our relationships with colleagues such as National Defence come into play very significantly. They're working with us and developing this suicide prevention framework at the federal level, the federal framework, and being very helpful in that respect.

They are also partnering with us to look at what tools and innovative developments can be brought to bear to meet the needs of mental health promotion generally, but also specifically for military families and DND personnel. It's a very important area of work, and we are delighted that they are coming to the table in the way they are to work with us on this.

**Hon. Laurie Hawn:** Are you paying special attention to the military, obviously, but also to first responders, through public safety and so on, and obviously fire, police, and so on? Are they kind of wrapped up in the same bit of cooperation?

**Hon. Rona Ambrose:** In terms of pandemic response, or in terms of PTSD?

**Hon. Laurie Hawn:** No, in terms of the first responders, who do respond just as—I mean, military are first responders in many ways and they suffer the same kinds of traumatic incidents.

**Mrs. Krista Outhwaite:** Yes.

**Hon. Laurie Hawn:** Your "yes" is actually to public safety and so on?

**Mrs. Krista Outhwaite:** Yes, they would be part of that larger family. Yes.

**Hon. Laurie Hawn:** Back to the Canadian Mental Health Commission for a minute. That was an initiative that has gotten off the ground very well. Is that meeting expectations? You talked about the international area a bit. Are they hooked in pretty closely with similar international organizations for research and sharing of information?

**Hon. Rona Ambrose:** I specifically mentioned the dementia issue.

**Mrs. Krista Outhwaite:** You're referring to the government support and implementation of the Mental Health Commission and how it's functioning.

**Hon. Laurie Hawn:** Yes. How are they working with international partners with similar mandates in terms of sharing information and research?

**Mrs. Krista Outhwaite:** The Government of Canada, in addition to the Mental Health Commission of Canada, has really been reaching out significantly to partners around the world to work on this important issue. I should also say the Mental Health Commission of Canada has seen many countries come to them to understand and learn from the work of the Mental Health Commission here in Canada.

The development of the first strategic plan for mental health has been received very positively, and in fact I would be remiss if I did not mention that Canada has been active in bringing this forward at the World Health Assembly—the topic of mental health. We've sponsored meetings and discussions, and the work of the Mental Health Commission, as well as all the partners, whether they're governmental or private sector, have factored into those discussions. And other countries are very keen to see what we're doing.

**The Chair:** Thank you, Mrs. Outhwaite.

Thank you, Mr. Hawn.

We're into our second round now with five-minute questions.

Mr. Marston, please.

**Mr. Wayne Marston (Hamilton East—Stoney Creek, NDP):** Thank you, Mr. Chair.

Welcome, Minister. We're pleased to have you here with us today.

A recent report from the Public Health Agency of Canada referred to more than 200,000 Canadians acquiring antibiotic-resistant infections while seeking treatment, and close to 8,000 Canadians die of these infections annually. I have tried to put these things into frame from personal experience. Recently, you may have recalled in the House, I spoke of my wife having surgery. She was scheduled for four days and she wound up with 13 days because she picked up an infection. Fortunately, antibiotics dealt with it.

This brings me to a point I'd like to make. My background is in the labour movement, and a lot of the work I did had to do with hospital unions and their representatives. A lot of Canadian hospitals are unionized, and in that environment they have a health and safety committee. If they're going through their daily work and they find a problem with procedures, they don't have to risk a confrontation with a manager. They can go through their union, which raises it as a health and safety concern. What I'm concerned about today is there are often times that work is contracted out to cleaning services, where you have a $10-an-hour employee, a part-timer, who is reluctant to raise issues because where he's contracted, he's easily disposed of by his manager—not necessarily the hospital. It opens the door to failure within the cleaning system when we're looking at those people who have acquired the resistant pathogens out there.

Canada's chief public health officer believes that 70% of infections could be prevented, and of course where the national role comes in is with a monitoring system of some sort. There have been complaints. I understand that doctors have pointed out that the federal government has offloaded the collection of this data to the provinces. Again, as you can see, that balances off with my earlier comments. How does the government explain that there's a 1,000% increase in these infections in Canada when places like the United Kingdom have cut their infection rate by half, with the leadership of that particular government? Is the minister prepared to address the concerns these doctors have in making sure that up-to-date information is provided to them?

● (1615)

**Hon. Rona Ambrose:** Well, I would just start by saying yes. And the Public Health Agency of Canada is actively engaged with provincial partners, monitoring the spread of infection. Any reports of disease surveillance are verified with outside medical experts, and they're regularly shared with key stakeholders. But they do have a rigorous process they go through before they post that information. I'm happy to let Krista expand on that.

But what I will say to you is that in this situation, on the labour side, anyone who is a patient and has been a patient, including myself, expects that people follow health and safety procedures, regardless of being unionized or non-unionized, obviously. But Krista can elaborate a little more on that because I know she has an issue she'd like to raise.

**Mrs. Krista Outhwaite:** Mr. Chair, the topic of antimicrobial resistance is an extremely important one. It's emerging in terms of discussions at the World Health Organization. The U.K. is providing some interesting insight into this particular area. In fact, all countries now are really putting a focus on antimicrobial resistance, for all of the reasons the member has brought to the table.

In this country, the Public Health Agency of Canada has a bit of a unique surveillance program in which we actually look for resistant microbiological agents—bacteria and things like that—in hospitals and health care settings. We do that with the cooperation of a number of hospitals across this country. We work very actively to get the results of that surveillance out to the public health community, which needs it and uses it as quickly as we can. It takes a little while, as the minister was mentioning, to make sure that the data are accurate, valid, and appropriate and that we protect any concerns with respect to individual patient information. We absolutely want to do that.

But once we've done that process, we give that data over, as I say, to the public health community. We are also working very actively to make sure that we also introduce the outcomes of those surveillance programs on our website as quickly as we can, which is I think the issue the member was pointing to.

**Mr. Wayne Marston:** How is my time, Chair?

**The Chair:** It was perfectly timed. That was five minutes. Thank you.

**Mr. Wayne Marston:** That's too bad. I had more—

**The Chair:** I know. Maybe Ms. Morin....

Mr. Wilks, for five minutes, please.

**Mr. David Wilks (Kootenay—Columbia, CPC):** Thanks, Chair.

Thanks to you and all your staff, Minister, for being here.

I'm going to carry on with the conversation that Ms. Fry and Ms. Davies had picked up on. You spoke in your opening remarks about healthy living and said further that protecting Canadians from harm is part of your mandate, as is ensuring that both licit and illicit drugs are dealt with in a manner that is responsible for all Canadians.

Recently, injection sites have been in the spotlight, and specifically how communities should have a say in their placement. As a former police officer, I think it's only fair that people have the right to say whether one is in their community or not. I wonder if you could comment from your perspective on the Respect for Communities Act and what it's trying to accomplish, and then, further to that, on the importance of treatment, recovery, and support.

**Hon. Rona Ambrose:** Sure, I'm happy to do that. I appreciate the question.

The legislation you're talking about with regard to supervised injection sites, the Respect for Communities Act, is being debated in the House right now. We introduced it last month.

This legislation will give law enforcement, municipal leaders, and local residents a voice, all of whom have asked for a voice before the permit is actually granted for a supervised drug injection site in the area.

This went to the Supreme Court, and in a 2011 Supreme Court ruling the justices were crystal clear. They ordered that I, or any health minister, must consider specific factors when reviewing applications that grant exemptions under our drug laws. In other words, we must look into specific factors before allowing a permit for a supervised drug injection site.

One of the five factors named in the ruling is expressions of community support or opposition. I do not, nor should I, ignore any of the factors named in the court's ruling. I think it makes good sense. I am required by the Supreme Court to consider community opinions in the process, and that information needs to be made available to me by the organization if it's seeking to build such a site.

I should say that there is no one now seeking to build such a site, but this bill also requires that these organizations submit the relevant scientific information demonstrating the effectiveness of illicit drug treatment at the proposed site as part of their application.

I think that all parties, or at least those with whom we have consulted, agree that this kind of information must be provided to decision-makers when assessing a permit of this kind. This information will be provided along with details about the resources of the proposed site and about how these resources will be used for drug treatment. Knowledge about the level of community support and the treatment options that are available will also help determine the merits of each application.

This is reasonable and it is also mandated by the Supreme Court, so that is what is in the bill. Those stakeholders who have been dealing with this issue for many years deserve a say in where these sites would be if we receive an application for them, so we are moving on this. The Supreme Court has ruled. We believe our communities deserve nothing less than to have a voice in that, and the Supreme Court has agreed.

I do encourage everyone to support the legislation and move it along.

Our government has invested quite a bit of money in drug treatment and recovery. I am of the belief that we spend a lot of time talking about a very small piece of the drug problem when we talk about supervised injection sites. There are literally hundreds of thousands, if not millions, of Canadians across the country who are either in recovery or suffering from addictions. A lot of them feel shame and they don't want to speak openly about their addictions and their need for recovery. We need to speak more about it because they need to feel comfortable about coming forward to seek help and intervention.

That is one of the messages that I bring, as the health minister in my tenure. We need to get people out of addiction, into recovery, and into the right kinds of treatment programs. Sometimes it takes years. Sometimes it takes multiple attempts. People talk about it not working, even after two tries. Sometimes it takes 15. As a police officer, you have seen this first-hand. Eventually, though, people can get up on their own two feet, recover, and lead a productive life.

The message is to not give up on people, any people, particularly those who are most vulnerable.

● (1620)

**The Chair:** Thank you, Minister.

Next is Ms. Morin.

[*Translation*]

**Ms. Isabelle Morin (Notre-Dame-de-Grâce—Lachine, NDP):** I would like to thank the minister for being here today. I quite enjoyed your speech.

You mentioned safe and healthy food for Canadians. You said a great deal about safety, regulation, providing information and communications, but you did not discuss food in and of itself. Yet, in the United States, the Food and Drug Administration has ordered the American food industry to begin to gradually eliminate trans fats from processed food. I think this is a good measure.

In this country however, the government is not listening. Even in your own department, certain experts have recommended the regulation of food processing and ensuring such foods contain less fat and salt. I believe these measures would improve the health of Canadians. I am not talking simply about influencing their food choices. Here in Canada, our cereal contains much more salt than it does in the U.S., and the quantity of trans fats found in processed food is truly unbelievable.

Why have we not followed the U.S. example and that of many other countries by taking similar measures? When will we be able to implement such measures?

[*English*]

**Hon. Rona Ambrose:** I don't know what you find, but in speaking to at least my cohort, more and more people want increased amounts of information about what they eat—the food they buy when they go to the store. They want more nutrition labelling, not less. I find that especially parents shopping for kids want to know if there is an allergen in this food, what ingredients are in it. It is even beyond nutritional information. This is why our government has announced in the Speech from the Throne that we will be consulting with Canadians about nutrition labelling. We will be working with CFIA, the Public Health Agency, and Health Canada together, to see what we can do better to support people in making good nutritional decisions.

On trans fats, there has been a lot of movement. Canada, as you know, moved to a voluntary system for trans fats. We've seen a huge improvement—

● (1625)

[*Translation*]

**Ms. Isabelle Morin:** I am sorry to interrupt you, but we do not have much time.

I agree with you. I think transparency in labelling is very important. Furthermore, I also believe we should change the food itself. It is not enough to say that it contains salt. Canada should commit to reducing the amount of salt in these foods.

Unfortunately, most of the people around me would be unable to tell me what the daily maximum dose of salt and trans fats is. However, we could go beyond this and ask the industry to reduce the amount of sodium and trans fats in the food they are producing. This is what we should do. It is not enough to be transparent. We must be proactive and ask that sodium and trans fat levels be reduced.

You yourself must recognize how important this is. In that perspective, when can we expect to see Health Canada take action?

[*English*]

**Hon. Rona Ambrose:** It's not only Canada's food guide; there are also incredible amounts of information that we provide to Canadians on www.healthycanadians.gc.ca. We have a nutrition facts education campaign that was launched in 2010 that talks about the nutrition facts table, how to read it and understand it. We've worked with industry to reduce the amount of trans fats in Canadian food and in promoting better labelling.

As a result of that, in a very short period of time we have seen Canadians' intake of trans fats decreased over 60% in just a couple of years. In fact, we know now from ongoing testing that in some segments of our population the intake of trans fats is reduced by almost 90%. So I think we're on a good track.

There are also early signs that decreasing sodium levels in some important food categories is happening. As you know, experts set those levels. What we do is try to disseminate all that information to people so they can make good choices. We literally can't be at the table with people and their salt shaker, but we can advise them on why they should not be using too much salt on their food. We do that widely. Promoting healthy options does get results. We have very good promotional awareness campaigns making sure that physicians have adequate resources to give to patients, nutritionists, and we do disseminate that information. We've seen great results because of that.

[*Translation*]

**Ms. Isabelle Morin:** Do you not believe it would be worthwhile to have regulations about salt consumption? You yourself said that we could not sit down with people for every meal. Yet, we know that generally speaking, more educated people will take the time to read nutritional information, unlike less educated people. Should we not help people and improve their health by committing to regulating trans fat and salt levels in food? We know that will allow us to save enormous amounts of money in health care.

[*English*]

**The Chair:** Thank you, Ms. Morin. I'm sorry, we'll have to get that answer another time because we're up against the clock.

We'll have Mr. Lizon for five minutes, and then that will wrap up our hour with the minister.

Mr. Lizon.

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

Minister, thank you for coming and meeting with us here today, and all the officials.

Minister, in your previous role as minister responsible for the Status of Women, you were a great and strong advocate for ending all forms of violence against women. As I understand, you continue this in your new capacity and portfolio as Minister of Health through the programs offered in the department in that area. This is very encouraging, since this is an issue that all the parties can agree on and should work together to address.

You highlighted in your opening remarks that the issue of family violence is one that you want to focus on. Can you please provide the committee with an update on the work you are doing with the Ministry of Health to keep the issues of family violence or issues related to family violence at the forefront?

● (1630)

**Hon. Rona Ambrose:** I appreciate that comment. Not only in my role as minister for the Status of Women previously, but throughout my whole life I've been involved in this issue, advocating for more awareness around it.

Our government has had an opportunity to bring a more holistic approach to the issue of family violence, whether it's child sexual abuse or intimate partner violence or honour violence. Family violence takes many forms, but the reality is that it is a public health issue. The consequences are far-reaching, both societally and also economically.

I mentioned the Justice Canada report that came out a year ago, which found that just in terms of intimate partner violence, the cost to society is $7.4 billion, and that's just for going to the emergency room with a broken arm or seeking psychological help. Let's remember that most women do not seek medical help, and even more so do not seek psychological help.

I would say that the cost is obviously much higher. We know that aboriginal women are suffering and experiencing violence at a much higher rate than non-aboriginal women—at least 3.5 times higher. They're much more vulnerable to becoming victims of family violence. That of course has profound financial and social impacts on them, their community, and their families.

Not only does it affect physical health; it affects mental health. It puts a huge strain on day-to-day personal activities, but also business activities. It leads to loss of work. All of that affects our communities and our economy, and it obviously has a huge impact on the public health care system.

The Public Health Agency of Canada has a clear mandate in this area, with responsibility for what is called the federal family violence initiative. That coordinates 15 different departments that have a role to play in any family violence. We are working right now to make sure that we're prioritizing all of this and are focusing our priorities in the right way.

I'm glad to say that the Canadian Institutes of Health Research is also now doing research in the area of family violence, with $8.5 million over five years to look at gender-based violence and family violence and its impacts.

So we all have a role to play. I have reached out to the provinces and territories, to the medical community, to physicians, to the Colleges of Physicians and Surgeons, asking all of the stakeholders what we can do together to advance awareness and prevention of family violence. I look forward to working with the committee on this issue and I look forward to the Public Health Agency coming forward with what I know will be some good opportunities to raise awareness on this issue.

You're right in saying that it affects everyone. It's one of those issues that is talked about a lot. It is finally not a private issue, but has become a public policy issue. We still don't do enough to coordinate across the country on this, and we look forward to doing that.

**Mr. Wladyslaw Lizon:** Mr. Chair, if I can—

**The Chair:** You have 30 seconds.

**Mr. Wladyslaw Lizon:** Maybe quickly I'll ask one of the officials, then, how the collaboration with provinces and territories on this issue is going so far.

**Hon. Rona Ambrose:** I would just say one thing. Interestingly, provinces are doing, each in their own capacity, different levels of work in this area. They're encouraged to know that we want to work together on information sharing and whatnot. But I look forward to a better opportunity to see the provinces wanting to engage us on this.

**Mr. Wladyslaw Lizon:** Thank you very much.

● (1635)

**The Chair:** Thank you very much. That should conclude the minister's time. I thank the minister and her staff for being present here for an hour.

I'd also like to thank my colleagues for keeping their questions tight and to the time and for asking them in a respectful manner.

We will suspend for a couple of minutes. Those who need to leave may do so.

When we resume we'll have the departmental staff here to answer questions for about 40 minutes, and then we'll have 10 minutes to go over the supplementary estimates and vote on them.

We are suspended.

● (1630)

______________________ (Pause) ______________________

● (1635)

**The Chair:** We'll call the meeting back to order.

We welcome our colleagues who are here from the various departments throughout Health Canada.

We'll get started in just a few minutes. We're going into our five-minute rounds. Ms. Davies will start off, and then we'll rotate through our regular session.

I'd like to remind my colleagues and anyone in the audience that if you have a mobile phone, please set it to “silent” or “vibrate” so that we don't hear it ringing during the question and answer period. I'd also ask that no pictures be taken with your mobile phones during the committee meeting—just to be clear.

As I said, we'll go till about 5:20, and at that time we'll conclude this portion of our meeting and we'll go through supplementary estimates. I thank you in advance.

Ms. Davies, you have five minutes to start, please.

**Ms. Libby Davies:** Thank you very much to officials who are remaining, because there are obviously a lot more questions that we have.

I actually want to focus my five minutes on the most recent issue of the *Canadian Medical Association Journal*, where a very strong editorial was written expressing their concern about the fact that RU-486, mifepristone—which is basically a medical abortion pill—has not yet been approved in Canada.

It is registered in 57 countries. It's a pill that provides very safe access for a medical abortion, particularly for women in rural and remote countries.

I think there's a lot of concern, and certainly when we see an editorial in the *Canadian Medical Association Journal* questioning why it hasn't been approved in Canada and why it's taking so long.... It's very timely that you're here, and hopefully we can get some answers on that.

The subtext of it is that more and more people are very concerned that there is an increasing politicization of medical decisions in Canada. We just had a little back-and-forth about the special access program and the SALOME trial program. There is a lot of concern that this is yet another example where we see the politicization of what should be an expert medical decision. Obviously this pill that's been approved in other countries is extremely important in terms of access and safety for women, so what's the holdup in Canada? Why have we not approved it, and why is it still sitting there to the extent that the *Canadian Medical Association Journal* now feels compelled to write a very strong editorial about it?

● (1640)

**Mr. George Da Pont (Deputy Minister, Department of Health):** The answer is relatively simple. To date, no company has applied to market the product in Canada.

Obviously if we receive such an application, we would study very much the data, the experience in other countries, and we would try to deal with it as quickly as possible.

**Ms. Libby Davies:** Given that it has been registered in other countries and approved.... I know it's been available in the U.S. since 2000, so it has a history, and it's not a new drug, although, as you point out, it's not yet being used in Canada. How long would that process take if there were an application made?

**Mr. George Da Pont:** I can't speculate on how long it would take. It would depend on the application.

But in this case, given widespread use, given lots of data from other countries, I would expect it would go faster than normal applications.

**Ms. Libby Davies:** Do I still have a little bit more time?

**The Chair:** Yes.

**Ms. Libby Davies:** Okay.

I'd just like to ask some questions about the very major changes that are going to take place to the medical marijuana program, which are going to come in next March.

I don't know about you, but we've had lots of emails from people. There are a number of concerns, but the ones that hit the top of the list are these: first of all, the new program will eliminate personal production; second, there is a lot of concern about the cost going from $1.80 a gram to $5 a gram and up to $8.80 per gram; and third, what have commonly been referred to as the compassion clubs or the community-based dispensaries are completely knocked out of the new system.

I just wonder if any of the officials here today can comment on why the decision was made to eliminate personal production, particularly for low-income people. As well, why was the decision made to, in effect, eliminate the community-based dispensaries that do have their own association, they have quality control, and they're very professional about what they do? It seems a shame to waste the expertise, the knowledge, and the local access they've developed, basically putting patients first. We're going to lose that under this new system.

**Mr. George Da Pont:** Again, let me offer a few comments on that.

The reason that a new approach was taken and a new program was put in place is because the existing model of personal production had very significant diversion from its intended purpose. And both municipalities and law enforcement were raising significant issues.

We very much realize the importance of having access. We believe that with the new system, which will be based on licensed producers, which will also have strong quality control processes in place that will be subject to regular inspection and will have careful tracking, we'll find that appropriate balance between ensuring that people have access to marijuana for medical purposes, but also taking into account the legitimate public safety and community concerns that were raised.

In terms of your question on price, it remains to be seen how that works out in terms of the marketplace. But what I can say is that the existing program right now is very heavily subsidized.

We believe the new program will be a significant improvement.

**Ms. Libby Davies:** Could I interrupt? Apparently there was an application made in Canada for the RU-486. There was an application made, so maybe you could check that.

**Mr. George Da Pont:** I will double-check that, because the information I received was the opposite.

**The Chair:** Thank you very much.

If there is, there is, and if there isn't, there isn't. But if there is, please forward it to us.

Thank you, Ms. Davies—

**Ms. Libby Davies:** Could we ask Mr. Da Pont if he would get back to the committee about whether or not there is an application? Thank you.

**The Chair:** Yes, I'm sure he will.

**Mr. George Da Pont:** Yes, I certainly will.

**The Chair:** Thank you very much.

Next up for our next round is Mr. Dreeshen, please.

**Mr. Earl Dreeshen (Red Deer, CPC):** Thank you very much, Mr. Chair.

I welcome our guests today.

As a food producer, I'm extremely proud of what we've done as far as ensuring food safety goes. Certainly, we're world renowned for what we do. We've been involved with ParlAmericas and in discussions with Central America and South America in talking about food security and food safety. Of course, they look to Canada as a model.

But we still need to remain vigilant. Of course, food safety is important to all Canadians, and just as it's important that Canadian consumers remember their lessons from home economics class on proper food preparation, it's also important that those companies that handle our food prioritize food safety as well. So the fact that the Canadian Food Inspection Agency has been transferred from the agriculture department to Health is truly a logical statement. I know that Ms. Fry spoke about that earlier.

Could you comment on the work that has been done so far to improve food safety even further?

● (1645)

**Dr. Bruce Archibald (President, Canadian Food Inspection Agency):** Thank you for the question. There are a number of areas in which I think the government has made some significant investments in terms of improving Canada's overall food safety system, which, as you mentioned, is already highly regarded throughout the world.

I think some of the more recent investments that have been announced, coming out of a review of various programs, include the establishment of inspection verification teams that are going to help us improve the overall performance of Canada's entire food inspection system. This allows us to establish various teams across the country to move in and work on evaluation and ensure that the system is actually meeting its various objectives, and to continue to make investments to look at Canada's overall prevention and detection of food-borne diseases through our listeria response to the Weatherill report in terms of inspection in various areas.

We've also continued to make investments in the meat area, with a daily presence of inspectors in all our federally inspected meat facilities, to ensure that we comply not only with our own requirements, but also with international requirements that facilitate trade.

As well, we continue to work with Health Canada and the Public Health Agency of Canada to improve detection of and response to food-borne outbreaks.

As you mentioned, I think there has always been good cooperation between the agency and the department and the Public Health Agency. I think these new reporting relationships actually allow us to strengthen that going forward in terms of our cooperation and working together.

Those are just a couple of examples of areas where we continue to make investments to further strengthen the system.

**Mr. Earl Dreeshen:** We've heard comments about some dollars coming out of CFIA when they were talking about food inspectors, but of course it had nothing to do with that. There was actually an increase in food inspectors and millions of dollars in new funding in order to help and prepare, so some of the things we heard from other sides have perhaps confused the issue.

Could you expand somewhat on the Safe Food for Canadians Act and the things that are happening there? I see a lot of that included in this brochure the minister presented to us, and of course this is something that many Canadians should take a look at. As I say, it's going back to what you should have learned in your home economics classes about how much you cook your food and the cleaning of the food and so on. I think that's important.

Could you expand upon that a little and give us a bit of an idea about what this brochure is and what it does to help Canadians?

**Dr. Bruce Archibald:** Yes, absolutely. I'm going to ask my colleague Paul Mayers, who is our associate vice-president in policy and programs, to expand a bit on that.

**Mr. Paul Mayers (Associate Vice-President, Programs, Canadian Food Inspection Agency):** Thank you very much for the question.

As the minister noted in her remarks, the framework focuses on promotion, prevention, and protection. Those three elements together reflect the work of not just the Canadian Food Inspection Agency but our colleagues in Health Canada and the Public Health Agency of Canada, in terms of an overall focus on strengthening Canada's already excellent food safety system.

In the context of the Canadian Food Inspection Agency, as we look across that framework, one particular area that I'll draw attention to is the Safe Food for Canadians Act and the work we're doing currently under the action plan to bring the legislation into force.

We've undertaken a significant consultative effort with Canadians around improvement, and a centrepiece to that is an improved food inspection system. Even though the food inspection system in Canada is strong, we recognize that there are opportunities to further strengthen that system to enhance the tools available to our front-line inspection staff, to ensure we have an integrated approach to information, to strengthen the support for our front-line staff in terms of decision-making, and to strengthen the risk basis for our system.

We're very proud of founding our decisions on science. We're building on that by introducing a strengthened focus on risk to guide the application of our inspection resources, so they have the greatest impact as we undertake our business in order to provide that protection for Canadians.

● (1650)

**The Chair:** Thank you, Mr. Mayers. Thank you, Mr. Dreeshen.

Next up we have Mr. Aspin, for five minutes, please.

**Mr. Jay Aspin (Nipissing—Timiskaming, CPC):** Thank you, Mr. Chair.

Welcome to our guests today.

I'd like to pursue a few questions with regard to CFIA, so I guess they would be addressed to Mr. Archibald and/or Mr. Mayers.

CFIA's authorities to date are just under $720 million, and it has requested almost $40 million in transfers and adjustments in these two supplementary estimates. There is about one-quarter of the requested funds, according to the supplementary estimates document pages 2 to 9, that are to go to maintaining an increased frequency of food inspections in meat processing establishments.

When and how did the frequency of inspections of meat processing establishments increase?

**Dr. Bruce Archibald:** There was an international audit done in 2009 that identified a number of areas where Canada was doing inspection in various meat processing facilities for both domestic and international use. One of the audit findings concluded that there needed to be more presence in terms of the facilities to ensure we were meeting all our domestic and international requirements.

As a result of that, there was an initial investment in budget 2010 of $26 million over two years to deal with a daily presence of inspection at all federally inspected meat processing establishments, both export and domestic. We expanded the number of inspectors and supervisors of program specialists and the training related to that. The request in supplementary estimates that you see for this is a continuation of that work, a continuing daily presence for 2012-13, as well as going forward in 2013 and 2014.

The original work was a result of an audit that was done. The government made investments, and part of the supplementary estimates request is to continue that work.

**Mr. Jay Aspin:** CFIA is a partner with Health Canada and PHAC in two initiatives listed in these supplementary estimates: enhancing the ability to prevent, detect, and respond to food-borne illnesses; and streamlining government import regulations and border processes for commercial trade. Approximately $15 million is requested in these supplementary estimates for the two initiatives combined.

Could you please describe CFIA's role in these two initiatives?

**Dr. Bruce Archibald:** I'm going to ask Paul to respond to this one.

**Mr. Paul Mayers:** Thank you.

Let me start with the second in terms of import control. The focus on strengthening Canada's import controls stems from the interests that Canadians have expressed in greater assurance that foods imported into Canada meet Canadian requirements. So the Canadian Food Inspection Agency has been enhancing its activities in terms of import control as a direct response to that interest expressed by Canadians.

The Government of Canada has invested in CFIA in order to enable that activity, and again, as noted in other areas, the supplementary estimates reflect our ability to continue that work. What we have done with that investment focuses on carrying out blitzes in collaboration with our colleagues at the Canada Border Services Agency, in carrying out targeted activities in response to where we've identified potential areas of risk associated with foods, particularly foods imported from countries whose food safety systems are weaker than our own. Canadians have indicated their interest in this and the agency has responded.

The other aspect that you note, in terms of our investigative capacity in collaboration with our colleagues in the Public Health Agency...it allows us to respond to food-borne illness events in terms of investigation, leading ultimately to the withdrawal from the market of suspect products demonstrated to be associated with such events. These actions, again consistent with the framework the minister has announced, enabled the protection element the minister noted.

● (1655)

**Mr. Jay Aspin:** Thank you, Mr. Chair.

**The Chair:** Thank you, Mr. Aspin and Mr. Mayers.

Next up for five minutes is Ms. Fry.

**Hon. Hedy Fry:** Thank you very much, Mr. Chair.

I want to go back to a question I had asked earlier. I gather that you didn't have the time to answer it because my time was up.

I don't think I would get disagreement from any one of the officials around the table that in fact if you are going to make good public policy, or if you are going to make any kind of good health decisions, then you have to look at evidence. Evidence drives it all. Outcome drives everything.

I had asked earlier about HAART, the active antiretroviral programs that go on in British Columbia. British Columbia is the only province in Canada that has this program.

It has caused a decrease. If we're talking about outcomes, then, what is it we're seeing in terms of evidence? The evidence is that British Columbia, since it adopted this program, is the only place— the only province, place, anywhere in North America—where the number of new cases of HIV is going down dramatically. Everywhere else, in every other province in Canada, and in the United States, it is going up, remarkably up.

In fact, I would like to tell you that in 1995 there were 18 cases per 100,000 in British Columbia. Now there are six cases per 100,000. That's a huge drop.

In Saskatchewan, for example, there were two per 100,000 in 1995. There were 16 per 100,000 in 2011.

Everywhere, in every jurisdiction, this has been proven to be important. We know that the medication stops the transmission of the virus because the virus is gone. It is not present in the blood.

I would hope that given the cost of taking care of every patient with new HIV, this would become a really important thing for the Canadian government to adopt, or for anyone to keep looking at, when this has been going on now for quite a while in British Columbia.

In fact, Brazil has adopted this policy wholeheartedly. The United Kingdom has adopted this treatment wholeheartedly. France has adopted the treatment wholeheartedly. We also see that the U.S. is already onside to adopt it wholeheartedly.

This should be, as I said, a triumph for Canada. This is a Canadian initiative, done here, built here. We should be proud of this.

No one wants to even speak to the people from the BC Centre for Excellence in HIV/AIDS. Well, no one at the political level; I'm sure bureaucrats have been speaking. What is it that prevents, with such remarkable outcomes, Health Canada from even looking at this in a way that...?

You can say that we're continuing to assess it, but it's been assessed. It's been assessed internationally. Peer reviews have shown that it works. The World Health Organization is saying that everyone should adopt it. China has adopted it, for crying out loud.

I just want to know why, when we could save lives and save costs in the health care system for every new case that we don't get, we are doing this. We could take that money and put it elsewhere in the system.

I just want to understand what is driving the decision to completely ignore and not adopt this when British Columbia is now being asked to international conferences. British Columbia is not Canada, but British Columbia is being asked to come and sit at the table with other nation-states.

Can someone explain this to me?

● (1700)

**Mrs. Krista Outhwaite:** I'll perhaps just add to my previous response. It's an important question that you're raising.

I would also like to introduce our deputy chief public health officer, Dr. Greg Taylor, who may also wish to make a few comments.

There is no doubt that the work in British Columbia, the work of Dr. Montaner, is very interesting, promising, and is delivering results in that particular context.

I would say to the committee and to the member that we are not ignoring that work, not at all. In fact, it is a topic of discussion not only with our partners in the HIV/AIDS sector, the ministerial advisory committee on the federal initiative, as well as the national partners that we engage with on HIV/AIDS, but also with our provincial and territorial partners.

British Columbia is bringing the concept to the table, and it forms part of the discussion of our public health network council in terms of how to best place this, how to look at this, in the array of responses to HIV/AIDS that this country is undertaking.

As I mentioned in my previous comments, this is also a topic of conversation, as the member has pointed out, at the World Health Organization, the World Health Assembly, and we also looked at it at the International AIDS Conference.

There have been advancements in the area of HIV/AIDS. People who have this disease are living much longer than they used to, and we are encouraged by that. Also, there has been huge progress made in terms of maternal transmission. Fewer and fewer children are contracting the disease.

**Hon. Hedy Fry:** I'm sorry, Ms. Outhwaite, but I know all this, and I think most of us know that.

I'm saying that this is not simply treatment that keeps people living longer with the disease; this prevents the disease from being transmitted. It would seem to me to be the first thing one would want to do. British Columbia has done it, with the success that I'm showing you here. They have brought down the rate of new cases by 60%. We have 4,000 new cases a year here in Canada. If we can bring that down by 60%, it would be a remarkable thing.

**The Chair:** Ms. Fry.

**Hon. Hedy Fry:** Sorry. I'm still not getting the answer I want.

**The Chair:** No, that's fine. Thank you.

**Hon. Hedy Fry:** “Looking at it” is not a good answer. I'm sorry.

**The Chair:** Thank you.

We'll try to keep our time here now.

As per the routine motions—actually, we're through all the rounds and now we're back up to the top of the order again. We're back to a seven-minute round.

Ms. Morin will lead off, and then Mr. Marston will split the time.

Go ahead, please.

[*Translation*]

**Ms. Isabelle Morin:** Thank you very much, Mr. Chair.

I have one quick question, and I will share the rest of my time with my colleague.

Mr. Mayers, you told us about the three P triangle in public health: promotion, prevention and protection. Promotion seems to be very important. As the minister said earlier, a great deal is done to promote healthy food, nutritional value and so forth. Prevention and protection require regulations. How would you balance these three aspects? As fas as I know, there is no balance. One seems far more important for the department than another.

We know that European standards are considerably higher than ours. Why can't Canada have the same standards as Europe when it comes to healthy food?

● (1705)

[*English*]

**Mr. Paul Mayers:** I might disagree that the European standards for food are significantly different than they are in Canada. Certainly among all countries, one finds modest differences. But the reality is that our European colleagues work very closely with us in the area of food standards under the United Nations Committee Codex Alimentarius, the international standard-setting body for foods. Canada, like the European Union, often bases its standards on Codex Alimentarius standards. Our European colleagues have a very rich trading relationship with us here in Canada, and while there are certainly some modest differences across many areas of the food supply, we are recognized by the European Union as equivalent. The focus is on not identical but equivalent outcomes, and that's critical to our success.

[*Translation*]

**Ms. Isabelle Morin:** I do not quite agree with what you said about standards.

Since we do not have much time and I would like to leave some time for my colleague, I would like you to tell me about the relationship between promotion, prevention and protection. After which my colleague can have the rest of my time.

[*English*]

**Mr. Paul Mayers:** The question you pose on promotion, prevention, and protection is not a question solely for the Canadian Food Inspection Agency, because all the agencies represented here have and play an active role in that regard.

As Canada's largest regulator, we at the Canadian Food Inspection Agency are particularly focused on the prevention and protection elements of the framework. When you posed the question about balance, the balance is achieved across all three partners, as opposed to only one partner.

At CFIA, we are more heavily focused on the regulatory elements, regulatory requirements, and enforcing those requirements, while others in the portfolio use promotion, so it is the balance achieved across all three that ultimately reflects the full suite of activities under the framework.

In our context, the Safe Food for Canadians Act and its regulations form our core.

**Mr. Wayne Marston:** Thank you, Mr. Chair.

I'll pose my first question to Mr. Da Pont.

There's been a lot of commentary lately that some departments have not spent their full budget from 2012–13.

Has this department spent its full budget in that budget year?

**Mr. George Da Pont:** No, we had a bit larger than usual carry-forward. Every department doesn't spend its full budget every year. Last year Health Canada had a larger carry-forward than normal, and that was due largely to some change trends in the first nations and Inuit health program, where spending didn't develop as we had projected.

**Mr. Wayne Marston:** Health Canada right now is requesting almost $3.2 million in additional funds to prevent, detect, and respond to food-borne illnesses. It shares that role with CFIA and others. What I'm interested in is, what activities are associated with prevention, detection, and the response to these illnesses? What will those dollars buy?

**Mr. George Da Pont:** It complements the response that was given by CFIA to the earlier question. The Health Canada role is to set standards and policies, and then CFIA implements those standards and policies. The specific funding and the enhancements for Health Canada are to work on reviewing standards. It's to increase our capacity to do health hazard assessments. When you have a potential food recall, it's Health Canada that assesses the risk, and then CFIA takes appropriate action. Finally, some of the money is also spent on the scientific side to develop new tests and models that would help us to detect some of these pathogens faster than would otherwise be the case.

● (1710)

**Mr. Wayne Marston:** Is any part of that added cost related to the fact that CFIA is now in the health portfolio?

**Mr. George Da Pont:** No, there's been no change in the responsibilities between Health Canada, the Public Health Agency of Canada, and CFIA, so it was not generated by that. In fact, those are responsibilities that the various departments and agencies shared prior to CFIA's coming to the portfolio.

**The Chair:** Thank you, Mr. Marston.

The last questioner of the day is Ms. Adams.

**Ms. Eve Adams:** Thanks very much.

I noted that the supplementary estimates reflect a rather sizable increase for patient-oriented research and food inspection and a decrease for travel in the ministry. Could you speak to that last item, the decrease in travel expenses?

**Mr. George Da Pont:** I can do that for Health Canada, and colleagues may wish to respond for their own elements.

You'll see that there's a decrease of about $1.1 million in travel. Within Health Canada, we work very hard to try to find the best efficiencies we can. What that means is that we're using far more video conferencing. We're looking at alternatives to get our job done without doing as much travel as we did before, so it reflects an efficiency savings.

We do, however, undertake all of the critical travel that's required. We put in place an internal process to monitor that and ensure that the critical stuff gets done.

**Ms. Eve Adams:** There are still investments being made to patient-oriented research, for instance. Would these be new moneys?

**Mr. George Da Pont:** Yes, and I think colleagues would want to speak to that.

Jane.

**Dr. Jane Aubin (Chief Scientific Officer and Executive Vice-President, Research and Knowledge Translation, Canadian Institutes of Health Research):** The patient-oriented strategy led by CIHR on behalf of the government was initiated in 2011. Through our collaborations with the provinces, we've ramped up activities and made great progress over the last year. The new moneys are to allow us to continue to roll out the specific programs that come under the patient-oriented strategy, including, as the minister mentioned in her remarks, the support units that are jurisdictionally based, provincially based, and territorially based. The first four have been adjudicated by an international panel. The first was announced in Alberta just about a week ago, and announcements on the others that have been adjudicated will be coming up shortly. Others are sending in their business plans, which will also be adjudicated. We need to continue to roll them out across the country.

**Ms. Eve Adams:** Thank you.

One final question: when it comes to prescription drug labelling, could you advise us of the changes that Health Canada has made?

**Mr. George Da Pont:** I will ask Mr. Glover to respond to that.

**Mr. Paul Glover (Associate Deputy Minister, Department of Health):** With respect to prescription drugs, we are working to make sure that the information that's contained, both for physicians and for consumers, is significantly easier to read. So we're introducing a series of steps. By means of these, the prescribers can make sure they have the information to determine the appropriate course of action for the patient. They know when to use it and when not to use it. They will know the potential side effects so they can make an informed choice. We're also working to make sure that this information is easier for consumers to understand, so they can participate in a dialogue with their physicians.

In addition, as the minister said, we're looking to make summaries of our drug safety reviews available. We hope to have the first one later this fiscal year. That's an important step in furthering transparency.

**Ms. Eve Adams:** I will ask one final question and split my time with the Honourable Laurie Hawn.

Finally, the investments that we'll be transferring to the provinces will reach an historic $40 billion by the end of the decade.

Could you briefly speak to the assistance we're providing to provinces and territories so that they can roll out their priorities, especially when it comes to health human resources?

**Mr. George Da Pont:** Let me start, and then colleagues may wish to elaborate.

As you've noted, there is now stable, predictable funding, creating a known envelope within which the provinces can do planning. In addition, the government continues to make significant investments in a number of other areas.

As the minister noted in her remarks, there have been investments of more than $2 billion to date in Canada Infoway. The provinces and territories match a chunk of that money for specific projects and are focused very much on getting eHealth and electronic medical records in place. There are also the significant investments of about $1 billion a year from CIHR as well.

The minister has met with her provincial colleagues and is looking for areas of collaboration in which we can continue to support them and the improvements they're trying to make in their actual health care delivery.

● (1715)

**Hon. Laurie Hawn:** Thank you. And thanks for saving a couple of minutes for me. I just have one quick question.

A number of times over the last several years I've had conversations with Dr. Louis Francescutti, who is the head of the Canadian Medical Association. He had some pretty firm opinions that we could save massive amounts of money in the injury prevention area. I'm curious to know whether he has brought any of those ideas to Health Canada, or to whoever is involved, and what we may be doing with those.

**Mr. George Da Pont:** Krista will address that.

**Mrs. Krista Outhwaite:** Thank you, Mr. Chair, for the important question.

There's absolutely no doubt that the newly elected president of the CMA is firmly focused on injury prevention as one of his areas of interest.

As you would know, this government invested in the Active and Safe injury prevention initiative a couple of years back. It was a program designed to run over two years to raise awareness and build some interest in this particular area and to encourage other partners in the private sector to come to the table to work on such important issues as preventing concussions in sport, safe swimming practices, particularly in first nations communities, helmet protection for ATV use among the Inuit in northern territories, as well as working with parachutes and the Lifesaving Society of Canada, so that they can better reach communities in their areas. We are now exploring with Parachute Canada what more work can be done.

**Hon. Laurie Hawn:** He was talking a lot about the workplace, and as you know, he's very passionate about it. He was pointing to examples of countries—I can't remember the countries, but a number of countries around the world—that have implemented some of the programs he has been promoting, apparently with very dramatic results.

I'm wondering whether we have encouraged, and if not whether we could encourage, some movement in that direction.

**Mrs. Krista Outhwaite:** Our colleagues at Labour Canada are very much engaged in that particular area, ensuring that programs are working not only for the federal community but for employees wherever they find themselves.

**Hon. Laurie Hawn:** Okay.

**The Chair:** Thank you, Mr. Hawn.

I would like to thank all of our guests and witnesses here today and all the staff at the back supporting their colleagues here at the table. I'd like to thank our members of Parliament for their detailed questions.

We're going to suspend for a minute or two. I'd ask the officials to leave, if they can, in a timely manner. Then we'll get along to the supplemental estimates and vote on them.

Thank you. We'll suspend the meeting for just a couple of minutes.

● (1715)

(Pause)

● (1720)

**The Chair:** We'll resume the meeting. Now we're into the real detail of the meeting, supplementary estimates.

I want to ask the committee their opinion first, and then we'll get into this.

There are ten different line items to vote on. We can do them individually or we can lump them all together in one amount. I can ask for the unanimous consent of the committee to vote on one dollar amount, one line item, and then I'll also ask your permission to report back to the House of Commons.

Are there any thoughts on lumping these ten dollar amounts into one?

The NDP supports that.

Ms. Fry, what is the view of the Liberals on that?

**Hon. Hedy Fry:** On the...?

**The Chair:** On the estimates. We have ten line items to ask from. We can do ten in a row or we can just do it in a lump sum.

**Hon. Hedy Fry:** Let's do it in a lump sum.

**The Chair:** Okay, thank you very much. That's good. I like how everybody has come to a consensus here.

We have 10 line items. My trusty clerk has them all listed. I'll ask for the committee's unanimous consent.

Shall all the votes under the supplementary estimates (B) carry?

HEALTH

Department

Vote 1b—Operating expenditures..........$235,479,489

Vote 5b—Capital expenditures..........$1

Vote 10b—The grants listed in the Estimates and contributions.........$101,958,206

Canadian Food Inspection Agency

Vote 11b—Operating expenditures and contributions..........$27,973,639

Vote 13b—Capital expenditures..........$4,924,955

Canadian Institutes of Health Research

Vote 15b—Operating expenditures..........$859,268

Vote 20b—The grants listed in the Estimates..........$14,000,000

Public Health Agency of Canada

Vote 45b—Operating expenditures..........$19,719,028

Vote 50b—Capital expenditures..........$1,081,962

Vote 55b—The grants listed in the Estimates and contributions..........$1

(Votes 1b, 5b, 10b, 11b, 13b, 15b, 20b, 45b, 50b, and 55b agreed to)

**The Chair:** Shall the chair report votes 1b, 5b, 10b, 11b, 13b, 15b, 20b, 45b, 50b, and 55b under Health to the House?

**Some hon. members:** Agreed.

**The Chair:** Thank you very much.

That concludes this meeting. Thank you for your attendance and your attention.

The meeting is adjourned.

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