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Chair

Mr. Ben Lobb

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● (0845)

[*English*]

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

We're very delighted to welcome the Minister of Health here at our committee.

Welcome, Minister Ambrose. We're here to deal with the main estimates today, and we look forward to hearing you. I believe you're staying for an hour. If you can stay longer, we'd be very delighted, because then we can ask you more questions. I know that your officials will be here for the two hours.

I'd like to call vote 1, which means that we now invite the minister to make her remarks.

Thank you.

The Honourable Rona Ambrose (Minister of Health): Thank you, Madam Chair, and good morning to all the committee members. It's a pleasure to be here with you.

[*Translation*]

Thank you for the invitation to discuss the main estimates for Health Canada, the Public Health Agency of Canada, the Canadian Institutes of Health Research and the Canadian Food Inspection Agency.

[*English*]

I'm joined by George Da Pont from Health Canada, our deputy minister; Krista Outwaite and Dr. Greg Taylor from the Public Health Agency of Canada; Dr. Alain Beaudet, who is here from the Canadian Institutes of Health Research; and Dr. Bruce Archibald from the Canadian Food Inspection Agency.

You're right, Madam Chair; after I depart you'll be in good hands with the officials. I'm sure they'll be happy to take more questions from the committee.

Before I begin my remarks on the main estimates, I would like to take a moment to commend this committee on the great work you've done recently. I know right now you're undertaking a current study on the health risks and harms from marijuana. I have a particular interest around the concerns of the health risks associated with children. I also want to thank you for the work you've done on prescription drug abuse. It's not an emerging issue; this issue has arrived. It is very much a public health issue here in Canada and in the United States. You've heard from many health officials across the border. I thank you for your recommendations. I know we've already acted on some of them. I look forward to acting on others.

On the current study you're doing right now, obviously as Minister of Health I am very concerned about the health risks associated with smoking marijuana, but particularly for our children and youth. I think it's important to know that Health Canada does not endorse the use of marijuana, nor has it approved it as a drug or medicine. I think that's an important message to send and for kids to understand.

When we have discussions around medicinal marijuana, it's important for young people to understand that while there is a program in place, this program has been put in place to respond to a court decision. Health Canada does not endorse the use of marijuana, nor is it approved as a drug in Canada, or as a medicine. This is an important message to counter the normalization around the use of it and some of the misperceptions that kids have. I understand you've heard from them.

I have been pleased that you've invited a number of organizations to your session, including the Canadian Medical Association and others who are raising similar concerns around the health risks. I've been reassured to hear that you've been seeking advice from very well-informed and credible medical experts—Michel Perron, who is the head of the Canadian Centre on Substance Abuse, and others, including researchers, in particular from the University of Ottawa and elsewhere, have also been speaking out about these well-established health risks.

So I thank you for that good work. I think what's coming out of this committee is important because it's credible evidence from those who are close to this issue and dealing with young people. I think that informs some of the work we do going forward.

I will now briefly go to the main estimates, and my priorities for the health portfolio, before answering questions. As Minister of Health, I'm very focused on improving Canadians' health and working with all partners to ensure that Canadians can continue to access the health services and products they need in a safe way. The department is providing services that are important to Canadians, such as stronger safety systems for health products and food, continued support for mental health research, and improved access to quality health services to first nations and Inuit.

Health Canada's main estimates for 2014-15 outline $3.66 billion in spending, which is designed to help Canadians maintain and improve their health. This represents a net increase of $365 million over last year. The increase is due mainly to the stabilization of first nations and Inuit health program funding, which accounts for $311 million, as well as the implementation of the very successful B.C. tripartite framework, which accounts for $63 million.

However, as members of the committee know well, main estimates do not reflect our recent budget investments, and economic action plan 2014 has several important investments that do continue to deliver on our government's commitment to the health and safety of Canadians. In fact this year's budget announced almost $400 million to strengthen Canada's food safety system and better protect Canadian families.

These investments will support the hiring of over 200 additional inspectors with CFIA and other staff, improve our systems to detect and respond to risks, and continue programming that keeps our country free of dangerous animal diseases that affect human health.

● (0850)

I was of course thrilled to hear the leader of the opposition say that this was good news in the budget with regard to food safety and that this was a good idea. Of course, I couldn't agree more.

Since I last appeared before you, I've also held round tables to hear what Canadians have to say about nutrition information. I raise this because there's a lot of discussion and interest in this from members and from the media around nutrition information and healthy eating.

We've also launched a regulatory transparency and openness framework for Health Canada so Canadians can easily find relevant drug facts and information about medicines that have been approved in Canada.

Working with the CFIA, I have also announced the healthy and safe food for Canadians framework. This framework describes how the government is working to inform consumers about healthy and safe food choices, minimizing food safety risks, and protecting Canadians when unsafe foods enter the marketplace, with our ability, of course, to recall them quickly.

I'd also like to spend a few moments talking about Canada's health care system, the pressures that it's facing, and the action we are taking.

[*Translation*]

Canadians are among the healthiest people in the world, living longer and enjoying more quality years in good health than ever before. And we are living in a time and place of remarkable progress in healthcare.

[*English*]

And indeed our government is providing the highest recorded health transfer dollars in history to provinces and territories. This record funding will reach $40 billion annually by the end of the decade and provide stability and predictability to the system. In fact, since we formed government, health care transfers have increased to the provinces by almost 50%, but there are also important issues that we need to continue to address. We simply must do more to ensure that our health care system is innovative and delivers the care that Canadians need and want, and ensure our system is sustainable for the long term.

[*Translation*]

Since my appointment, I have had the privilege to meet and hear from Canadians across the country about our healthcare system.

[*English*]

I've also met front-line staff workers and even had a chance to work with residents for a day in Toronto at St. Joe's Health Centre to understand the important work they do and the challenges they face.

I've heard from Canadians that they feel that the system needs to adapt to changing economic, demographic, and technological pressures. They need to know that we are working to improve the health system and ensure its sustainability, not just for themselves but for generations to come.

These concerns reinforce the most critical challenge facing Canada's health care system, and that is its long-term sustainability. The reality is that more money is not going to fix the inefficiencies in our health system. Currently we spend 11.2% of our GDP on health care, significantly more than many other countries, and, left unchecked, some experts like David Dodge suggest that by 2031, public and private spending on health care could be 15% of our GDP, or higher.

I believe the key to the long-term sustainability of our health system is innovation. We need to make better use of our existing resources and target best practices. This means breaking down barriers, tapping into creative minds, and working collaboratively to improve the productivity, efficiency, and responsiveness of the health care system.

To that end, a few months ago I announced the creation of an expert panel to find the most promising innovations in health care, not just here but abroad, whether they are technologies or models of care. This panel will focus on finding innovative solutions to these challenges and informing our future policy decisions. It will also identify promising innovations within Canada and abroad, as I've said, that have the potential to reduce growth in health spending while improving care, and it will recommend ways the federal government can better align its efforts to support such innovations.

I look forward to the advice of this panel. It will be invaluable in guiding us toward a sustainable and responsible health care system that meets the needs of Canadians now and to the future. I look forward to announcing more details about the panel to you very soon.

● (0855)

[*Translation*]

All jurisdictions in Canada are starting to focus on innovation within the healthcare system, and we are making progress.

[*English*]

Our government plays a key role in these efforts. On the research front, we invest almost $1 billion annually to support Canada's best health researchers and trainees through the Canadian Institutes of Health Research. I am particularly pleased with our investments in Canada's strategy for patient-oriented research.

SPOR, as we call it, in which the CIHR plays a key leadership role, is a coalition of federal, provincial, and territorial partners, patients, researchers, and industry, all dedicated to ensuring that the right patient receives the right intervention at the right time.

I was pleased that in budget 2014 we committed to ongoing support of this initiative when we increased its investment by $15 million. This will help support the expansion of SPOR as well as the creation of the Canadian Consortium on Neurodegeneration in Aging and other health research priorities.

Of course, building partnerships among governments, industry and others in the private sector, the health care community, and academia will be critical going forward. We've extended a challenge to the private sector to partner with us and the non-profit sector to invest in public health objectives specifically and to co-create initiatives that help make Canadian society and workplaces healthier. l am pleased to say that we've had a great response from non-profits and from the corporate sector to step up for this challenge.

Examples of this would be that through our partnership with Air Miles for Social Change and the YMCA, gym members receive Air Miles reward miles if they reach certain physical activity milestones on a weekly basis. We're testing whether this incentive-based approach leads to longer-term behaviour change.

We've also partnered with Canadian Tire, LIFT Philanthropy Partners, and the CBC for what we're calling The Play Exchange in order to appeal directly to Canadians themselves for healthy living ideas that we want to put into action. That's because we know that Canadians are among the most resourceful and innovative people in the world, so we're tapping into their ingenuity as well. We had a chance to launch this initiative during the Winter Olympic Games and we have seen great participation so far.

By joining forces with both the public and private sector, we are fostering innovation, making the most of our resources, amplifying the impact on our communities, and creating environments that help make the healthier choice the easier choice.

Madam Chair, I'll end my comments there. I am happy to take any questions from members.

The Vice-Chair (Ms. Libby Davies): Thank you very much, Minister Ambrose, for your comments. I'm sure there will be lots of good questions from the committee.

We'll begin our first round, which is a seven-minute round, with Dr. Morin.

[*Translation*]

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

I also thank the minister for joining us. I would like to ask her to give brief replies to all my questions, given that I have a number of questions to ask.

[*English*]

If, unfortunately, the answers are not very short, I will have to cut her off, and I don't want to do that.

My first question for you, Minister, is this. When we had government officials before the committee in November, they mistakenly said that no application for mifepristone had been made, but in fact it had been submitted to Health Canada for over a year.

The drug is approved in 57 countries, including the U.S.A. The medical community even calls it the gold standard of care.

Considering that safe access to abortion is a fundamental right in Canada, could the minister confirm that Health Canada's approval process for mifepristone will be fully independent and be based on science alone?

Hon. Rona Ambrose: Yes, I'd be happy to answer that question. Of course, I do understand that the last time officials were here, that information was there; I know that the deputy minister addressed that issue to the committee.

In terms of drug approval processes, this drug like every other is under an approval process whereby decisions are made by scientists within Health Canada, not by politicians or ministers. Under the Food and Drugs Act and its regulations, manufacturers submit applications for the approval of drugs to Health Canada, and the timing of the reviews for drug submissions varies depending on the information provided by the manufacturer.

Mr. Dany Morin: So it will be independent?

Hon. Rona Ambrose: Yes.

Mr. Dany Morin: Thank you so much.

My next question is this. The main library at Health Canada has been closed, and the library's physical collection has been moved. Can the minister confirm that she is aware that understaffed and under-resourced libraries present a liability for the department, putting the health of Canadians in danger?

Hon. Rona Ambrose: What I can tell you is that I've been reassured by the department that the change to digitize our library services means that more Health Canada officials and bureaucrats will be able to access those documents, and so they see it as very positive. All of the documents are accessible and available to employees through our library services.

● (0900)

Mr. Dany Morin: Well, in fact managers at Health Canada admitted that changes to the departmental library services would lead to risks to the department's credibility and its ability to produce evidence-based decisions. Was the minister aware of these concerns?

Hon. Rona Ambrose: As I said, I've been reassured by the department that employees maintain free access on a broad electronic database of publications and can request any item that is not yet available electronically.

You should know that the entire library collection remains accessible to all Health Canada employees, whether through loan request or electronically via the National Research Council.

Mr. Dany Morin: But before, I believe, there were 40 researchers working at the library, and now there are only six of them. Do you honestly believe that they will be able to produce more research and make it more available, with so many fewer people on staff?

Hon. Rona Ambrose: I appreciate your comments, but officials have reassured me that this is a good decision, because more people will be able to access the documentation.

Mr. Dany Morin: Okay, then. Thank you for the answer.

Here is my next question. Canada's first nations and Inuit face significant barriers when accessing dental care, and they experience much higher rates of dental disease, but we have heard of significant concerns with the rules and requirements of the program responsible for ensuring their dental care, the non-insured health benefits program. These rules can cause delays in treatment and increases in transportation costs and can deter follow-up treatment. All of these effects have direct impacts upon patients' health.

Can you confirm that you plan to have a joint review for the non-insured health benefits program to ensure that it is meeting its goals and is meeting the needs of first nations and Inuit people in Canada?

Hon. Rona Ambrose: Yes, I can confirm that we're in discussions related to a review.

Mr. Dany Morin: Do you have a timetable for when that study will start and when it should be complete?

Hon. Rona Ambrose: No. I discussed this a number of weeks ago with Chief Atleo, and we made a commitment to him and to the AFN for this review. In fact, the review was already something we were looking forward to doing.

Mr. Dany Morin: Do you believe that this joint review will start before the election?

Mr. George Da Pont (Deputy Minister, Department of Health): Perhaps I can add a few comments on timing.

AFN is in the process of finalizing its own internal views on the review. I understand they will do it over the summer, and then we would be in a position to start the process after that.

Mr. Dany Morin: Thank you very much.

My next question is to the minister again. As you must know, the problem of drug shortages has gotten worse. Doctors and pharmacists say they are spending more and more of their time scrambling to make up for drugs in short supply and to find substitutes.

What actions have you taken as this problem has continued to spiral out of control? Give me a short answer, please.

Hon. Rona Ambrose: Sure.

We all worry about drug shortages, obviously. Drug shortages are not just an issue in Canada; they are a global problem, which we take very seriously.

We established a stakeholder steering committee on drug shortages. It is co-chaired by us and the Province of Alberta, with all provinces and territories as part of it. As part of that committee, we're working with drug companies. We have a pan-Canadian strategy to manage and prevent shortages and reduce their impact.

We have seen real progress and we have announced increased communication strategies. Plus, as you know, if the drug companies see a drug shortage coming, they alert us. We put it—

Mr. Dany Morin: But it is not mandatory.

Hon. Rona Ambrose: It is not mandatory,

Mr. Dany Morin: Should it be?

Hon. Rona Ambrose: I have said many times that if it's not working, we will make it mandatory. I have told the provinces that; I have signalled that to industry. We are obviously keeping a close eye on this, and if we feel that it is not sufficient....

It was an agreement among the multi-stakeholder committee that this would be a voluntary approach, but I've told everyone very clearly that from the federal point of view, if it is not working effectively we will move to a mandatory system. I can tell you that we have already begun formal consultations.

Mr. Dany Morin: Thank you.

Here is the last question. Resistance to antibiotics is a growing public health issue and falls directly under the responsibility of your ministry. I'd like to ask what action has been taken to protect public health and to monitor this issue.

Hon. Rona Ambrose: There is a lot of action being taken on this issue.

I'd like to turn it over to Dr. Gregory Taylor to make some comments about our AMR strategy—

● (0905)

The Vice-Chair (Ms. Libby Davies): We are now over our time, so I think what we might do is come back to this question. It's a very important question, so we'll come back to it.

I'd now like to invite Mr. Wilks to put his questions.

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

Thanks to the minister for being here today. We appreciate it.

During our study on prescription drug abuse, we heard testimony from several witnesses on the need to ensure that Canadian families have the information they need to make informed choices on the medicines they are taking.

With the numerous risks inherent in many drugs, I think everyone around this table can agree that we simply must do better at making people aware. It's imperative that drug safety information be available and accessible for not only overburdened doctors but also parents and families. As a father and grandfather myself, it's critical for me as well to have the information necessary on drug safety, in order to fully understand the risks and benefits of certain medications.

Can you inform this committee on what is being done to ensure that drug safety information is available to those who need it?

Hon. Rona Ambrose: Thank you very much, and thank you for your good work on the committee.

I appreciate that question because it gives us an opportunity to speak about what I think is very good work that Health Canada is undertaking to become a leader, if it is not already a leader, on transparency. Nowhere, I think, is confidence in transparency more important than in our health system and around the decisions that our regulators make for health, whether it's products or medicines that Canadians take. So I was very pleased. We've done quite a bit of work in the last number of months, and very recently we launched what is a world-leading regulatory transparency and openness framework. So for the first time in Canada, practical and world-leading drug safety review summaries are being posted online, transparently, in an accessible format to Canadians. These summary safety reviews will provide the public with plain language descriptions of Health Canada's findings around drugs and their actions, so that Canadians can make informed decisions about their health.

With this new framework, Canada is now a world leader in a transparent posting of practical drug safety review summaries, ahead of both the United States and the European Union, in fact. Previously, as you know, drug review information like this was only accessible to those who made access to information requests, and I didn't believe that was sufficient.

I would also like to add for clarity that although not many regular Canadians are interested in the full-length technical reviews, a lot of researchers, doctors, and others in the health system and potentially journalists might be, and these are also available on request from Health Canada. On this point, we've also been receiving great feedback. In fact, the CEO of the Canadian Pharmacists Association commended the government for our efforts to increase transparency by making drug safety reviews publicly available. In the development of this framework, we consulted with a wide variety of stakeholders, and I have to say, a number of caucus members on all sides of the House worked on this issue. So I really commend the practical work that parliamentarians do around the issue of transparency.

These full technical documents are not only very exhaustive and complex, but they also range from hundreds to tens of thousands of pages in length. That is why I said while we'll make the practical, understandable summaries available, we'll also have those available on demand. It's also important to note that these steps forward in transparency are only the beginning. I have made that commitment. We will be looking at further steps to ensure that crucial drug safety information is made available to Canadians, and I will ensure that Health Canada continues to find ways to be more open and more transparent with Canadians each and every year.

But the bottom line is that our government is making this issue more relevant. We're making the information around drug safety information more useful and timely than ever before, and I know that it's information that Canadians want. We have a lot of Canadians who seek out this information on our Health Canada website. One of the positive things about the initiative, I think, is that we're engaging Canadians through a portal now, actually asking them for feedback on how much more they'd like to see, or what else we can do to be more transparent, and what kind of information we are lacking and what it is they're looking for. I think that's also a very positive step in the right direction.

Mr. David Wilks: As you're aware, the court rulings in 2001 have required the government to allow legal access to marijuana for those authorized by a physician. However, the use of marijuana and the system that allowed homegrown ran amok, shall I say, and is contrary to the concerns of doctors and certainly the police community as well. In fact, over the past few weeks, this committee has heard from doctors and researchers on the serious and harmful effects associated with marijuana use. Their testimony has revealed the damaging effects on the developing brain and the harm it inflicts on communities.

As a retired police officer, I'm concerned about the existence of marijuana in our community, and especially its negative effects on young Canadians. Can you please tell the committee what our government is doing to protect the health and safety of Canadian families and communities with regard to this?

● (0910)

The Vice-Chair (Ms. Libby Davies): You have a little over a minute.

Hon. Rona Ambrose: Sure.

I think the health committee study that you've done has really articulated the risks to youth well, particularly the health risks to youth. The issue of normalization of smoking marijuana is one that concerns me greatly. I worry about the discussion around legalization because it insinuates that this is a healthy thing to do and it's an acceptable thing to do if and only you're over the age of 18. That's not a great message for kids. It's not a great message for youth. We know that every year more research comes out about the health impacts of smoking marijuana. So there is a concern there.

On the issue of grow ops and the medical marijuana program, we've brought a lot more discipline and rigour to the program in a number of ways, especially bringing in commercial operators that are approved by the RCMP and have a great deal of security around them, and ending home grow ops, which, as you know, were a real problem in a lot of communities.

We did have to make changes to this program. In fact, I will say it was not a well-run program. I'm glad that we have made changes to it. The average approval for a licence for marijuana for an average patient was between 45 and 90 joints a day, which is completely unacceptable. We need to have medical supervision and physician supervision, which is what we're asking for now.

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

Thank you, Mr. Wilks.

We'll now go to Dr. Fry.

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

Welcome, Minister. I will put a preamble, as my colleague did, in that I have so many questions to ask you, I would really appreciate it if your answers could be short. I'll try to keep my questions short.

The report on plans and priorities identifies about $7.7 million to be allocated to the immunization program at the Public Health Agency of Canada. There are declining rates of vaccination in this country. We know in some areas it's as low as 60%.

I know that you have said, Minister, that you've put on an online system for parents who have vaccinated their kids to keep track of their vaccinations. I don't think that's good enough, because you're preaching to the converted here. I'm wondering if you have a plan with that $7.7 million to find a way to ensure that the vaccination rates go up to the 95% that it used to be—if possible 100%, but we know that's never possible. I think it's really important, because we're only waiting for an accident to happen. Measles outbreaks can kill children.

I think this is a really urgent problem. I want to know what you're going to use that money for and how you're going to address the non-vaccination rates.

Hon. Rona Ambrose: I agree with you completely. It's a very disturbing trend that we're seeing with parents who are refusing to vaccinate their children, making decisions based on misinformation —for instance, that vaccines cause autism, when we know clearly that they do not. Vaccines, in fact, save lives. Just today, in Edmonton, in my hometown, another case was announced, and this was a child who had not been vaccinated.

Hon. Hedy Fry: Do you have a plan, Minister?

Hon. Rona Ambrose: We have the national immunization strategy. We are reaching out. We work very closely with the public health officers across the country. We work closely with the provinces and territories. We have a coordinated approach to vaccine purchasing, to vaccine education, to leadership in the event of outbreaks or emerging vaccine safety and supply issues.

We are doing everything we can, but I do encourage you to also speak out. All of us need to speak out, because there's a great deal of misinformation out there in this anti-vaccine movement and trend. The more education and awareness we can do, the better. And we are doing that.

Hon. Hedy Fry: The provinces have some tools that they can use, and I hope you will work with the provinces—

Hon. Rona Ambrose: Yes.

Hon. Hedy Fry: —to make those tools national.

Now, the 2014 budget changed the funding formula for transfers to provinces to a per capita formulation. This means that funds will not only be allocated based on population: it will only be allocated based on population.

We know that demographics are a huge issue in which we could have some provinces with very high costs for seniors, etc. One of the problems we have is that now that you've done this, it will mean, for example, that Alberta gets almost $1 billion in transfers this year when they have a very low seniors population. Yet a place like Nova Scotia gets $17 million; they have very high aging populations in the Atlantic, as they do in my province of British Columbia.

Do you intend to find a way to equalize the transfers based on demographics? If you don't, provinces will in fact not be able to address the needs of their population anymore because you've moved the formula from needs and demographics into a simple per capita basis.

● (0915)

Hon. Rona Ambrose: I think the per capita formula is a fair one. I do think it is.

Hon. Hedy Fry: I disagree with you.

Hon. Rona Ambrose: There are always issues when you decide on a funding formula. But I do believe, when you look at the level of funding in this funding formula, this is a record funding that will reach $40 billion by the end of the decade. Health transfers have increased by almost 50%, and the transfers continue to grow on an escalator of 6% per year over the next three years.

I say that because the good news is that we've seen from the Canadian Institute for Health Information's most recent report that total health spending growth in the provinces is actually starting to slow down. That's a good thing. That means provinces, and those who are responsible for this direct spending of health services in their jurisdictions, are starting to look at ways to create efficiencies and look at sustainability. That's positive.

Hon. Hedy Fry: But health outcomes is not a black and white equation, Minister. Because health spending goes down in the province, it doesn't suddenly mean that quality and timely access to care is being given. I also think this is a gross inequity. I just wondered if you had a plan to fix it, and obviously you don't, because you think it's a good idea.

Now, I want to suggest that the $41.2 billion that was put back into health care over this last decade ending in 2014 was put in by, as you well know, a Liberal government with a 6% escalator clause. That brought up health transfers to the provinces and the federal part of health funding to 20%. The change, when you go to the 3% in 2017, is going to continue now to bring down the health portion of funding so that, as the Parliamentary Budget Officer said, it is going to drop to 13% from 20% in the next 20 years.

This will mean, given that the government continues to say that health is a provincial jurisdiction, that the ability to deliver good care to people will depend on the province in which you live, as we've already heard from the Canadian health reports out of CIHI, etc.

So the question is what are you going to do? This is going to mean that medicare is at risk now. Are you going to take steps to make sure that the funding remains at 20% or at least goes up to 25%? Because the track you are on is going to decrease funding to 13% of the federal share.

Hon. Rona Ambrose: Let's be clear; for the next three years, health transfer increases are projected to continue to rise at more than double the rate of spending in the provinces and territories.

I do believe there is a consensus in this country that more money is not going to fix the problem. We have a 6% escalator. We have growing spending rates. Provinces are doing very good work to bring that spending in check, not because they are cutting, but because they know they want a sustainable health system. If we want to address that directly, we need to look at better ways of delivering care and innovative technology. We need to look at innovation in our system. When we look at countries comparable to Canada that are spending less by getting better results, we know that there are inefficiencies in our system that we can address. I'm very optimistic that, working with the provinces and territories, we will find those solutions for better care and more innovative care.

I know those solutions are there and I know my provincial and territorial colleagues have also committed to an innovation framework to ensure that we have a strong and sustainable system.

Hon. Hedy Fry: But your provincial and territorial colleagues have been asking for a meeting with the Prime Minister so that they can look at the innovation that was promised in the 2014 health care accord, which was a whole transformative change. It didn't happen because you walked away from the table.

The Vice-Chair (Ms. Libby Davies): Doctor Fry, we are at seven minutes now.

Hon. Hedy Fry: Thank you.

The Vice-Chair (Ms. Libby Davies): The time has run out, so maybe we can come back to it. Thank you.

We'll now turn to Mr. Young.

Mr. Terence Young (Oakville, CPC): Thank you, Chair.

Welcome, Minister.

Fourteen years ago my daughter, Vanessa Young, died tragically from a heart arrhythmia due to the prescription drug Prepulsid, which was deemed not safe and later removed from the market. In fact it was removed from the U.S. market three days after she died.

Vanessa's death and the deaths of many others could have been prevented with stronger safety warnings on labels and clear communication with doctors. Moreover, during our study on prescription drug abuse, a number of witnesses ranging from doctors to researchers testified that there needs to be stronger label warnings and restrictions put in place on prescription drugs that clearly identify addictive properties and potential adverse drug reactions.

Minister, several important steps have been taken to strengthen patient safety in Canada. Can you inform the committee on what is being done to strengthen drug and patient safety in Canada to better protect all Canadians from the potentially dangerous consequences of adverse drug reactions?

● (0920)

Hon. Rona Ambrose: Sure. A great deal of the work is being done because of your leadership, Mr. Young, so thank you very much for your question.

As you know, we not only committed to introducing new patient safety legislation in our Speech from the Throne, we also did that recently with the introduction of Vanessa's law late last year. I just want to thank you for the great work you've done in leading the awareness around drug safety issues. You have obviously been a very powerful advocate on this.

But stories like your daughter's really do remind us all about the serious consequences that pharmaceutical drugs can have and the role that the regulator has to ensure—that's Health Canada's role and the role of government—that we have strongest possible safety systems in place to ensure that we're preventing other families and patients from going through an experience like your family's in suffering such a terrible loss.

Of course, Health Canada is responsible for reviewing all drugs for sale in Canada to ensure that they are safe and effective, but the powers included in Vanessa's law will ensure that we are able to take that to a new level. We must continue to remain vigilant, even after the law passes. Health care institutions, of course, are not currently required to report adverse drug reactions, as you noted for example, and there exists no authority to order label changes or packaging if we feel that additional information or studies are required around a particular safety issue we might find. And of course, as you know, Vanessa's law will address that.

Science and medicine have evolved considerably in the last 50 years, as we know, since the Food and Drugs Act was last updated. I believe Canada does lag behind our international regulatory counterparts, which have improved patient safety through their enhanced regulatory oversight of products on the market. But Vanessa's law will bring us in line with where we should be, and in fact it will take us even further. We are going to be introducing, through Vanessa's law, tough new fines for those who don't comply in addition with any of the measures that we're putting in place. The law allows for quite significant penalties, as you know, including jail time. Just to put it into perspective, a previous fine would be about $5,000 a day. As you can imagine, that's about the same as somebody could be fined for littering under some municipal bylaws. When Vanessa's law comes into force, we'll change that to $5 million a day. I think that sends a strong message to pharmaceutical companies about the need to work with us on safety.

Vanessa's law also speaks to the importance that we place on ensuring that Canadian patient safety remains paramount. As a government and as a regulator, I hope that all parties will support this bill. I was very pleased to see when you spoke in the House that you did receive the support of all parties. I know there has been an interest from members, including yourself, for potential amendments, and we're open to those, as I said. I look forward to seeing those amendments and working with members to strengthen the bill even further.

Mr. Terence Young: Thank you.

Our committee recently undertook a study on the troubling rise in prescription drug abuse. We heard expert witness testimony from doctors, pharmacists, regulatory bodies, law enforcement officials, first nations leaders, and parents on the scope and severity of prescription drug abuse, as well as some suggested solutions to the problem.

One of the problems we kept hearing about was a lack of awareness among Canadians about the risks associated with prescription drugs that can be addictive. We also heard from experts that proper storage and disposal of prescription drugs was paramount to protecting against the un-prescribed consumption of these drugs. We heard in fact that teenagers in some communities actually go and grab a bunch of pills out of their parents' medicine cabinet and throw them in a bowl, and this is called a “pill party”, which is extremely dangerous.

Minister, the problem of prescription drug abuse is a problem that impacts many Canadians and their families. Can you inform this committee on the work being done to address the problem of prescription drug abuse in Canada?

● (0925)

Hon. Rona Ambrose: Sure. Thank you very much.

Thank you to the committee for the work you did on this as well. This is a major public health issue and we have been raising more awareness of it, reaching out to the medical community. We recognize that prescription drug abuse is a growing problem in Canada. I am very concerned about it.

We are actively working with the provinces and territories as well to address this issue. We have worked with them. As you know, some of them have drug monitoring programs, others don't, but I know they are endeavouring to put that in place.

I'm also pleased to note that just recently in our budget we committed to extending our national anti-drug strategy to include the fight on prescription drug abuse, which I think is an important one. This includes educational measures; prevention and treatment services, particularly in aboriginal communities; and also improved surveillance. This will build on actions we've already taken to tighten licensing rules for pharmaceutical companies that will help to prevent drugs like oxycontin from being illegally distributed. This includes implementing strict controls in the public drug plan that's administered by Health Canada, including maximum monthly and daily drug limits, monitoring the usage of certain drugs to address potential misuse, and real-time warning messages to pharmacists at the point of sale.

One of the other things that was important that we did was to reach out to the medical community—

The Vice-Chair (Ms. Libby Davies): Minister, could you just wrap up your response? You're just a few seconds away from the end of the time.

Hon. Rona Ambrose: Sure.

I think one of the most important things we did was reach out to the prescribers themselves. For the first time we put everyone in a room to talk about what we can do together, what the health community and what the medical community can do. We held a symposium, and there is a lot of work being done collaboratively to tackle this issue.

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

I know I keep interrupting, but I'm trying to keep to the time just so as many members as possible can get to ask a question.

Next we go to Mr. Gravelle. Now we're on a five-minute round.

Mr. Claude Gravelle (Nickel Belt, NDP): Thank you, Madam Chair.

Thank you, Minister, for being here.

We've covered a lot of ground and a lot of different subjects here so far this morning. I'd like to talk about something that we haven't mentioned yet, and that is dementia.

I have a personal interest in dementia. As you are probably aware, there are 747,000 Canadians who have dementia right now, and that number is expected to grow to 1.4 million by 2030. Presently it's costing Canada's health care system $33 billion per year, and that is expected to rise to $293 billion per year.

Madam Minister, can you tell me, do you support a national strategy for dementia?

Hon. Rona Ambrose: I'm interested in a national strategy, but I have approached the provinces, and there is no consensus for the creation of one. What we will do with the provinces is continue to work with them in any way that we can, but we do have our own federal plan, if you want to call it that, to work on dementia. There is a great deal of work that's being done in Canada.

As you know, we have joined forces, even internationally with our G-8 counterparts, to commit to finding a cure for dementia by 2025. We've now invested close to $1 billion in dementia research and Alzheimer's research, so there is a lot of work being done at the federal level.

As you know, we've expanded our patient-oriented research to create the Canadian Consortium on Neurodegeneration in Aging to tackle the growing onset of dementia and related illnesses. So there are a number of actions that the federal government is taking.

Mr. Claude Gravelle: Thank you.

How many provinces have you met with?

Hon. Rona Ambrose: I meet with all of the provinces together at our federal-provincial-territorial meetings. On this particular issue I worked with my co-chair from Alberta and asked him to approach the rest of the provinces.

As I said, some provinces have their own. For instance, Quebec has a very good seniors plan that includes dementia, and they're not interested in working on a national strategy. But that does not stop us from working with the provinces and supporting them, particularly with the research they need, so that they can put in place practical programming at the local level.

Mr. Claude Gravelle: You keep mentioning research. Research is good, and I agree totally with research. We want more research. But what about early diagnosis and prevention? I think that's also important. What about training for the dementia workforce? What about support for caregivers? Those are all important things. Can you tell me why we can't get that done?

You said that you've met with some of the provinces, so which provinces are not in agreement with a national strategy?

● (0930)

Hon. Rona Ambrose: Provinces are doing good work in their own area of jurisdiction, and we want to support them in any way we can. For instance, we are supporting 44 research projects on Alzheimer's disease and related dementia in universities and hospitals.

You asked, where is the training? Much of that does result in the support for the appropriate training and the appropriate practice on the ground. That is one of the ways we can support the good work of the provinces.

Mr. Claude Gravelle: You mentioned research again, and I totally agree with you that research is good. Research is good. But what about the caregivers? Why can't we help the caregivers? Why can't we help the doctors, especially the older doctors? They're not necessarily trained in detecting dementia and working with dementia patients.

Why can't we do more? Research is fine, but we have to do more.

Hon. Rona Ambrose: I know you're passionate about this issue, but I think we have to recognize that the research that we do actually informs what is the best way, the best practices that are then used by physicians. That's what they look to. They look to finding out from research what is the best practice for them to use to identify Alzheimer's, for instance, or to identify the onset of dementia. That's what they look to us for and that is what we do to support the practical information that they need.

I can ask Dr. Alain Beaudet to perhaps speak specifically to some of these issues.

Dr. Alain Beaudet (President, Canadian Institutes of Health Research): Well, I can only concur, Minister. You're talking about the issue of prevention and early recognition.

We're funding a lot of things. For instance, what are the right biomarkers? What are the standards in terms of the early deterioration that you can see through, for instance, brain imagery? In terms of caregivers, what are best standards of care? A big part of the CCNA will actually be looking at funding standards of care, models of care.

The Vice-Chair (Ms. Libby Davies): Thank you, Dr. Beaudet. We've reached the five minutes. I know it goes fast.

We'll now go to Dr. Lunney.

Mr. James Lunney (Nanaimo—Alberni, CPC): I think Wlady was up next.

The Vice-Chair (Ms. Libby Davies): Sorry: go ahead, Mr. Lizon.

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

Thank you, Minister, for being here with us today.

Minister, I often hear that Canada has one of the safest and healthiest food systems in the world. This is very encouraging to hear, as one of the most important things for Canadian families is the safety of the food that is put on the dinner table. Indeed, Minister, I've heard and I've been very pleased to see that the number of food safety inspectors continues to rise as a result of the investments in the Canadian Food Inspection Agency that our government has been making.

Could you please inform this committee on our government's latest investments in food safety?

Hon. Rona Ambrose: Thank you very much for that, MP Lizon.

Let me begin by saying that you're right, Canada has one of the safest and healthiest food systems in the world. In our recent budget we further reinforced this by delivering almost $400 million to strengthen Canada's food system. This is in addition to the more than half a billion dollars we've already invested in various food safety initiatives since 2008.

It includes enhancing food inspection programs and also hiring more on-the-ground food inspectors. Indeed, since 2006 there has been a net increase of over 750 inspectors, and of course the recent budget commits to hiring even more inspectors.

But other measures, I think, are important to highlight. We've brought into force tougher penalties for those companies that violate our food safety system. I think that's important. We have enhanced controls on E. coli; new meat labelling requirements as well that speak to safety; and more than 750 new inspectors, as you know. Of course, Canadians have concerns about food that is imported, so we're making sure we have the right measures in place to crack down on unsafe food imports. Canadians need to know that is being done, and it is.

The feedback from this work has been tremendously positive. In fact, I would say that we've come a long way in making sure that we have the right people in place to do this work. But we will continue to strengthen the food safety system.

We also have recently launched our safe food for Canadians action plan. This is working very well and it's delivering the peace of mind I think that Canadian families expect and deserve. In fact, the Food and Consumer Products of Canada has said that these changes are going to further enhance Canada's reputation as a global food product safety leader.

In that spirit, we brought together all the players that we think contribute to food safety under one roof. As you know, we have made a policy change as it relates to the Canadian Food Inspection Agency. I think this is simply good policy. We've brought the Canadian Food Inspection Agency into the Health portfolio. That means that Canadians can be assured not only that we have one of the safest food systems in the world but we will also be focused on encouraging Canadians to eat healthy food. They can rest assured that the safety of food will always come first, will always trump trade or any industry issues.

We're also working, as you know, to expand our food-borne illness surveillance program, known as FoodNet. It's very important in that we can communicate with public health officers and others around the country to ensure that risks are identified quickly so that we can deal with them quickly. This is a system made up of surveillance sites. It helps track our food-borne illnesses at their sources. Scientists then use this data collected to communicate important information to governments, industry, and Canadians. That in turn helps us to prevent any disease from occurring.

Essentially this program tracks food poisoning and traces illnesses back to their source, which is important because we're trying to work on the preventive side of things, not just to be reactive, be it food, water, animals, or any combination of these. With that information in hand, I think the agency can then determine which sources are actually making Canadians ill at the source.

Expanding FoodNet Canada will improve food safety surveillance and assist our partners across all levels of government and industry when it comes to taking the right preventative measures to help keep our food system safe. There's a great deal of work being done, and we'll be doing more.

Thank you.

● (0935)

The Vice-Chair (Ms. Libby Davies): You have just 15 seconds left.

Mr. Wladyslaw Lizon: I will give up those 15 seconds.

Thank you.

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

We're now back to Dr. Morin.

[*Translation*]

Mr. Dany Morin: Thank you very much.

[*English*]

Minister, regarding food safety, can you tell us what is being done to monitor the truth of claims on food packaging? I know you talked about this issue earlier.

Hon. Rona Ambrose: Food labelling?

Mr. Dany Morin: Yes.

Hon. Rona Ambrose: Well, I personally believe that Canadians want more information on their labelling. I launched a consultation, not necessarily with industry, as we've done in the past, but with Canadians, especially parents who do all the shopping. How do they feel about our food label? Do they understand it? Does it make sense to them? Does it mean anything to them?

We had a really great response. We did an online consultation with Canadians, and we also did round tables. Of course, we will also do consultations with stakeholders, such as health groups, about what they think needs to be changed.

So we're working, just putting all that information together, and we'd like to see what we can do to make our nutritional information on packaging more relevant to Canadians.

Mr. Dany Morin: Thank you, yes, because some of those claims on food packaging can be not so truthful. Are you proactively testing whether these claims are accurate when they put those health claims on food packaging?

Hon. Rona Ambrose: Yes. CFIA and Health Canada both do that.

Mr. Dany Morin: That's fantastic. Thank you very much for the answer.

My next question will be about mental health. We know that workplace mental health problems cost the Canadian economy billions every year. You have expressed support in principle for the national strategy on mental health developed by the Mental Health Commission of Canada.

Are you aware of whether the government has plans to adopt the Mental Health Commission's national standard for psychological health and safety in the workplace?

Hon. Rona Ambrose: I'm not sure. I will find out. I only hesitate because I know I've spoken to the Minister of Labour about this, but I'm not sure what the status is on the file.

Is there any information that you could share, Krista?

Mrs. Krista Outhwaite (Acting Deputy Head and Associate Deputy Minister, Public Health Agency of Canada): Yes, Minister, I would be happy to.

Very briefly, the workplace standard for mental health is something that the Treasury Board Secretariat is looking very closely at. In fact, it is encouraging a small group of departments and agencies to pilot this program. The Public Health Agency is looking very closely at that, possibly also Health Canada, to see if we can work with the Treasury Board Secretariat to look at the adoption of this on a pilot basis with a view to perhaps a broader adoption.

● (0940)

Mr. Dany Morin: Thank you very much. I do believe it is a pressing issue, so I would much appreciate it if you could work with your colleagues at the Treasury Board to make sure we can put that into effect as soon as possible. Thank you.

I'll go back to my antibiotic resistance question. If you remember the preamble, basically I'm going to ask the question again. Can the minister or her officials explain what steps would be taken if our antibiotics prove to be insufficient?

Hon. Rona Ambrose: As you know, it is a very complex issue that requires a multi-sectoral collaboration, which is under way. I can reassure that you we are working with governments, with human and veterinary health, pharmaceutical, agriculture, and the food sectors to address the public health threats from AMR. These include surveillance, research, public awareness, and the development of guidelines and policy instruments.

I can also tell you that at the upcoming World Health Assembly we are co-sponsoring a resolution on the need to take further action on AMR. We're working with our U.K. colleagues, who are obviously seen as leaders in the response to AMR, on important AMR research through the Canadian Institutes of Health Research. We're also working with the provinces and territories and other stakeholders, as I mentioned, to strengthen our surveillance of AMR in hospitals, in communities, and in the food chain.

Mr. Dany Morin: I do understand that you work closely with all those experts, but the resistance to antibiotics is a growing problem. Even though you're monitoring the situation, if it's getting out of control, what steps right now in Canada have you decided to put in place if our antibiotics prove to be insufficient?

The Vice-Chair (Ms. Libby Davies): Just a very brief answer, please.

Hon. Rona Ambrose: I'll ask Dr. Taylor to comment quickly.

Dr. Gregory Taylor (Deputy Chief Public Health Officer, Public Health Agency of Canada): I'd be delighted to comment.

As you're aware, antibiotic resistance is something that occurs naturally. When you get a new antibiotic, that happens. We have guidance to physicians. We've been doing that so that it's more targeted and there are more appropriate prescribing practices. We're working with the agricultural sector to assist in terms of the same on the animal side of that.

There are some really innovative new approaches to treatment, some designer vaccines, for example. There are some new technologies where they actually produce antibodies. So that may actually replace that.

It's a big issue, and we're working in a whole variety of areas—

The Vice-Chair (Ms. Libby Davies): Dr. Taylor, I'm sorry to interrupt you, but the time is up.

We have time for one more question, so we'll go to Dr. Lunney.

Mr. James Lunney: Thank you, Madam Chair.

Minister, thank you so much for being with us today.

I just wanted to mention first how much I appreciate the efforts you're making. You spoke briefly to this regarding drug safety and transparency as well as Vanessa's law and the changes that is bringing in, which are actually world-leading. I think there's been tremendous movement on that file.

I wanted to ask you to briefly address innovation, because you've been a champion for innovation from day one in the file, and I've heard you speak to this on numerous occasions. I know there's a long way to go. I appreciate that we're working with the provinces and, I think, there are some examples already. I'm wondering if you can provide us with some examples of how innovation is showing promising avenues of delivering better health care to Canadians.

Hon. Rona Ambrose: Sure. I'd be happy to.

Of course a big part of innovation is research, and we're the largest single investor in health research in Canada, obviously, investing close to a billion dollars a year through the Canadian Institutes of Health Research. These funding commitments result in about 13,000 innovative health researchers doing great work across this country. But of course related to that are 10,000 different projects. When you look at this kind of research, you see advances in care around dementia, cancer research, HIV/AIDS, and many other things.

Obviously research has a great deal to do with making sure we're going in the right direction when we look at inputting money into particular best practices or standards of care or innovative technologies. So I'm pleased that we're making progress on that front. Of course, outside of CIHR, we've also invested a great deal of money into neuroscience research, and we see quite a bit of work being done there.

I think one of the best examples of innovation happening among the provinces, the federal government, post-secondary institutions, and research institutions is the strategy for patient-oriented research, which is designed to ensure that patients receive the right treatment at the right time. It puts research into the hands of health care providers. It's what health care providers want, and it focuses on health challenges that are identified by the provinces and territories themselves. We then use research to bridge that gap and support them.

These have been excellent projects. At the FPT table in October, there was unanimous support to continue doing this kind of collaborative work, so in the budget we renewed funding for strategic patient-oriented research, which is a very innovative way of approaching work we can do with the provinces. We have to continue to do that. The provinces and territories and I agree that we should keep working on an innovation framework to look at how we can share best practices across the country, identify excellence in different parts of the health care system, and build on those.

There is a lot of good work being done. I'm very optimistic. I know that people have a lot of negative experiences sometimes in the health care system, but I think we can take those and turn them into positives if we can identify where things went wrong. I do sense from the provinces that they are very keen to work on innovation. They're doing this work with us on the strategic patient-oriented research. We'll continue to do that, and we're going to look for other ways we can partner with them and with research institutions to target that level of excellence. We want good research, but we also want really good patient outcomes, which is what this kind of strategy is about.

● (0945)

Mr. James Lunney: Great. Thank you.

The Vice-Chair (Ms. Libby Davies): You have one minute left to use.

Mr. James Lunney: Okay.

I understand there was a program—I heard you speak at the economic forum—applying a questionnaire on common infections in hospitals. I think was developed with the Canadian Foundation for Healthcare Improvement. Just by having the staff ask appropriate questions and follow up, they were actually able to reduce urinary tract infections and other common things that take seniors into hospital, where they get some very serious outcomes. So you're looking for better outcomes.

Hon. Rona Ambrose: Yes, better outcomes, and identifying where those best practices are and sharing them. We live in a federation. That's our reality. There are a lot of really good things happening in different provinces that other provinces are not aware of. So we're working really hard to create those networks and we're doing good work there. Sharing best practices is a very practical way in which we can help those on the front lines deliver better care.

Mr. James Lunney: Great.

There was another one I was aware of whereby they simply developed questionnaires for the staff to engage people in their life, in what their life was formerly, especially in the case of seniors in institutional care. They kept them off of a lot of medications that would just put them out of communication with the world around them, and the unnecessary use of medications to subdue people was eliminated simply by engaging them in their life and helping the staff to develop best practices in that realm.

Those are simple things, but they're making a big difference in quality of life for patients.

The Vice-Chair (Ms. Libby Davies): Thank you, Dr. Lunney. We'll leave it at that.

Thank you, Minister Ambrose, for coming before the committee today and answering the questions. We certainly look forward to your coming again.

We'll suspend for a minute so that the minister can leave, and then we'll begin our questions with the officials.

Thank you very much.

● _____ (Pause) _____

●

● (0950)

The Vice-Chair (Ms. Libby Davies): We'll call the meeting back to order.

Could the members take their seats at the table, please?

Thank you to the officials for staying around for the second hour. We're now going to continue with our questioning.

Our next questioner will be Mr. Gravelle, for five minutes.

Mr. Claude Gravelle: Thank you, Madam Chair.

Thank you to the witnesses for being here.

I'm going to stick with my favourite subject—dementia, Alzheimer's. We heard the minister say that she has met with the provinces on this issue, and some of the provinces don't agree or don't want to take part in a national dementia strategy. Can you tell me what provinces the minister has met with, and what provinces don't agree?

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

I believe the minister commented on the fact that she'd had a conversation with her provincial-territorial co-chair, Minister Horne, who is from Alberta, on the question.

I can tell you that in point of fact, that particular question first came to us at the international dementia summit, which was held in London in December 2012. Minister Horne agreed to discuss this with his PT colleagues, and my understanding is that's in the process of unfolding. I don't personally have knowledge of those conversations that he's having with his PT colleagues.

In reference to the point you made earlier around research and, again, referring to the international summit convened by the U.K. on dementia, it is very much the view that, for all of the issues you mentioned, research is key. We don't have the solutions we need to address these very important questions and issues, and research is key. It's not only fundamental research, but applied research, to help health care workers, to help people who are suffering from the condition to live better lives, as well as prevention and mitigation.

Mr. Claude Gravelle: I think I mentioned to the minister that we're all in favour of research. Research is good. Nobody is against research. But we have to do more.

What are we going to do to help the caregivers? Research is not going to solve the problem for caregivers. We have to do more for caregivers. We have to do more for training the workforce. Why can't we do more?

Mrs. Krista Outhwaite: These are tremendously important questions you're asking. Again, I am struck by the fact that the very questions you're raising today were also raised at the dementia summit, not only by those who are working very hard in the field but also by those who are suffering from these conditions.

Provinces and territories—in their respective jurisdictions responsible for health care delivery—are doing their very best to deal with the issues as they're manifested within their particular jurisdictions. There are initiatives under way that are grounded in research but also informed by the work that the department is doing with provinces and territories to look at how health care generally can be improved. It may even factor into the innovation work that is being undertaken by provinces and territories, as well as what the minister is talking about.

● (0955)

Mr. Claude Gravelle: Canada does a lot of work with the provinces for cancer. There's a cancer partnership. I don't see any reason we can't do the same thing for dementia.

I want to quote from Mimi at the Alzheimer Society of Canada. She's talking about dementia:

> It's coming upon us fast and furious....As baby boomers age, age is one of the risk factors [and] we're seeing a major increase in people with disease at a younger age. Early on-set is absolutely devastating to a family when you think of a 40-year-old getting the disease.

Caregivers are working an estimated roughly 444 million unpaid hours per year. That's a loss of income of $11 billion per year. That's a lot of money.

The Vice-Chair (Ms. Libby Davies): There's just time for a very brief reply, perhaps 30 seconds.

Dr. Beaudet.

[*Translation*]

Dr. Alain Beaudet: Once again, I can only reiterate the importance of fully understanding the reasons for it and of seeing how we can help caregivers.

Let me remind you that, next September, Canada and France will host one of the G8 summits, the one following the London summit. The summit will specifically examine the best ways to collaborate on an international scale with the industrialized world, the world of medical devices and information technology, so that we can find ways to better assist caregivers in particular.

[*English*]

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

We'll now move over to Dr. Lunney.

Mr. James Lunney: Thank you, Madam Chair.

Thanks again to our officials for being here.

I want to start with you, Ms. Outwaite, as the acting head of the Public Health Agency of Canada right now, with the unfortunate departure of Dr. Butler-Jones, who is phasing out, I understand, after his circumstances have impaired his ability to continue. We certainly respect the work he's done at the agency over these years.

We're talking about innovation. We've had some discussion already about prescription drug issues and how to get a handle on the overuse of prescriptions. You're, of course, aware of the issue that I have been raising for a number of years. In fact, I think the first time I asked this question on the record was when Ujjal Dosanjh was minister in 2005.

I'm talking about proton pump inhibitors and C. difficile infections. There are an estimated 1,400 deaths a year. We don't have complete figures every year in Canada. It's clear these drugs are overused. I've been asking about the Canadian nosocomial infection surveillance program. Nosocomial, of course, is hospital-based, for those who aren't familiar with the language.

It seems to me I was told that in that area they were going to get to the bottom of the issue by looking at the issue in teaching hospitals. But somehow they failed to collect data at that time on the meds they were on at admission. It seems to me that would be a very simple thing to correct. Would you agree?

Mrs. Krista Outhwaite: First, I'd like to thank you for your kind words about Dr. Butler-Jones. He is, indeed, a leader in the field of public health and certainly to all of us at the Public Health Agency.

To your second question and comment with respect to Clostridium difficile and the Canadian nosocomial infection surveillance program, if I may, I'm fortunate to have with me a colleague, the deputy chief public health officer, Dr. Gregory Taylor. Gregory has worked closely in these areas. I'd like to turn to Gregory to respond.

Mr. James Lunney: Sure. I was hoping the answer could be fairly quick. I have another question.

Dr. Gregory Taylor: Very quickly, the CNISP, as you referred to, was set up as a surveillance system. It wasn't set up as a research system. And what you're looking for is some research. I think there's lots of evidence to suggest an association. It's that causal proof that needs to be the next step of looking at the evidence of that.

We are going to work with CNISP. We're trying to expand and enhance CNISP; it seems relatively easy to add that question, as you've said. We're going to work with the folks at AMMI, the Association of Medical Microbiology and Infectious Disease, who are the folks who work in the hospitals that do that data collection, to see if we can add it as part of that and take advantage of the existing networks and do a little bit of research with the surveillance network.

● (1000)

Mr. James Lunney: Thank you.

You'd be aware, of course, that the drug safety and effectiveness network reported back that, in fact, there's a strong association.

On CIHR, or Canadian Institutes of Health Research, I see you've made a remarkable transformation here. The money used to be almost all dedicated to investigator-initiated health research. But I see your second is priority-driven health research.

On the same issue, we have a promising, but not established yet, use of probiotics as a preventative measure, not as a treatment measure, for C. difficile. But the study done, right out of a hospital here, nine years experience in Montreal as a lead agency, had 95% reduction in C. difficile. It hasn't been confirmed with other studies, because many use underpowered probiotics. This is nearly 100 billion CFUs administered through Bio-K Plus.

Would that be a possibility as a priority-driven health research, which is designed, as I see, targeted research to address challenges facing Canadians, where we might be able to engage CIHR to take some of our worst hospitals where there's a high incidence of C. difficile and actually check out the preventative measures—36 hours after starting antibiotics, they get a probiotic—and eliminate a high percentage of these infections?

Dr. Alain Beaudet: Very rapidly, the answer is yes, and we've started.

I'm proud to report that when I was president of the Fonds de recherche en santé du Québec, before holding this current job, I called upon CIHR when there was the scare of C. difficile in Quebec —as you know, a few years back—to work with CIHR to develop a major program of research on ways to diagnose early and find new ways of treating C. difficile. The probiotics studies that you referred to was some of the work that we funded at the time. It is part of our priority research in what we call emerging threats.

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

We'll now turn to Mr. Young.

Mr. Terence Young: Thank you.

Thank you, everyone, for being here today.

Mr. Da Pont, I wanted to ask you about new drugs on the market. As you know, all drugs cause adverse drug reactions, and new drugs on the market do not have an established safety profile. They're essentially in phase four of testing. In the U.S., one in five new drugs put on the market will either have a new high level of warning—the highest level of warning, a black box warning—put on the label within two years, or actually be taken off the market for harming patients.

Vanessa's law will create an obligation for health care institutions to report all serious adverse drug reactions. This is great as an early warning system, but also while a drug is on the market to get warnings from doctors that a drug could be causing liver damage or heart arrhythmias, etc.

These wonderful people take care of us, and I mean it sincerely; they are wonderful people. My own brother is a surgeon, a tremendous surgeon. The problem is that our doctors refuse to accept responsibility to report adverse drug reactions, the serious ones. They don't want to do it, and there are a whole range of reasons they don't. I recently met the incoming president of the Canadian Medical Association and asked for help on it: this information is lifesaving information.

Do you have any ideas or any comments on how we might encourage our health care professionals, let them know the critical importance of reporting serious adverse drug reactions, and encourage them to report them so we can get this information early and get risky drugs either off the market or get proper safety warnings put on the labels?

Mr. George Da Pont: Thank you for that.

As you've noted, a big start, obviously, is Vanessa's law, which will make mandatory reporting on adverse drug reactions from hospitals and institutions. Within Health Canada we are organizing ourselves to actually have better capacity, then, to take those reports, analyze them and, of course, put out information, as required, to the medical community.

In terms of encouraging more adverse drug reaction reporting from individual physicians, we do try to do that. We work, as I'm sure you know, with the Canadian Medical Association and a variety of other associations, the colleges, to encourage that.

One of the things we would like to do is move to a more electronic system, a simpler mechanism for reporting to make it easier. We hope that will help.

● (1005)

Mr. Terence Young: Thank you.

Mr. Da Pont, I'm sure you and your senior staff have been following the testimony we've heard on our study on opioids, addictive drugs. We heard that Purdue Pharma marketed OxyContin and oxycodone in the 1990s illegally, fraudulently, by telling doctors that it was not addictive, or that it wasn't as addictive as other drugs.

The president of Purdue Pharma actually came before our committee by his own request. I pointed out that his company had paid a $635-million fine in the U.S. to settle criminal charges for doing that, and how much harm the drug had caused. And I think he admitted.... I quoted a number of $23 billion in sales since 1995 of OxyContin worldwide. I asked him, being that his drug, OxyContin, oxycodone, has caused such a high number of addictions and so much human misery—500 Ontarians die a year from addictions related to OxyContin and oxycodone—if his company would consider matching the $45 million that the federal government put into our recent budget to help treat people who are addicted to opioids and help prevent further addictions.

I just wondered, have you heard anything about that, or any response to that? You haven't by chance received a cheque of $45 million from Purdue Pharma, have you?

Voices: Oh, oh!

Mr. George Da Pont: Not as of yesterday.

Mr. Terence Young: Okay. Thank you.

With regard to health care transfers, health care transfers have been growing 6% a year, and they'll continue to grow after 2017. They're at a record number of $32 billion—$32.1 billion this year—and they'll be at a record number in 2018. But we know that in some of the provinces, the rate of increase in their spending has gone down, so there seems to be a spread there. In other words, we're giving them more money for health care than they're actually spending.

Do you have any idea where the money that they're not spending in health care is going? Are there any restrictions on that at all? Or can they just take the money and spend it on anything they want?

The Vice-Chair (Ms. Libby Davies): We'll need a very brief reply, perhaps 20 seconds.

Mr. George Da Pont: The transfer doesn't have specifics attached, obviously, to what the money is for. That downward trend is pretty recent. It just started in the last year or two. It is encouraging, and it should give the provinces more flexibility to deal with some of the chronic issues like continuing problems with wait times and so forth.

The Vice-Chair (Ms. Libby Davies): Thank you very much, Mr. Da Pont.

We now go over to Dr. Fry.

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

I want to pick up on Mr. Young's question with regard to OxyContin. I think, as we well know, this is all...having made that statement and seeing that Canada is now the number one country in the world with regard to OxyContin abuse.

Can you explain to me the rationale as to why the government and Health continue to give an okay to six generic companies to produce this particular drug when the U.S. is no longer doing it and other countries are no longer doing it? It doesn't make any sense to me to, on the one hand, put millions of dollars into some sort of prevention and surveillance and tracking when the drug, the one that everyone is begging the minister and the Department of Health not to give any approvals to...have gone ahead and given approvals to six new generic companies.

I don't understand it. It just defies any kind of common sense.

Mr. George Da Pont: That decision was taken, but when it was taken in terms of allowing OxyContin to remain on the market—and having allowed it on the market, if there are generic versions available it's very hard to deny them—at that time a number of stronger restrictions were put in place in terms of the licensing for reporting, for diversions, and so forth. We have been monitoring that very closely. From that monitoring we haven't seen any spike or increases yet.

But as the minister has said I think on a number of occasions, it is a significant concern. That's why there's going to be significant additional investment in dealing with prescription drug abuse. I would say the minister has also indicated that an important component of this is to look at options for tamper resistance that would also be a factor in helping.

Hon. Hedy Fry: Thank you for that answer. I don't agree; I think if other countries can decide that they will no longer allow for generic OxyContin, we could. I don't know what our reasons are for not doing this.

Many countries, such as Scandinavia and Switzerland, have a HAT program, which is obviously heroin replacement therapy. The studies that have been done by NAOMI and SALOME in Canada have shown very clearly that for a small group of patients who are addicted to heroin and who are not responsive to methadone, they can benefit from prescriptions of diacetylmorphine.

I know that the department itself has actually agreed that it should be allowed under the SAP program, that it should be given to doctors who ask for this prescription. The minister has said no. Can you tell me if there is any move to let the minister read or to show the minister the clinical trials that are telling her that this is going to drive these people who cannot respond to anything other than diacetylmorphine and heroin, to go back on the streets and get street drugs again, when they could be treated with a pharmaceutical product that has been proven to be so internationally out there? Is there an answer to that?

Dr.Taylor, maybe you can answer it.

● (1010)

Mr. George Da Pont: Maybe I'll start, and then if Dr. Taylor has comments he can add them.

To my understanding, the science and the clinical trials are not yet as clear-cut as you're suggesting. As you know, that is really one of the main purposes of the clinical trial that's currently under way. That clinical trial will end I understand in the next year or year and a half. We will see from the results of that clinical trial whether the evidence is actually there. That's the whole purpose of the trial.

Hon. Hedy Fry: I understand that, but it's also my understanding that the department suggested that this drug be allowed and the minister said no to it.

There is one other thing I wanted to ask, and it's to CIHR. You're reforming your funding and grant review programs. The new foundation scheme is going to give you a new set of two existing grant cycles. It would mean that there would be two applications and three distinct review stages. In 2015 and 2016, between the ending of the old cycle and the new cycle, there's a three-month shortfall in which many people who are doing the research and the granting cannot have the money to hire and keep their staff.

How are you going to address that particular and specific problem, a very practical problem actually?

The Vice-Chair (Ms. Libby Davies): A very brief reply, please, because we are just about at time.

Dr. Alain Beaudet: Well, very briefly, you're right; these reforms —and by the way, Canada has recently been commended in a PNAS article for these reforms—mean that we're going for a set of grants from two competitions a year to one competition a year, and that explains the so-called gap that you're talking about. You're absolutely right; it's not six months as it used to be. We managed to reduce it to three months, and it affects a very small number of individuals, between 75 and 100 in the whole country. We've negotiated with the presidents of the U15 universities, research-intensive universities, to ensure there's no disruption of the work of these individuals for this period.

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

We'll now go back to Dr. Morin.

Mr. Dany Morin: Thank you very much.

Regarding maternal health, in Canada maternal death rose from 6 per 100,000 births to 11 per 100,000 births between 1990 and 2013. Many European countries and Japan have mortality rates in single figures. Why are today's Canadian women more likely to die in childbirth than their mothers were?

Mr. George Da Pont: Sorry, where are you quoting from?

Mr. Dany Morin: A CBC report.

Dr. Gregory Taylor: I don't think that's consistent with the surveillance information we're collecting. Are you talking about maternal deaths?

Mr. Dany Morin: Well, it will be a pleasure to find the information and give it to you.

The Vice-Chair (Ms. Libby Davies): Maybe Dr. Morin can supply the information to the officials. You can look at it, and then send something back if you dispute it.

Mr. Dany Morin: If the CBC report is indeed true, it is highly concerning.

Dr. Gregory Taylor: Absolutely. I'd love to see that information, please.

Mr. Dany Morin: Okay. My next question.... Time is running out.

Regarding diabetes, diabetes rates are set to double in Canada in the next 25 years. Last year your diabetes prevention strategy was blasted by the Auditor General of Canada for having no timeline, no goals, and no objectives, and for spending more on administration than on community programs. Can you tell us how you have fixed the program?

● (1015)

Dr. Gregory Taylor: I'll answer that.

Our diabetes program—and we're well aware of what you said, that diabetes is increasing—is trying to move upstream and trying to move away from.... We originally were looking at treating diabetics and assisting with that guidance, which we've done. We're starting to focus upstream to prevent diabetes. The risk-factor approach is looking at physical activity and nutrition to try to encourage people to adopt healthy lifestyles and reduce levels of obesity to try to preventing the onset of diabetes.

At the same time we've done some really innovative work that led us to the innovation agenda with CANRISK. That's a screening questionnaire that we've partnered with drugstores. People can pick them up in Shoppers Drug Mart in particular, who are very proud to partner us with this. Folks can answer this simple questionnaire, see if they're at risk for diabetes, and then see their doctor and follow up to have interventions focused on reducing the risk factors.

We believe in prevention, that Canadians would not want to get diabetes at all rather than have better treatment. It doesn't mean you have to ignore them; you have to focus on the folks who have diabetes. But I think going upstream and looking at the risk factors combined is a much more effective approach to prevent the diabetes onset to begin with.

Mr. Dany Morin: But since the Auditor General of Canada said the comments I conveyed to you, have you modified the programs to respond to his concerns?

Dr. Gregory Taylor: We've addressed that. We're continuing to work with the Auditor General. We discussed this issue with him just last week, and we're making it much more targeted. We put it under the rubric of our integrated chronic disease strategy, so it makes sense, it's connected, and has its own targets, as well. So we're well on the track of addressing all of those issues.

Mr. Dany Morin: Okay, on track, but you haven't yet implemented any of his recommendations.

Dr. Gregory Taylor: We're almost done. We've met almost all of them.

Mr. Dany Morin: Okay. I'm looking forward to seeing those new changes.

So what are you doing to prevent diabetes, particularly in the most vulnerable communities? I fully agree with you that prevention is the key, but we know that in vulnerable communities in Canada it is very hard to prevent.

Dr. Gregory Taylor: As I say, a lot of our programs are targeted to those. Risk factors are extremely important, and determinants of health are important. I believe Health Canada has a targeted aboriginal diabetes strategy.

Mr. George Da Pont: Yes, we do. We have, as just mentioned, a targeted diabetes strategy that we invest in. It's part of what's covered off, obviously, by some of the funding here in the main estimates, and we continue to work with aboriginal communities to help them put the resources in place to deal with this issue.

Mr. Dany Morin: Okay.

This is my last question for you. We have heard troubling news of the possible spread of the infectious Middle East respiratory syndrome coronavirus. Can you tell us what the Public Health Agency is doing to monitor this public health threat?

Dr. Gregory Taylor: I'd be delighted to answer that question.

This is very much in the media these days. I did five interviews on that yesterday alone. We are very well prepared for that. We have equipped laboratories across the country to detect this. That's coming out of our national laboratory, where we've equipped them and assisted them to do that. We've got guidance in working with physicians for heightened awareness. That means that when they're seeing somebody with symptoms that are compatible, they're asking for the travel history, asking whether somebody has been in the Middle East. They're doing the tests to confirm and be sure.

We have our quarantine officers who have worked to train border services and folks at the airports and crossings to look for disease like that. We've been working very carefully and very closely with the WHO. In fact, Canada's providing leadership. A doctor in our agency, Dr. Theresa Tam, is the co-chair of the emergency committee that just met. As you're aware, it was declared yesterday that this was not an emergency concern. That information is based on—

The Vice-Chair (Ms. Libby Davies): Thank you, Dr. Taylor.

Dr. Gregory Taylor: We're well prepared.

The Vice-Chair (Ms. Libby Davies): All right.

Mr. Lizon.

Mr. Wladyslaw Lizon: Thank you, Madam Chair.

Again, welcome and thank you for coming here today.

On prescription drug abuse and misuse, one of the issues that we deal with and that I think should be addressed more strongly is the safe disposal of not only prescription drugs but prescription drugs in particular. Last Saturday I had a chance to attend the community event organized by the Peel Regional Police. It's a great day of fun where they show equipment and show the way they work. I always, when I have a chance, want to brag about the local police. It's a great police force. But one of the things they were doing was collecting unused prescription drugs. I don't know how much they collected. They did this last year as well. It's part of the initiative supported by the chiefs of police.

What advice would you have on how we can raise awareness? I think there are still too many people who think that you can just simply throw this in with your trash, or flush it down the toilet or down the sink. I know if you check different websites you can find instructions on which ones you can, which ones you cannot, but nobody reads this.

My simple question is this: should part of the labelling state how to safely dispose of it? This could be a simple “Don't throw it away with the trash”.

Perhaps you can expand on that and elaborate on it.

● (1020)

Mr. George Da Pont: Well, that an interesting idea. You mentioned national take-back day, and actually this year there were many, many more sites. It's expanded significantly. I actually checked yesterday to see if we have the stats yet of how much was collected, but they're still being compiled. I would expect it will be significantly better than last year.

One of the key things the minister mentioned in her remarks around prescription drug abuse was that among the things being done and contemplated with the new investment that was in the 2014 economic action plan is more emphasis on education, from the perspective of both educating physicians on prescribing practices and educating the public on the dangers of prescription drug abuse. I think an interesting idea is whether we should look at more information on safe disposal.

I don't know, Dr. Taylor, if you had anything to add.

Dr. Gregory Taylor: I'd be delighted to add to that.

I think the drug take-back day is very positive. I would worry a little bit that by having it focused by the police this would be seen as a little bit punitive by folks. We've been working with some of the drugstores, as I mentioned earlier—Shoppers for many years has had a policy that they will always take back drugs—putting a positive spin on it: it's not abuse, but just get rid of that stuff, because there's inadvertent misuse of drugs like that.

When we did the announcement at Shoppers for the day last Saturday, I had a chance to talk to some of the executives. They collect hundreds of tonnes of drugs. They dispose of it more appropriately so it's not being flushed down and released into the environment. My understanding now is that more and more drugstores will take them back. Certainly for Canadians, I can relate to this; when my mother died I had bags of drugs. What would I do with them? I walked down to the local pharmacy and asked what I could do with them, and they were delighted to take them back.

It's about having the pharmacist play an educational role with patients who've been prescribed drugs, that when you have unused drugs, just bring them back to us, and with the children of elderly parents, who accumulate a lot of drugs, that this is a very safe place, no questions asked, just bring the stuff back and we'll get rid of it.

I think it's a really important issue that you're bringing up, that we, as Canadians, need to encourage people to get rid of the stuff. It's bad for the environment; it can be misused. Earlier, one of the members said that children do this for parties, but a lot of elderly folks don't know what drugs they have or why they would take that, particularly folks with early dementia. So getting rid of those is just a really good way to reduce the risks to a lot of Canadians.

The Vice-Chair (Ms. Libby Davies): Mr. Lizon, you have 45 seconds.

Mr. Wladyslaw Lizon: Quickly on the same topic, when we were doing the studies, one issue that was brought before the committee was that with prescription drug misuse or abuse there is a problem of inadequate training of doctors.

Can you comment on this?

Dr. Gregory Taylor: At one of the round tables the minister mentioned, which I was at, and the president of the Canadian Medical Association and several other physicians were at, there were some pain control specialists present. They are very keen to change and produce better guidance for doctors when they're prescribing.

As a physician myself, when I used to prescribe things there was precious little guidance concerning pain medication. I think it's very important that specialists help some of the general practitioners. The CMA is very much dedicated to doing that.

The Vice-Chair (Ms. Libby Davies): Thank you, Dr. Taylor.

We'll now go to Dr. Fry for five minutes.

Hon. Hedy Fry: Thank you.

I want to pick up on a question that was asked earlier. I'm asking about infant mortality rates.

It has been quoted that, for a country with a high socio-economic status among our peer groups in the OECD, our infant mortality rates are shockingly high.

How do we account for that, and what is being done to deal with it?

Dr. Gregory Taylor: My understanding is that there are methodological issues with the OECD study and that our methodology wasn't the same as theirs. Looking at the methodology we've been using, the rates have not done that.

We're working hard to figure out what was wrong in terms of the OECD, but primarily that comparison is not valid because of methodological issues in tracking.

Hon. Hedy Fry: Yes, but instead of also wondering why and checking up on whether or not the OECD has used the right methodology, since a methodology ranks everyone according to the same methodology the question is whether anyone has tried to find out why the rate is so high or why it could possibly be so high and to find out ways to deal with this instead of just blaming the investigator.

● (1025)

Dr. Gregory Taylor: We're not blaming the investigator. The actions are based on evidence. Our evidence doesn't support that study's findings. Our evidence suggests that infant mortality rates are still good.

We have a number of children's programs—CAPC, Aboriginal Head Start—that are targeted to improve children and infant mortality.

Hon. Hedy Fry: Well, we agree to disagree, because we also use OECD rankings, when Canada does well, to shout from the rooftops how well we're doing; yet when it shows that we're not doing well, there isn't that kind of critical thinking that asks why this is so.

Even if the methodology is in question in this particular instance, why is this so, is there any truth, and what can we do to deal with it? We know that some of those rates are attributed to aboriginal infant mortality rates and we know that poverty and lack of housing are really big issues.

This is a shameful blot on Canada's record, and I would like to hear that the ministry of health and the Public Health Agency are looking at causes and at solutions. Health is more than just research; it's more than just what numbers say. It's about the lives of people in this country. I would like to see some more due diligence done on this.

Thank you.

The Vice-Chair (Ms. Libby Davies): You have two minutes left.

Hon. Hedy Fry: Okay, thank you.

I noticed that the minister spoke about a strategy for making labelling more easily readable by the public. I think that's a good thing, so I commend her for that and I commend you for it. But I want to know why there is still resistance, despite advisory committees and advisory groups, to mandatory labelling of salt and sugar and with regard to certain foods that we know are unhealthy. People aren't able to determine, when they read the label, how much salt and how much sugar they're getting, and how much trans fat.

Why is it that we do not look at international guidelines for the amount of sugar and trans fats? We have twice the amount of salt that any other country has. Why is this not part of the new labelling regime?

Mr. George Da Pont: Actually, it is part of the new labelling regime and of the consultations the minister was talking about. It's not just on making it more readable; it's also on the content.

One thing that has come out in the early round of consultations is exactly what you said: capturing things such as sugar better. So it's both the content of the label and the readability. It's quite broad.

Concerning guidelines, we are obviously working with the World Health Organization, which as I'm sure you know has started a broader process on consultations about appropriate guidelines for sugar. On that, we are basing our guidance on science, and this is one of the mechanisms.

As you know, I'm sure, sodium, trans fat, and sugar are currently all on the nutritional food table.

Hon. Hedy Fry: Are they mandatory? You were told that they should be seven years ago and it has not been done. That's my question.

Mr. George Da Pont: My understanding is they are mandatory.

Hon. Hedy Fry: They're not mandatory.

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

A welcome to Mr. MacKenzie for coming to our committee today.

Mr. MacKenzie, you have five minutes.

Mr. Dave MacKenzie (Oxford, CPC): Thank you, Madam Chair.

Thank you to the panel for being here.

I'm not a regular member of the committee, but it's interesting for me to sit in.

One of the things that I know in life is if we don't put money into research and innovation, we keep doing the same things over and over with the same results, and I think health care has been one of those things where innovation and research have led us to great advances in many things. Some of the research and the innovation is actually from our own country and we should be very proud and yelling from the rooftops about it. When I look at some of these things from a pure layman's perspective, laparoscopic surgery, cataract surgery, all of those things are now meaning fewer hospital stays for patients. That has to be good for everybody.

It would seem to me that more money in research and innovation is far better than just throwing money into the system expecting the same results. I welcome what the minister has said here. I am just convinced that this is the right approach to take. More money doesn't fix a bad system. We need the innovation and research to do that, and I think you're on that path.

I would just say one little thing, Dr. Taylor: the police aren't punitive. Having said that, I understand a wise person's panel has been struck by the minister. Can you tell us how that is moving forward? What can we expect going forward with some of the things from that panel?

● (1030)

Mr. George Da Pont: My expectation is that the minister will be making an announcement around that very topic in the near future.

Mr. Dave MacKenzie: Okay. I thank you.

The another area that we see frequently, certainly in my home province of Ontario, is that money in health care has not necessarily gone to health care. The federal government does not have controls over the province in the administration of delivery of its health care system. When we look at what we could do with innovation and research with money, how do we better work together with our provinces on the delivery, which is their responsibility? How do we better work with them to try and provide some direction or guidance?

Mr. George Da Pont: In my experience, not all provinces want direction and guidance, but the main mechanism is as the minister noted—the regular meetings that she has with all of the provincial health ministers. They identify areas of common concern, areas where they can work together. Prescription drug abuse is one, or looking at bulk buying of drugs. There is a variety of things that are carved out in that process, where the federal government and the provinces work together, looking at, as the minister said, having the innovation panel looking at this more broadly and seeing what ideas there are for best practices and things that we could adopt, either best practices that are already under way in some part of this country or from abroad.

I think that will be a catalyst, hopefully, to look at some of these issues on a broader basis.

Mr. Dave MacKenzie: I think it's important that Canadians recognize that the federal government does not have that power or that direction to deliver to provinces. It's up to the provinces to deliver that.

Mr. George Da Pont: Yes.

Mr. Dave MacKenzie: I think sometimes that gets lost in this place here especially. Your role is not one to tell the provinces how to spend the money. We do send them the money in the transfers on the health and social side of things, but the actual direction on how to spend it is the responsibility of the provinces, and how they do it or don't do it becomes their responsibility.

Mr. George Da Pont: Exactly.

Mr. Dave MacKenzie: Certainly more research and innovation in just those two areas that I as a layman would understand has to mean tremendous savings in the provincial health care systems in hospital stays for patients.

The Vice-Chair (Ms. Libby Davies): You have 30 seconds left, if you want to use it.

Mr. Dave MacKenzie: I'll give it up.

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

We'll move back to Dr. Morin.

Mr. Dany Morin: Thank you very much.

I'll continue my questions to Dr. Taylor. We had an interesting discussion about the MERS-CoV.

First of all, thank you for saying that you do monitor this very closely. I want to make sure, are you working with the provinces to ensure we are prepared nationwide?

Dr. Gregory Taylor: Absolutely. We have a variety of mechanisms to work with the provinces and certainly directly with the public health network. I co-chair the council of that. This is a topic of great concern. In fact, we have a special meeting with all the chief medical officers of health on Friday, tomorrow, to address this very issue. We're watching the measles outbreaks and how to best deal with that, and MERS-CoV as well, and the topic of H7H9, H5. These things are consistently followed.

Those are formal mechanisms. We have informal mechanisms at the technical level where we're constantly in touch with the provinces and territories. Typically, for example, the chief medical officer will call me or send me a personal e-mail in a particular province. You saw the things in the media yesterday. We were given a heads-up by the province, very personally, very quickly.

So it's a variety of formal mechanisms and informal mechanisms that keeps us well connected across the country.

Mr. Dany Morin: Do you feel that you have enough resources to ensure an appropriate emergency response?

Dr. Gregory Taylor: Yes, we are well resourced to do that. We work with the provinces and territories; this is that joint capacity that exists.

Over the last few years, the provinces and territories have also built their own capacity. We now have three different public health agencies across the country. My understanding is that some of the provinces are toying with creating their own, again, so from a resource perspective, I think Canada is very well positioned.

Mr. Dany Morin: Thank you.

I would like to go back to maternal health. I have the data that I didn't have before and that you don't have either.

On May 6 the World Health Organization released a report concerning the millennium development goals that the United Nations set for 2015. The report is pretty clear that, if we look at the number of maternal deaths per 100,000 live births over a 20-year period, there were six per 100,000 in 1990, seven in 1995, seven in 2000, 11 in 2005, and 11 maternal deaths per 100,000 live births in 2013.

The statistics are there. What do you have to say?

● (1035)

Dr. Gregory Taylor: I say that we need to get that report and take it very seriously and see whether there are any underlying issues that we need to address. Thank you for bringing it to our attention. I was unaware of that report, and we will most certainly follow it up very closely.

Mr. Dany Morin: What is very troubling about this is that worldwide the death rate has fallen by 45%—that is, globally since 1990—and that in Canada it is on the rise. So please look into this. It would be great if you could get back to us on this issue.

My next question is about food safety. We have heard conflicting numbers on the resources allocated to food safety inspection in this country. We know that the 2012 budget involved $56 million in cuts and the layoff of 308 staff members. Now an almost 10% decrease in projected spending is predicted.

Can you tell us clearly the number of staff at CFIA in 2011?

Dr. Bruce Archibald (President, Canadian Food Inspection Agency): I don't have the 2011 number with me, but I do have it for 2012 and 2013.

Mr. Dany Morin: Please tell us.

Dr. Bruce Archibald: The total number of staff in 2012 was 7,291. In 2013 it was 7,119, which is a slight decrease. But I would also point out that the number of the inspection staff increased over that same time period; it went from 3,534 to 3,577.

So you're right, there was a reduction in the overall budget as a result of budget 2012, but the agency looked at a number of different places to find efficiencies and did not reduce the inspection staff or any of the food safety activities.

Mr. Dany Morin: So if I understand correctly, there was no decrease in the number of inspectors?

Dr. Bruce Archibald: There actually was a slight increase.

Mr. Dany Morin: Okay, good.

How about the number of inspectors working on raw meat processing lines, such as XL beef?

Dr. Bruce Archibald: I don't have the specific numbers, because we don't break it down that way in our counting; often inspectors will do multiple tasks, working on different areas. But we have increased our inspection in the meat program as well as in a number of other areas across the board. Overall, the number of people working in facilities, particularly in meat facilities in Canada, has increased.

The Vice-Chair (Ms. Libby Davies): We're over our time. Thank you, Mr. Archibald.

We have time for one last five-minute question and answer.

Mr. Wilks.

Mr. David Wilks: Thank you, Madam Chair. I'm going to defer my time to Dr. Lunney, who has some more questions.

Mr. James Lunney: Thanks very much.

Continuing on the matter we were discussing earlier, prescription overuse of the proton-pump inhibitors, they estimate that 70% of the people taking these meds should not be. They shouldn't be taking them for heartburn. This is where the regulator's role is so important. If the patient is on a PPI, the evidence under the literature is a 40% to 275% increased risk—40% to 275%—and it's dose-dependent and time-dependent. I think you'd see that as what was found in the DSEN report, Drug Safety and Effectiveness Network. Although they didn't give the numbers, that's on the FDA website.

Further, if they're on those meds, not only do they have increased risk of infection, but they also have three times the risk of the worst complications, which includes unnecessary bowel surgery. Of course, extended hospital stays are costing us hundreds of millions of dollars across the country. But also the research shows that if they're on those medications, not only is there an increased risk of infection and increased risk of complications, they also have five times the increased risk of death. That's the worst outcome. So I hope you understand the urgency I attach to that.

The number one thing on your Public Health Agency website is “elderly”, especially over age 80, but it's well known that the elderly have reduced stomach acid; it's part of the normal aging process, and puts them at a higher risk. It's really the same issue as acid suppression.

There's an immense urgency to taking some action on this. I hope you understand why, when we talk about CNISP, maybe it was designed for surveillance, but we should be collecting data on this. We can't wait another 10 years to start helping people avoid these risks of unnecessary death in the hospital and hundreds of millions of dollars in expenditures. We're hoping to be more nimble as we look at ways at innovating.

There are big concerns about antibiotic overuse. Of course, the risk of recurrence if you're on a PPI when you're in the hospital is 42%. With vancomycin, I think it's 25%; and in the new drug DIFICID it is 15%.

Back to Dr. Beaudet, this why there is urgency to check out prevention with the probiotic, and I hope you'll be on board in advancing that. If we can avoid these infections with such a simple thing, it's much easier than a fecal transplant, might I say, in managing it later on.

Finally, you're working with physicians, with CMA and with the Choosing Wisely Canada program, on this. They're talking about the appropriate use of medical imaging and antibiotic use. It seems to me, after my conversation with Dr. Chris Simpson, as my colleague mentioned, the head of the CMA, that this might be a way to help physicians engage with their patients on the unnecessary use of these meds for managing dyspepsia.

Could you comment briefly on that program, Choosing Wisely Canada?

Then I'll hand it over to my colleague.

● (1040)

The Vice-Chair (Ms. Libby Davies): There are just two minutes. Depending on how long the response is, we really won't have much time.

Who is giving the response?

Mr. George Da Pont: I don't think there is a response. As you've just noted, we are working with the CMA, and, through them, the colleges, on Choosing Wisely, which is intended to put into the hands of physicians more information and education on prescribing practices.

Mr. James Lunney: I hope you'll agree, Mr. Da Pont, that it starts with the appropriate warnings from Health Canada, because the hospitals depend on those warnings, as do the doctors.

Mr. George Da Pont: Yes.

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

First of all, thank you to—

Mr. Terence Young: [*Inaudible—Editor*]

The Vice-Chair (Ms. Libby Davies): There is a minute left. Go ahead.

Mr. Terence Young: In 2010 Eli Lilly was in court in the United States and was asked to produce any evidence that their drug, a powerful anti-psychotic, Zyprexa, helped Alzheimer's patients. They provided seven studies with no evidence.

Zyprexa and Johnson & Johnson's drug, Risperdal, are being used widely in our long-term care facilities on seniors for Alzheimer's, when there is no evidence it helps them at all. There is evidence, proven in court by their own studies, that those drugs, particularly Zyprexa, increase the risk of death for our seniors by 200% to 300%. Zyprexa causes diabetes. It also numbs out our seniors. They fall out of bed. They break a hip. They're dead six months later.

So our seniors in North America are literally—literally—dying in our long-term care facilities, taking a drug that offers them no medical benefit, but that—

The Vice-Chair (Ms. Libby Davies): Mr. Young the time is up, and we still have to vote.

Mr. Terence Young: —increases their risk of death by 200% to 300%.

I just wondered if the Public Health Agency has any influence or can help with this problem.

The Vice-Chair (Ms. Libby Davies): We're seconds away; we still have to vote, and the other committee's beginning to show up.

Mr. George Da Pont: This probably would be with Health Canada, as the regulator. I'm not familiar with the issue you've raised. Perhaps, though, we can get back to you separately or through a letter to the committee.

The Vice-Chair (Ms. Libby Davies): Thank you, Mr. Da Pont. You can provide the information to the committee.

I'd like to thank the officials for being here today for the main estimates.

We will proceed directly to the votes. There are two ways to do this. We could go through each vote, and there are 10 votes. Or, if the committee concurs by unanimous consent, we could just go down to two votes, and I presume possibly go on division. It's up to the committee.

Is there agreement that we basically do the votes together?

Okay. Thank you very much. I don't see anyone objecting to that.

Shall the votes before the committee, less the amounts approved in the interim supply, carry?

CANADIAN INSTITUTES OF HEALTH RESEARCH
Vote 1—Operating expenditures.....$47,112,396
Vote 5—The grants listed in the Estimates.....$932,143,424

(Votes 1 and 5 agreed to on division)

HEALTH
Vote 1—Operating expenditures.....$1,774,856,975
Vote 5—Capital expenditures.....$31,656,363
Vote 10—The grants listed in the Estimates and contributions..... $1,683,745,108

(Votes 1, 5, and 10 agreed to on division)

PATENTED MEDICINE PRICES REVIEW BOARD
Vote 1—Program expenditures.....$9,949,348

(Vote 1 agreed to on division)

PUBLIC HEALTH AGENCY OF CANADA
Vote 5—Capital expenditures.....$6,100,596
Vote 10—The grants listed in the Estimates and contributions.....$253,014,798

(Votes 5 and 10 agreed to on division)

CANADIAN FOOD INSPECTION AGENCY
Vote 1—Operating expenditures and contributions.....$470,029,881
Vote 5—Capital expenditures.....$24,264,263

(Votes 1 and 5 agreed to on division)

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

Some hon. members: Agreed.

An hon. member: On division.

The Chair: Thank you very much to everybody.

The meeting is adjourned.