HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 061 • 2nd SESSION • 41st PARLIAMENT

EVIDENCE

Thursday, May 7, 2015

Chair

Mr. Ben Lobb

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● (1530)

[*English*]

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

We're here today to study the main estimates. This afternoon we have the minister here as well as many of her officials.

Minister, thank you for taking the time out of your schedule to appear today and have your officials all be here as well. You have prepared a statement. We'll allow you to present it and then follow it with our standard round of questions.

Thank you.

Hon. Rona Ambrose (Minister of Health): Thank you very much, Mr. Chair, and thank you to the committee. I want to thank all of you for the work you do on the health committee. I know many of you are passionate about the issues of health, and I thank you for your commitment to that.

I'm joined by Simon Kennedy, Health Canada's new deputy minister; Krista Outhwaite, our newly appointed president of the Public Health Agency of Canada; and Dr. Gregory Taylor, whom you've met before, Canada's chief public health officer. I know he'll be here for the second half. You might want to ask him about his trip to Guinea and Sierra Leone to visit our troops and others who are working on the front dealing with Ebola. I'm sure he'll have some great things to share with you.

Michel Perron is here on behalf of the Canadian Institutes of Health Research. He's also new. Last time I know you met Dr. Alain Beaudet.

We also have Dr. Bruce Archibald, who's the president of the Canadian Food Inspection Agency. I think you've met Bruce as well.

Mr. Chair, I'd like to start by sharing an update on some of the key issues that we've been working on recently. I'll begin by talking about Canada's health care system, the pressures it's facing, and the opportunities for improvement through innovation. I will then highlight some recent activities on priority issues such as family violence and the safety of drugs in food.

According to the Canadian Institute for Health Information, Canada spent around $215 billion on health care just in 2014. Provinces and territories, which are responsible for the delivery of health care to Canadians, are working very hard to ensure their systems continue to meet the needs of Canadians, but with an aging population, chronic disease, and economic uncertainty, the job of financing and delivering quality care is not getting easier.

[*Translation*]

Our government continues to be a strong partner for the provinces and territories when it comes to record transfer dollars. Since 2006, federal health transfers have increased by almost 70% and are on track to increase from $34 billion this year to more than $40 billion annually by the end of the decade—an all-time high.

This ongoing federal investment in healthcare is providing provinces and territories with the financial predictability and flexibility they need to respond to the priorities and pressures within their jurisdictions.

[*English*]

In addition of course, federal support for health research through the CIHR as well as targeted investments in areas such as mental health, cancer prevention, and patient safety are helping to improve the accessibility and quality of health care for Canadians.

But to build on the record transfers and the targeted investments I just mentioned, we're also taking a number of other measures to improve the health of Canadians and reduce pressure on the health care system. To date we've leveraged over $27 million in private sector investments to advance healthy living partnerships. I'm very pleased with the momentum we've seen across Canada.

Last year we launched the play exchange, in collaboration with Canadian Tire, LIFT Philanthropy Partners, and the CBC, to find the best ideas that would encourage Canadians to live healthier and active lives. We announced the winning idea in January: the Canadian Cancer Society of Quebec and their idea called “trottibus”, which is a walking school bus. This is an innovative program that gives elementary schoolchildren a safe and fun way to get to school while being active. Trottibus is going to receive $1 million in funding from the federal government to launch their great idea across the country.

Other social innovation projects are encouraging all children to get active early in life so that we can make some real headway in terms of preventing chronic diseases, obesity, and other health issues. We're also supporting health care innovation through investments from the Canadian Institutes of Health Research. In fact our government now is the single-largest contributor to health research in Canada, investing roughly $1 billion every year.

Since its launch in 2011, the strategy for patient-oriented research has been working to bring improvements from the latest research straight to the bedsides of patients. I was pleased to see that budget 2015 provided additional funds so that we can build on this success, including an important partnership with the Canadian Foundation for Healthcare Improvement.

Canadians benefit from a health system that provides access to high-quality care and supports good health outcomes, but we can't afford to be complacent in the face of an aging society, changing technology, and new economic and fiscal realities. That is why we have been committed to supporting innovation that improves the quality and affordability of health care.

As you know, the advisory panel on health care innovation that I launched last June has spent the last 10 months exploring the top areas of innovation in Canada and abroad with the goal of identifying how the federal government can support those ideas that hold the greatest promise. The panel has now met with more than 500 individuals including patients, families, business leaders, economists, and researchers. As we speak, the panel is busy analyzing what they've heard, and I look forward to receiving their final report in June.

● (1535)

I'd also like to talk about another issue. It's one that does not receive the attention that it deserves as a pressing public health concern, and that's family violence. Family violence has undeniable impacts on the health of the women, children, and even men, who are victimized. There are also very significant impacts on our health care and justice systems.

Family violence can lead to chronic pain and disease, substance abuse, depression, anxiety, self-harm, and many other serious and lifelong afflictions for its victims. That's why this past winter I was pleased to announce a federal investment of $100 million over 10 years to help address family violence and support the health of victims of violence. This investment will support health professionals and community organizations in improving the physical and mental health of victims of violence, and help stop intergenerational cycles of violence.

In addition to our efforts to address family violence and support innovation to improve the sustainability of the health care system, we have made significant progress on a number of key drug safety issues. Canadians want and deserve to depend on and trust the care they receive. To that end, I'd like to thank the committee for its thoughtful study of our government's signature patient safety legislation, Vanessa's Law. Building on the consultations that we held with Canadians prior to its introduction, this committee's careful review of Vanessa's Law, including the helpful amendments that were brought forward by MP Young, served to strengthen the bill and will improve the transparency that Canadians expect.

Vanessa's Law, as you know, introduces the most significant improvements to drug safety in Canada in more than 50 years. It allows me, as minister, to recall unsafe drugs and to impose tough new penalties, including jail time and fines up to $5 million per day, instead of what is the current $5,000 a day. It also compels drug companies to do further testing and revise labels in plain language to clearly reflect health risk information, including updates for health warnings for children. It will also enhance surveillance by requiring mandatory adverse drug reaction reporting by health care institutions, and requires new transparency for Health Canada's regulatory decisions about drug approvals.

To ensure the new transparency powers are providing the kind of information that Canadian families and researchers are looking for, we've also just launched further consultations asking about the types of information that are most useful to improve drug safety. Beyond the improvements in Vanessa's Law, we're making great progress and increasing transparency through Health Canada's regulatory transparency and openness framework. In addition to posting summaries of drug safety reviews that patients and medical professionals can use to make informed decisions, we are now also publishing more detailed inspection information on companies and facilities that make drugs. This includes inspection dates, licence status, types of risks observed, and measures that are taken by Health Canada. Patients can also check Health Canada's clinical trials database to determine if a trial they are interested in has met regulatory requirements.

Another priority of mine is tackling the issue of drug abuse and addiction in Canada. There's no question that addiction to dangerous drugs has a devastating and widespread impact on Canadian families and communities. In line with recommendations from this committee, I am pleased that the marketing campaign launched last fall by Health Canada is helping parents talk with their teenagers about the dangers of smoking marijuana and prescription drug abuse. The campaign addresses both of those things, because too many of our young people are abusing drugs that are meant to heal them.

Our government also recognizes that those struggling with drug addictions need help to recover a drug-free life. From a federal perspective, of course, we provide assistance for prevention and treatment projects under our national anti-drug strategy. We've now committed over $44 million to expand the strategy to include prescription drug abuse and are continuing to work with the provinces to improve drug treatment.

I've now met and will continue to meet with physicians, pharmacists, first nations, law enforcement, addictions specialists, medical experts, and of course parents to discuss how we can collectively tackle prescription drug abuse.

Finally, our government continues to make very real investments to strengthen our food safety system. As only the latest example, I recently announced a five-year investment of more than $30 million in the CFIA's new food safety information network. Through this modern network, food safety experts will be better connected, and laboratories will be able to share urgently needed surveillance information and food safety data, using a secure web platform. This will put us in an even better position to protect Canadians from food safety risk by improving our ability to actually anticipate, detect, and then effectively deal with food safety issues. This investment will continue to build on the record levels of funding we've already provided, as well as the improved powers such as tougher penalties, enhanced controls on E. coli, new meat labelling requirements, and improved inspection oversight.

● (1540)

In conclusion, those are just some of the priorities that will be supported through the funding our government has allocated to the Health portfolio. This year's main estimates, notably, include investments for first nations health, for our ongoing contribution to the international response to the Ebola outbreak in West Africa, and the key research and food safety investments that I have already mentioned.

I'll leave it at that. If committee members have any questions, my officials and I would be very pleased to answer them. Thank you.

The Chair: Thank you very much, Minister.

Mr. Rankin, go ahead. You have seven minutes.

Mr. Murray Rankin (Victoria, NDP): Thank you, Minister Ambrose, and your officials, for being with us today. It's a pleasure to see you.

My first question concerns Parliament's motion, unanimously passed in December, to provide full support for the victims of thalidomide. As you may know, since that motion was passed, the 97 who were identified as survivors have now, sadly, been limited to 94. There have been three deaths. The government—I think you, Minister—on March 6, promised $125,000 as a lump sum this year, and then $168 million for their lifetime care.

I wonder if you could explain to the committee how the department came up with that particular number of $168 million.

Hon. Rona Ambrose: First of all, let me say it's important that we remember this tragic event that happened in the 1960s, reflect upon the good work of this committee around Vanessa's Law, and remember why it's so important that we have strong drug safety laws in this country.

Our government has very deep sympathy for what happened. While this happened in the sixties, I offered our government's and all Canadians' public regret and apologies to those who were affected by thalidomide. We know we can never undo the pain and suffering that people have experienced.

I had an opportunity to meet a few times with Mercedes Benegbi, who is the head of the Thalidomide Victims Association of Canada. As you know, we did announce $180 million to be distributed among the survivors. I'm pleased to say that we've been able to get out the $125,000 tax-free lump sum immediately to survivors. The reason we worked very quickly is that it will take us some time to get the yearly pension set up with the other $168 million we have. Also, we have an extraordinary medical assistance fund. We're in the middle of working out the details of that.

Mr. Murray Rankin: Are you able to identify when that might be done? Will it be done this year?

Hon. Rona Ambrose: Yes, absolutely.

Mr. Murray Rankin: You indicated in the budget very specific numbers for radiation protection, $20.2 million, and $40 million for pesticides, but we couldn't see any specific reference to that $168 million in the estimates.

Hon. Rona Ambrose: The money is there and it's budgeted. It's in the fiscal framework. Yes, we do expect to work out the details of the annual payments in the near future. We're working very hard on it.

Mr. Murray Rankin: In the near future...?

Hon. Rona Ambrose: We knew it would take some time to create. It doesn't happen overnight to create all the parameters. We also have the need to identify an appropriate third party that will help us with the distribution of the funds.

Mr. Murray Rankin: You appreciate how difficult it is for the survivors to plan their lives and pay for renovations to their houses and for transportation and the like, in order to address this crisis going forward. You're not able to tell us when. Will they know before the election?

Hon. Rona Ambrose: Absolutely.

Mr. Murray Rankin: They'll know before the election.

Hon. Rona Ambrose: Absolutely. We hope we'll be able to tell them in the very near future. We're working expeditiously, but it's why we wanted to get out the $125,000 sum immediately, so they had something they could rely on.

● (1545)

Mr. Murray Rankin: I have very little time. I really appreciate that.

On the issue of drug safety inspections, we had an order paper question that revealed that since April 1, 307 inspections on drug safety were carried out, but only one company received a "proposal to suspend" their licence—one of 307. By contrast, the U.S. Food and Drug Administration, through 110 inspections of Canadian-owned facilities in the last 10 years, found objectionable activity.

The *Toronto Star* reported that 4,000 clinical trials are conducted per year in Canada. But only 1.5% of them are being inspected annually.

How many inspections result in actions being taken in respect of drug safety, on an annual basis?

Hon. Rona Ambrose: I can't give you the exact number, but I am happy to say that with our transparency framework at Health Canada around drug safety and drug trials, Canada now has the most transparent system in the world. Canadians will actually be able to go on a website to see what plant was inspected, what problem there may or may not have been, and if there was a problem, what corrective action was ordered.

Mr. Murray Rankin: But when you—

Hon. Rona Ambrose: Simon just gave this to me because you were asking for numbers.

In 2013-14, we did 428 inspections.

Mr. Murray Rankin: How many enforcement actions...?

Hon. Rona Ambrose: Overall, 96% of the establishments that had an inspection were assigned a compliant rating. There were 19 that were found to be non-compliant. We do keep track of all of those numbers.

Importantly, I think, is that people wanted to know what was happening, so now that is transparent under our new framework.

Mr. Murray Rankin: I appreciate that.

As you speak of transparency, that takes me to Vanessa's Law, to which you made reference earlier.

Toronto doctor, Nav Persaud, made an information request to Health Canada to get clinical trials on a pregnancy drug, an anti-nausea drug called Diclectin. He tried that three and a half years ago. He finally got 359 pages, 212 of which were completely redacted or censored.

In March, after Vanessa's Law came in, he resubmitted the request for all of the 359 pages, and so far has been given nothing. I got that as recently as two days ago in a letter. The clinical trial data was something that was to be made available, as I understood it, under Vanessa's Law. His experience has been entirely frustrating.

Hon. Rona Ambrose: I sympathize with his experience.

Under Vanessa's Law, the intention is to make clinical trial information available, but still to some extent—and for legal reasons obviously—protect confidential business information. Our intention under Vanessa's Law—and it's my belief—is that we should be sharing as much as we possibly can.

On that specific one, I think that's still under way, but I know Simon is working on that.

Mr. Simon Kennedy (Deputy Minister, Department of Health): Thanks, Minister.

On this particular case, the original submission was made under the access to information rules. The ministry is obliged to apply the access law, which does require a number of exemptions for business information and so on.

With new authorities under Vanessa's Law, there is this other avenue we can use to make information available where there is a health or safety threat. We've spoken to the researcher in question, and we sent him a fairly detailed letter to explain the process to make an application under Vanessa's Law. That conversation is going on and our hope would be to be able to move through that avenue to deal with the issue.

Mr. Murray Rankin: Am I out of time?

The Chair: Mr. Rankin, we are out of time. We're at seven minutes and 20 seconds.

To be fair to everybody, Ms. McLeod, go ahead.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Chair.

Thank you, both to the minister and to all the officials who are here today. It's always a nice opportunity, and really an important opportunity, as we talk about the main estimates.

I think one of the things that is critically important, of course, is the transfers that we do to the provinces. It's certainly an enormous part of our support for the health care system in Canada. Over the last number of months, I've had a lot of constituents writing to me and suggesting that there has been a cut in terms of the transfers to the provinces, which, Minister, as you're probably aware, is totally inaccurate. I believe that the misinformation should be, and I'm trying to ensure that it is, corrected.

We can certainly see in the budget document where the trajectory has gone in terms of these transfer payments. I understand that our government is going to be increasing payments to the provinces by over $27 billion over the next five years. We have done significant measures in terms of trying to support additional physicians coming into Canada.

I would appreciate if you could set the record straight in terms of the transfers to the provinces and where we're going, and where our commitment is as a government to what is very important in terms of the provinces being able to deliver health care.

● (1550)

Hon. Rona Ambrose: Yes, absolutely.

When Finance Minister Jim Flaherty renewed our commitment to the provinces and territories at the end of the health accord, he renewed, for the next 10 years, record-level funding. Of course, that includes an escalator of 6% up to 2016, and after that a 3% escalator for the provinces. That means that by the end of the decade that amount will reach $40 billion annually. That's a 70% increase in federal transfers, just for health care, since 2006.

That is very important to the provinces and territories because it has allowed them to plan their own budgets in a much more predictable way, and it's probably the area in which they are struggling the most when they think about the impact on other parts of their own provincial budgets. Let's remember that health care takes up a great deal of the federal budget, but it takes a great deal, if not 50%, of most provincial budgets, so they are struggling with figuring out ways to curb costs at the provincial level, because otherwise they're going to have to look at the impact it has on other services.

I think one of the things we should think about is the latest information out of the Canadian Institute of Health Information. Since the year 2000 health spending by provinces and territories grew by less than 5%, and since 2010, spending by provinces grew by less than 3%. So if you think about that and the amount of increase and the escalator we're applying to the funding we give to provinces and territories every year, that means that for the next three years, with a 6% escalator, our transfer increases are projected to continue to rise at more than double the rate of health spending increases by the provinces. We are well in line with providing them with the appropriate amount necessary.

However, I think the other part of the discussion has to be around money, because while health transfers are at record levels, the truth is that provinces are trying to find ways to curb their costs, because if you look 20 years out and if we continue down the track we're on, it would basically take up the entire budget of every province, and that's completely unsustainable.

That's why we're focused on innovation. That's why we're focused on working on the recommendations that come out of the panel in June, with the provinces and territories, to look at what we can do to innovate our health care system. If we don't do that, I think we're letting Canadians down, because we invest heavily per capita in health care, but we don't have the best health care system in the world. I like to brag about this health care system, but there are areas in which we can improve, and I think only through innovation will that happen.

We are making those investments in innovation and we'll continue to have that conversation with the provinces about supporting them in areas, such as the strategic patient-oriented research partnership we have with the provinces, and other investments we made recently in the budget.

This is a good time to have this conversation because we have money on the table for the next 10 years in health care. Let's talk about the smart way to spend it, and the best way to get the best possible outcomes for Canadians. I think that's what our government is focused on now with the provinces, and I think it will benefit the health care system.

Mrs. Cathy McLeod: Thank you.

I certainly appreciate your comments about innovation. I think we've all seen things that we know will work very well. They improve quality of life and of course are very cost-effective. I think that shift in terms of supporting innovation is going to be essential, and this leads me into my next question and my thoughts.

Certainly, I would expect every person at this table, whether parents or constituents... Of course, the bulge, in terms of the senior population, is going to create some extraordinary challenges over the next few years. Could you highlight some of the things that you're planning on looking at in terms of supporting health of seniors? I think it will be something that's very prominent over the next number of years.

● (1555)

Hon. Rona Ambrose: Yes, I think you're right. I couldn't agree more that a focus on the health of seniors is incredibly important. I think that provinces are seized with that as well in their delivery of health care and trying to figure out how to reorganize their models of care so they can address what is a huge demographic challenge coming down the line.

We're doing our part to address those issues. In the budget I was very pleased to see significant funding for the creation of the Canadian centre for aging and brain health innovation. Really, if you're interested in these kinds of issues, everything right now is a conversation around brain health, and the government has made incredible investments in brain health, whether it's through our investments in neuroscience or our investments in dementia or Alzheimer's. This specific centre will be based in Toronto, at the Baycrest Health Sciences centre, and will support new research and also develop, importantly, new services to address the particular health challenges we face as we age.

That, I think, will provide good data evidence and support to the provinces as they try to figure out how to deal with this big challenge.

The Chair: Thank you, Minister.

Ms. Fry, go ahead.

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

I want to thank the minister for coming today. I'm going to ask the minister a series of questions. I'm looking for short answers because I have quite a few questions I want to ask you.

With regard to innovation, I notice that the CIHR has been cut. It's a decrease of $4.5 million from the estimates to date in 2014-15 and knowing that the Naylor report on innovation is coming out, how would the CIHR deal with this if you don't increase the budget for CIHR to fund further research into innovation of the health care system?

The second piece is that we know that currently the agencies that are doing research are having to find a fairly large amount of money, $8.5 million, for these groups that don't have anywhere to raise the money to be able to do that little transition for three months each year for the last two years. This cut means they're going to have to.... Nobody knows what they're going to do because there's no way to be able to get that transition money from CIHR, because CIHR is going to have to be cutting certain things. That's about CIHR.

I also wondered why.... For instance, we looked at the fact that the budget for first nations and Inuit primary health care has been cut by a fairly large amount, $45 million, from 2014-15, and $59 million.... That's going to leave us with a real shortfall at a time when we see that the Auditor General has been talking about the quality of care and outcomes and the number of nurses and the ability to deliver care in the north and to Inuit and first nations populations.

We see the increase in infectious diseases, in obesity, in type 2 diabetes. We see rickets in the north, which I only learned about in medical school as a historical fact. Nobody has seen rickets here for, I don't know, almost a century, and we're seeing this in the north. The nutrition is no longer good. We're seeing overcrowding. We're watching tuberculosis increasing. We're watching this kind of falling happening, and I know the minister will say that this cut has come about because of the sunsetting of the water and waste water action plan.

Since February of this year we've had 139 drinking water advisories in first nations communities, so the water isn't safe and it's getting worse. In three months we've had 139 advisories. Why are we cutting such essential programs for a group of Canadians who have the worst health outcomes in the world as seen in the last UNICEF report that was done here?

There is one last piece I wanted to ask you about as well because I think that's all I'll fit, so I'm putting these three on the table. One of them has to do with the CFIA. It's receiving $107 million less than it did in 2013-14. We're also seeing that there is a plan in your planning and priorities for 2015-16 for 271 full-time employees to be eliminated for the meat and poultry subprogram of the food safety enhancement program.

We also know that we're hearing about E. coli in beef and we want to know how many meat inspectors were employed in 2013, 2014, and 2015. Were any positions left unfilled? Have the number and frequency of inspections been cut back at any plant, and if so, which plant and why? How many times a year are general sanitation inspections done at ready-to-eat food plants, like Maple Leaf Foods or raw food plants, such as beef and poultry, etc.

Why would there be a cut in something that is so essential and which has had really bad outcomes for the last three years?

The minister said in the House that she would get inspectors to inspect inspectors because of the bad results that have been happening. What is the quality and the level of the training of the inspectors there? Do they have any requirements for their training if they allow such huge problems to occur?

I'm going to leave those three questions on the table and I'm hoping to get every piece of them answered. That's why I was so specific.

● (1600)

The Chair: Minister, you have two and a half minutes.

Hon. Rona Ambrose: Great.

There have been no cuts to CIHR. In fact, there are increases. I'll leave it to Michel Perron in the second hour to elaborate on all of those.

To aboriginal health there have been no cuts whatsoever. Anything in the estimates that shows a decrease is because those we're sunsetting. We've approved and renewed those, so you'll see them come back. There are no cuts to aboriginal health.

There are no cuts to CFIA. In fact, there was $400 million extra in the budget last year. I'll let Bruce explain to you the specifics around that.

In terms of aboriginal health, I want to say how committed our government is to the $2.5 billion we invest every single year and the 24-7 access to essential nursing services we have in 80 communities.

Let's remember, no matter where you are, if you're an aboriginal Canadian we will provide emergency evacuation for something as simple as a regular appointment, no matter where someone is. If they live in an area where there are no roads, we will provide emergency evacuation transportation to get people to a hospital, to a doctor, to wherever they need to make sure they have access to care. We spend over $200 million a year just on evacuation and transportation for medical purposes for aboriginal Canadians.

Of course, we have coverage, whether it's medical transport, dental care, or prescription drugs. We provide a very comprehensive care for aboriginal Canadians on first nations when it comes to health care. We've now increased our support for aboriginal health by 31% since 2006. We will continue to work with all of our aboriginal partners in the now 734 health facilities across Canada that are on aboriginal first nations that we support.

Hon. Hedy Fry: I have another 30 seconds, Minister. You have said there are no cuts, but there are. I've been looking since 2013, and I'm looking at what was removed that was not replaced.

The point about the whole thing is that if everything is so wonderful, how come the outcomes are becoming worse and worse? I think that if one is spending on any particular program in any particular way and people have pointed out the problems, we should see, over the course of a three-year cycle—just three years going from 2013—and be able to say there is improvement. There has been no improvement in any single one of those three areas I've brought forward.

There is a cut, Minister, to CIHR. Adding new money is—

The Chair: Ms. Fry....

Hon. Rona Ambrose: Ms. Fry, Canada's now considered the best country in the world when it comes to food safety. That's a Conference Board of Canada report. In the entire OECD, we're number one, even better than the U.S., and we should be proud of that. We should never fearmonger Canadians about our food safety. Our food safety system is incredibly effective and very safe.

The Chair: Thank you very much—right on time.

Mr. Wilks, go ahead, sir.

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

Thanks, Minister, for being here. I was happy to hear you talk about addiction recovery. It's a passion of mine, as you know, as someone who is in long-term recovery. As a result of that I wanted to bring two specific questions to you, and they revolve around illegal substances in Canada: one being marijuana and one being heroin.

As you know, Minister, this committee undertook its own study on the serious health risks and harms of smoking marijuana. We recommended that a public awareness campaign be undertaken, given that we heard clearly from doctors and researchers about the serious and harmful effects of smoking marijuana, especially on teens' developing brains and the unborn child.

The recent health campaign that was launched was an excellent way to educate families about the health risks of marijuana. I find it very concerning that the leader of the Liberal Party proposes to legalize and normalize marijuana. I think it's completely irresponsible. In that case, I think our progress in this has been crucial.

First, I'd like you to speak about the government's efforts to stop kids from smoking marijuana.

● (1605)

Hon. Rona Ambrose: Sure. Thank you, and I want to congratulate you on your private member's bill, on your personal recovery, and on your advocacy of that in supporting those who are working so hard to live drug free.

Obviously, as health minister, I'm very concerned about the impacts of marijuana smoking on kids in Canada, and you know, from the committee study that you did, the severe health impacts. Marijuana is an illegal drug for a reason. It's illegal because it's very harmful and it does have serious health effects on youth. This committee heard that loud and clear, and when I had an opportunity to bring together health stakeholders from the mental health and addictions field, they talked about their concerns around the proliferation of marijuana and how many young people were exposed to it who didn't know enough about how this could harm them. I asked, “What is the one thing I could do to help you in the work that you do?” They said, “We want a smoking cessation campaign, a national campaign.”

What we committed to doing was an ad campaign so that we could get to parents and kids, get that information to them. That's what we did, and we targeted the issue of marijuana and prescription drug abuse. It was very effective because a lot of parents said, “You're kidding. I didn't know that this stuff that's out on the streets is something like 500 times stronger than it was when I was a kid”, and there are all of these health impacts, whether it's the early onset of psychosis or schizophrenia, obviously decreased IQ, and many of the things that you heard from the committee study.

We know that especially in youth the evidence is irrefutable, so we have to get that information out there. I would quote the current Canadian Medical Association president who said, “Any effort to highlight the dangers, harm and potential side effects of consuming marijuana is welcome”.

We'll continue to do that.

What do I think of Mr. Trudeau's idea of legalizing marijuana? I don't like it. I've seen what's happening in Vancouver where pot dispensaries are selling pot to kids, well, to a 15-year-old the other day who ended up very sick and overdosed. I think making a harmful drug more accessible and normalizing it by selling it in storefronts is a very bad idea. I don't know how, as health minister, I could think in any other way. This has a serious health impact on young people. I think parents need to educate themselves and think very clearly about what kind of city they want to live in, and make that known to those who are making these decisions. I think it's irresponsible.

We clearly have heard from communities and parents across Canada that home grow ops pose a public health issue, but more so a public safety issue, so we have fought to shut those down. We've passed regulations to shut down home grow ops. Of course, we're now fighting the courts because the courts have put an injunction in place, and we'll continue to fight that in court. We don't think home grow ops are a good idea. We've heard from the police, from the firefighters, and from parents in neighbourhoods that they don't want marijuana grow ops in their neighbourhoods, and we'll continue to fight that fight.

We know that a UNICEF report a few years ago said that Canadian youth were the number one users of marijuana in the world per capita, and that was very concerning. We have really made an effort in schools and in other ways to reach out to young people in our ad campaign. I was very pleased about a recent report that, according to the Canadian Centre on Substance Abuse, there is a decrease, from what I understand, in the number of kids using marijuana, so that's a good thing. The strategy is working. This idea that, if we make it legal, somehow kids will use less, makes absolutely no sense to me. I think we have to keep warning kids about the dangers of it and parents as well so that they have that conversation with their kids and keep it away from them.

Mr. David Wilks: Quickly, Minister, another passion of mine with regard to addiction is that I was adamantly and I continue to be adamantly opposed with regard to drug injection sites. I think in my humble opinion, we're enabling and we're not dealing with the problem, which is getting them off of the drug and providing addiction recovery services to them.

I wonder if you could just speak to that bill with regard to injection sites. It's moving through the Senate right now. It's having some difficulties with the opposition opposing it, and I wonder if you could just speak to that for a few minutes.

● (1610)

Hon. Rona Ambrose: Sure. I actually had a good meeting with the Senate yesterday. Most members, Liberal and Conservative, thought the bill was a good idea, so I find it odd that in the House of Commons the opposition is not willing to support a bill that is in line with the framework we have created to respect the ruling of the Supreme Court in relation to injection sites.

At the end of the day, when people ask why you would not support Justin Trudeau's idea of opening injection houses across the country without having to consult with people, I say, “What is this?” It is an exception under the Controlled Drugs and Substances Act to allow illegal heroin that's brought in off the street to be injected in a location. Let's remember what that means. That means the police need to think about what kind of criminality might occur around that site. We need to have municipalities prepared to deal with any issues that might happen around a site like that. We need parents to know about it. We need the neighbourhood to support it. We need the province and the public health authorities to be ready to deal with it and to actually put resources around supporting those who are addicted. Prevention—we want them to have treatment available and safe options available other than using heroin. There are so many things that go into that, and that's the framework we have put in place.

The most important thing is public consultations. I don't understand why the other parties are opposed to publicly consulting with neighbourhoods, police, public health authorities, provinces, around the location of an injection site.

The Chair: Thank you, Minister. We're a little over time.

Ms. Morin, go ahead,

[*Translation*]

you have five minutes.

Ms. Isabelle Morin (Notre-Dame-de-Grâce—Lachine, NDP): Okay. Thank you, Mr. Chair.

I'd like to talk about the Canadian Food Inspection Agency. In April, a slew of articles came out about the shortage of inspectors.

Minister, you told us that the funding had not been reduced but, in fact, raised slightly. In your presentation, you mentioned that a secure Web platform would be used to share information. That's a positive measure. But does the government also intend to hire more inspectors?

According to Bob Kingston, the president of the Agriculture Union, which represents federal inspectors, the government is really cutting corners when it comes to food safety. More and more, the responsibility for food inspection is falling on companies. In Montreal and throughout Quebec, a minimum of 45 inspectors are needed, but there are only 30. Overall, 10 inspectors are lacking when it comes to satisfying the required minimum number of inspectors at a number of meat-processing plants. Has any money been set aside to hire new inspectors? This is, after all, an issue that has a tremendous impact on Canadians.

My understanding is that meat intended for export to the U.S. is inspected on a daily basis, while meat for Canadian consumption is inspected just three times a week.

I'd like to know the reason for the double standard. Why, under the budget, is meat for Canadian consumption subject to less inspection than that intended for U.S. consumption?

Are there plans in the budget to do away with that double standard?

[*English*]

Hon. Rona Ambrose: Thank you.

First of all, I reiterate the fact that Canada has the safest food system in the world, and that includes putting it up against the United States. In terms of investments, there are absolutely no cuts.

I understand the head of a union has made the claim that there are cuts, but the president of the CFIA has said there are none. So while Mr. Kingston wants to grandstand, I would just refer him to the actual budgetary numbers and he'll see there are absolutely no cuts. In fact, we have now invested almost $1 billion—

● (1615)

[*Translation*]

Ms. Isabelle Morin: Actually, he hasn't necessarily said that there are cuts but, rather, that there aren't enough inspectors.

[*English*]

Hon. Rona Ambrose: Again, he's wrong. He said there were cuts. We've invested almost $1 billion. In the last budget we invested $400 million that will result in CFIA hiring over 200 more front-line food safety inspectors. Again, as another opportunity for making sure that our food safety system is strong, we've also—

[*Translation*]

Ms. Isabelle Morin: There's a processing plant—

[*English*]

Hon. Rona Ambrose: Can I answer your question?

[*Translation*]

Ms. Isabelle Morin: Yes, but I want to give you a real-life example. There is a processing plant in Montreal West.

[*English*]

Hon. Rona Ambrose: Again, now we have—

[*Translation*]

Ms. Isabelle Morin: It should have at least 45 inspectors, as per the standard, but has only 30. Are you going to demand that it have an adequate number of inspectors?

[*English*]

Hon. Rona Ambrose: I appreciate that you want to do the bidding of the union leader, but we have made very clear investments. We have enough inspectors. In fact, we are now rated the safest food system in the world.

Let me read to you what some actual experts, not union leaders, in the food safety system say. Dr. Keith Warriner, director of the food safety and quality assurance program at the University of Guelph, said that the suggestion that meat sold in Canada is unsafe is just scaremongering.

Another professor, who's in bio-resource policy at the University of Saskatchewan and a food safety expert, says:

> Canada has one of the top, if not the top, food safety systems in the world. Other countries look to our regulatory system as a model of food safety....
>
> ...food products that are available for purchase in our grocery stores are as safe as they possibly can be.

I would ask you to not fearmonger because food safety is very important to Canadians. Our inspectors are doing an excellent job.

[*Translation*]

Ms. Isabelle Morin: Absolutely. But Canadians obviously want enough inspectors on the job.

[*English*]

Hon. Rona Ambrose: Our inspectors have all of the resources they need and they're doing an excellent job.

[*Translation*]

Ms. Isabelle Morin: I'm going to switch topics. I want to make sure I have enough time for my question.

In 2012-13, the budget for the animal health and zoonotics program was $175 million. And in the 2014-15 and 2015-16 budgets, that amount was $90 million.

With respect to jobs and human resources, the number of full-time equivalent positions for the animal health and zoonotics program—

[*English*]

The Chair: Ms. Morin, we are over time.

[*Translation*]

Ms. Isabelle Morin: was significantly cut, and I'd like to know—

[*English*]

The Chair: You were a little over five minutes. We did give you a bit of extra time.

Mr. Young, you have five minutes.

Mr. Terence Young (Oakville, CPC): Thank you, Minister, for joining us today, and to everyone else who came.

Before I ask my question, I would like to congratulate you and Health Canada on the anti-drug online and television ads, which we saw, which you commissioned. I thought they were very effective. Obviously, they would get the viewer's attention. It appeared as if they were slanted toward young people, which is very important, before they decide to try drugs, so they are aware that they would be very bad for their health. I thought they were excellent so I wanted to congratulate you on them.

As you know, Minister, drug safety issues have been a focus of my life for many years, so I was very pleased to have had the opportunity to take part in our review of Vanessa's Law. We ensured that the final wording of the bill addressed long-standing issues that drug safety experts have been raising for years about the lack of transparency by Health Canada.

When we're drafting legislation on issues as important as drug safety, it's absolutely essential that we listen to the experts and accept good advice when it is offered. Your openness to hearing that advice has strengthened the bill, and I believe it will serve to strengthen our drug safety system for years to come.

We have now had the law passed for some time. I know that a number of measures are undergoing consultation to ensure that the details are implemented effectively; in other words, we're going to get it right. Can you please provide some additional details to the committee about the continuous monitoring of the development of these powers that have been put in place?

Hon. Rona Ambrose: This one of our top priorities. Before the bill was even passed, we were already writing the regulations and working with the appropriate experts and stakeholders to get the regulations moving because we want them in place as quickly as possible

For instance, you might know that on the issue of adverse drug reactions, we need the information from hospitals. Some hospitals were a little concerned about how we would implement that regulation, so we're right now working to consult with them on what's the best way to collect that information quickly and efficiently, and in a way that isn't going to slow down the work that they do on the front line. That's an example of the people with whom we need to coordinate.

I can reassure you that, as I said, before the law even passed, we started to work on the regulations and we wanted them in place as quickly as possible. Of course, you know that some of the powers, which are in the legislation and didn't require regulations, came into force as soon as the law passed.

● (1620)

Mr. Terence Young: The adverse drug reaction piece, which requires health care institutions to report adverse drug reactions, I understand that they're in the process of coordinating with hospitals and health care institutions. I've been doing this for many years. My experience is that doctors, for various reasons, do not want to report adverse drug reactions, the serious ones, and we're only talking about serious ones. They just don't want to report them for a range of reasons and they just outright refuse.

I wonder if you have any information at this point regarding the level of cooperation that health care institutions are getting from their own doctors. All hospitals have a process already that's supposed to capture the serious adverse drug reactions. They're supposed to be reported internally, but this is another step. As I said, my experience is that doctors don't like to report them.

Have you heard anything or had any feedback on how the process is going with the doctors?

Hon. Rona Ambrose: I don't have any feedback at the moment, but I can tell you if we run into a problem, I'll be open to doing whatever we have to do because this is incredibly important. There's no reason that a physician especially would not want to participate in a law like this and make sure that we can track and use this information about adverse drug reactions so we as a regulator of pharmaceuticals can make decisions on whether or not drugs are safe.

I don't have any reason to believe things aren't going well, but I can reassure you that if they don't go well, we will apply pressure in whatever way we have to.

Mr. Terence Young: Thank you.

The Chair: Mr. Young, you have thirty seconds.

Mr. Terence Young: I've discovered in my research that some of the reasons that doctors don't want to report them are very good reasons. It's very painful for a doctor who's prescribed a drug to discover that the drug has harmed a patient. These are wonderful people who dedicate their lives to helping others.

Hon. Rona Ambrose: Yes.

Mr. Terence Young: Sometimes they're very busy, which is a less useful reason, in my view, because if that life-saving information gets back to the regulator, they can spot a drug that may be harming a patient very early on. I think sometimes they're afraid of being sued, which is a very practical side of it. In the past they were sending the reports in to the Canadian Medical Association, but no one was doing anything with them. I think that doctors felt nothing was going to happen with them, so why take time to fill out a form—

The Chair: Mr. Young....

Mr. Terence Young: —but Vanessa's Law gives a place for them to go where something will be acted on.

Hon. Rona Ambrose: Absolutely.

The Chair: Thank you, Mr. Young.

Next up, we have Ms. Ashton. Go ahead. You have five minutes.

Ms. Niki Ashton (Churchill, NDP): Great, thank you very much, Mr. Chair.

Minister Ambrose, I want to go back to what I think are some of the more urgent issues facing our country when it comes to health, and those are the challenges faced by indigenous communities.

I'm very troubled by the statement that you made earlier with regard to the reductions in budgets that we've seen to be at about 15% since 2011 not counting as cuts but as sunsetting.

Minister Ambrose, if we are to simply stick with the idea of sunsetting, we're talking about programs that were never replaced and certainly not replaced in terms of the critical care that was provided to communities. I know in certain cases those programs were indigenous, run by indigenous people; indigenous health professionals catered to indigenous communities and had high rates of success. Given that we've figured out there has been a slash of 15% to primary health care budgets since 2011, I'm wondering how you and your government can excuse that kind of a cut in an area where it's needed most.

Hon. Rona Ambrose: You might want to repeat that question to the deputy minister, but he assures me, in fact, that there is no decrease. There is in fact an increase of $164.8 million, and that is for renewal of growth in first nations and Inuit health programs and services, an increase in funding level change for implementation of the British Columbia tripartite framework, an increase in the renewal of the first nations water and waste water action plan, and an increase in a territorial health investment fund.

But further to that, one of the things that came out in the Auditor General's report about first nations health is this jurisdictional issue. I would encourage you as a member from Manitoba, and I've encouraged the Manitoba government and first nations from Manitoba, to think about the innovative idea that's happening in British Columbia where we have the province, the federal government, and first nations creating health—

● (1625)

Ms. Niki Ashton: That's fine and I appreciate that, but my role here is as a Canadian parliamentarian and I do want to bring it back to primary health care. The statements that you referred to cover a wide range, and if you would be—

Hon. Rona Ambrose: I'd be happy to do that.

Ms. Niki Ashton: If I can just complete my comment—

Hon. Rona Ambrose: The increase is now 30% in terms of increases—

Ms. Niki Ashton: Perhaps you could provide us with the information in health care for the aboriginal file, Minister Ambrose.

Hon. Rona Ambrose: Again, we deliver health care with the provinces for first nations. In terms of the funding that has gone into first nations health from the first nations and Inuit health branch at Health Canada, there's now an increase of 30%.

In terms of what appears in the estimates, Simon can go through the technical aspect of that, but there is no decrease. In fact, there is an increase of $168 million, and I would encourage you to ask him to explain that technicality to you so that you can see—

Ms. Niki Ashton: Absolutely, and I would welcome that material, if you could present it in writing to our committee here.

I do want to single out one of the programs that was proven to be very successful and falls under this category that you referred to as sunsetting, which you've said is not cutting, and which I think anybody in the universe that sees the value of these programs sees as cuts. I refer to the strengthening families maternal child health program, an incredible program in Manitoba, seen as a best practice. I was told it would be sunsetted despite the fact that it responds to a major need regarding maternal and child health on first nations, a supposed priority of this government certainly when it comes to anyone outside of Canada.

So I'm wondering, here's an example of an indigenous-led health program that should be supported and grown, and instead your government deprioritized it. Will you provide stable and secure funding for this program in the future and certainly see fit to support similar programs focused on maternal child health in indigenous communities across the country?

Hon. Rona Ambrose: Yes. We have made generous investments around the issue of maternal and child health on first nations. If you are referring to a program that is delivered on first nations, yes, it sunsetted but it's been renewed, so it will be in the supplementary estimates. That's what I was referring to. It might look like there's a reduction in the estimates, but we have renewed these programs under the federal aboriginal health program initiative. They were sunsetted, but they will appear in the supplementary estimates.

Ms. Niki Ashton: That's great news. When will that begin being delivered?

Hon. Rona Ambrose: Well, there's a renewal, so the funding will continue to be renewed and it will continue to be delivered.

Ms. Niki Ashton: It's currently not being delivered in the context that was illustrated.

Hon. Rona Ambrose: We're happy to look into this specifically, but if it's a Health Canada program, the renewal will be there.

Ms. Niki Ashton: I'd certainly appreciate the particular attention to that.

I do want to go back to—

The Chair: Ms. Ashton, we're at five minutes.

Ms. Niki Ashton: Thank you.

The Chair: Thank you.

Okay, Mr. Lizon, go ahead, sir.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): How much time do I have, Mr. Chair?

The Chair: You keep going and I'll tell you when you're done.

Mr. Wladyslaw Lizon: Okay. It doesn't look like I have much time.

Thank you very much, Minister, and all the officials, for coming. I'll ask a very quick question.

Minister, I would like to ask you if you could update this committee on the tripartite agreement that's been in place in B.C. for about a year. I know you've been to B.C. to discuss it. Please update us. What changes do you see in the first nations in B.C.?

Hon. Rona Ambrose: Sir, I'd be happy to. In fact, I am a very enthusiastic supporter of what's happening in British Columbia, and I believe very strongly that this is the policy answer for other first nations, provincial governments, and Health Canada for the delivery of health care to first nations. It's progressive, it's groundbreaking, it's integrated, and it is doing fantastic things in terms of empowering the first nations members to not only be accountable for their own health but actually be involved in the creation of their own health programs.

The transfer happened, of course, in late 2013, where British Columbia first nations now have responsibility for their own health services. Health Canada still provides the funding, and Health Canada in no way has left the table. Health Canada is there every step of the way, working with the First Nations Health Authority and the provincial government to integrate the services at the provincial level.

But what this means now is that when the Province of British Columbia speaks about health, it says it has seven health authorities, and it includes the First Nations Health Authority in all of its plans as a government when it comes to first nations health. The funding is in no way offloaded. We still are providing the funding, but it's a really transformative, fantastic way to integrate health services in a way that empowers first nations communities and integrates them into what is really the health service delivery model of the province.

We're hoping to have conversations. I've spoken to all of my health minister colleagues across the country. We are hoping to sit down soon with Saskatchewan to discuss the same model. We have been encouraged by Manitoba, but we haven't had conversations with them yet, We've discussed this with first nations in Alberta.

It's a big undertaking, but British Columbia, the first nations in British Columbia, and Grand Chief Doug Kelly have proven that it can be done. We're at the one-year anniversary, and we're seeing some very good, positive results. I met with the committee and the health authority on Monday, and I'm just absolutely thrilled to see the enthusiasm at the community level to take charge of their own health. It's really excellent.

We hope that other provinces will also be interested in talking to us about this same model.

● (1630)

Mr. Wladyslaw Lizon: Would you say this is a model that can be adopted across the country to provide health care for first nations?

Hon. Rona Ambrose: Every province is unique. All the aboriginal communities would have to come together. It may not be exactly like British Columbia, but it is an excellent model, and we're already seeing really great things happen on the ground there. I think it's a model to be emulated, and I'm very hopeful that other provinces will start the conversation and stop the haggling over constitutional jurisdiction and start to think about the fact that every aboriginal person who lives in their province is a citizen of their province. We need to focus on that and the delivery of health care to them as opposed to who's responsible and the finger pointing. I'm very hopeful we'll be able to do that.

Mr. Wladyslaw Lizon: Thank you very much.

The Chair: Thank you very much, Mr. Lizon.

Thank you very much, Minister.

Hon. Rona Ambrose: Thank you.

The Chair: You actually stayed a little bit over time, so we appreciate that.

We will suspend for a minute or two and then we'll come right back.

● (Pause)

● (1635)

The Chair: We'll continue on with our meeting. We'll continue on through our rotation with Mr. Rankin for five minutes.

Mr. Murray Rankin: Thank you very much.

Thank you very much, officials, for being here. As I said earlier I appreciate it. I'd like to first talk about off-label use of drugs as an issue. That is the misleading advertising for unapproved uses of drugs. The *International Journal of Risk and Safety* examined how Health Canada regulates and enforces Canadian drug advertising. It reviewed complaints for a decade between 2000 and 2011, and it concluded that Health Canada was not doing enough.

The official opposition asked an order paper question that revealed Health Canada received 359 complaints about pharmaceutical advertising, but didn't levy a single fine in response. They wrote letters and Health Canada "worked with them to achieve compliance". There are big fines under the amendments of Vanessa's Law to the Food and Drug Act, big fines of $500 million and so forth, but if you don't enforce them why would anybody take it seriously?

We appreciate your having to work with companies to achieve compliance, but if there are no teeth in the rules prohibiting it, why are they ever going to comply or ever going to do the right thing? If you just get a warning letter, what does it matter?

Mr. Simon Kennedy: Mr. Chair, thanks for the question.

As part of the department's plan for transparency and openness, we're going to be moving ahead shortly to make available publicly all of the various advertising complaints we receive and the manner in which the department takes action to address the issue. The health and safety of Canadians is obviously our top priority, and the way in which we respond to these issues is always proportionate to the risk. In many circumstances we discovered sending a warning letter and talking to the firm in question leads to a resolution. They cease their activity. We will be making those statistics, what our follow-up actions are and whether they were successful, publicly available in the next number of months. I hope that will shed some light on what we're doing in this area to try to make sure we have compliance.

Mr. Murray Rankin: That would be helpful. Thank you, Mr. Kennedy.

Now I'm going to talk about research and the Canadian Institutes of Health Research, or CIHR. In budget 2015 there was a zero increase to the granting councils, but for the $15 million a year that went to the CIHR, $13 million of that was for the strategy for patient-oriented research, of which the minister spoke, and $2 million for antimicrobial research.

The information I've been given is that there's essentially what has been termed a “time out” for researchers. They expected money to continue flowing. but there's a gap in the funding and researchers are simply waiting to hang in there while that gap during that time out is filled. They need $8.5 million for each of the two years to cover the gap during the transition of the phasing out of the old programs. There's great concern in the research community about that. There was lots of rhetoric about the innovation panel, but the concern is about the actual dollars. I wonder if you could comment on that.

● (1640)

Mr. Michel Perron (Vice-President, External Affairs and Business Development, Canadian Institutes of Health Research): Thank you for the question.

Just to clarify, the question of gap that the member refers to relates to the change in our funding approach with our open investigator grant program, which is a significant portion of our budget that allows investigators to apply for funding. There has been a change to the program. We consulted with the universities and the academic institutions for approximately three years to inform them of the change. It has been minimized as much as possible to a shorter time of a three months potential gap, which is not unusual in the research setting among academics in terms of funding the start and cessation of different funding programs. For that gap that is referred to, we don't know the exact number because we haven't concluded the first pilot program results, which will be available shortly.

In the course of the gap it has been identified very early on with the academic institutions to minimize any potential impact that could not be avoided otherwise. The gap time has been shortened as much as possible to three months.

Mr. Murray Rankin: The scathing report of the Auditor General on the failed diabetes prevention strategy would be something I would love to get into. It was absolutely scathing, and I'm just wondering if anything has been done to address the scandalous conclusions that they reached in their 2013 report. Weak management practices, no strategy, no priorities, no performance measures are the words that they report.

The Chair: Mr. Rankin, maybe we could have a brief response and then we'll turn it over to the next questioner.

Mrs. Krista Outhwaite (President, Public Health Agency of Canada): Thank you for the question.

We've actually done quite a bit of work on the chapter that the member is referring to in terms of the audit of the diabetes prevention strategy. In fact the world, Canada, the Public Health Agency, and all of its partners have moved upstream to address the causes of diabetes. A lot of work has gone into healthier lifestyles for children and adults that will help to prevent or mitigate the onset of diabetes.

We have substantive action plans in terms of addressing the specific concerns of the Auditor General in that particular chapter. We have completed almost all of the work that we had set out for ourselves in response to the concerns. In fact we may have even completed all of it. I would be happy to provide a report to this committee that demonstrates that.

Mr. Murray Rankin: Thank would be wonderful.

The Chair: Thank you.

Mr. Toet.

Mr. Lawrence Toet (Elmwood—Transcona, CPC): Thank you, Mr. Chair. It is a real pleasure to be here.

I wanted to start, Mr. Kennedy, with you. The minister invited some of the members opposite to go through the process with you on the technical aspects of how the estimate process works. I've sat through many of these meetings on the estimates, and every time I walk away just kind of floored and flabbergasted by the simplistic approach that is quite often taken in trying to compare a main estimate to a main estimate and not understanding the whole supplemental process and how it all works.

Maybe you could give us some edification on that. We know we can't allocate funds to a program that has not been designated, so that's where the supplementaries come in. Maybe you could give us some focus on that and make sure we have a clear understanding of how this process actually works.

Mr. Simon Kennedy: Mr. Chair, sometimes I think the officials are as flummoxed as the honourable members are. On the issue that had been raised around the table with the minister on funding for first nations in particular, there are a number of programs in the department's budget where they do not have ongoing funding. They're programs that have periodic renewals, and that's often very useful because it's an opportunity to take stock to look at the underlying policy or spending and make adjustments.

In the case of the main estimates, what you see in the main estimates doesn't account for a number of those programs for which the money is actually there in the fiscal framework and they're going through a renewal process. Just in terms of the technical detail, under voted appropriations we have funding increases of $164.8 million, and those are for the following: $63.5 million for growth in first nations and Inuit health programs and services, $29.3 million in funding for implementation of the B.C. tripartite framework agreement on first nations health and for funds for the First Nations Health Authority, $22.3 million for the renewal of the first nations water and waste water action plan, and $23 million for the territorial health investment fund.

Now the main estimates also include decreases of $170.6 million, but those are for the programs that are actually being renewed, so those funds will actually show up in supplementary estimates. Between the $170 million sort of phantom decrease, which will be renewed in estimates, and the funding increases, there's a negative so it looks in the mains as if the funding is dropping. In fact the funding is increasing because we are going to have those renewals. You have to add both sets of programs together.

Generally speaking, we have a predictable steady increase in funding every year for the spending that takes in the first nations and Inuit health branch, and those funds are required because our expenses are rising. The funds provided in the fiscal framework actually go up every year. I can assure members—and I'd be happy to send a letter—that there is no decrease in funding in this area.

● (1645)

Mr. Lawrence Toet: Thank you. I appreciate the explanation.

Dr. Taylor, I had the real pleasure just a short while ago to meet with you at the microbiology lab in Winnipeg and had the opportunity to see the work being done there, the great work that was done on the Ebola vaccine by the people in the lab there. I also had the opportunity to see the behind-the-scenes work that is done that I think a lot of us aren't aware of.

Concerning the implementation of these vaccines around the world, the central control that comes out of the microbiology lab, and the reports back, I'm wondering if you could give the committee a bit of a sense of the work that happens there. We hear about the vaccine, but what really happens with the rollout? What happens with the support in the background? How does that all come together? I was really fascinated at that visit to see all the different components coming together to really make something very special that Canada should be proud of.

Dr. Gregory Taylor (Chief Public Health Officer, Public Health Agency of Canada): Thanks for the question; it's a great opportunity. We're very proud of the work that's going on in our laboratory. It's world class and the laboratory has been recognized as world class for quite some time. On the vaccine itself that we developed, as you know we've licensed that out for commercialization. It's in the midst of clinical trials in West Africa right now.

On my recent trip to West Africa I came to see one of the Ebola treatment centres just as the staff were beginning an information session for the clinical trials that would actually try it on the staff. My understanding from the clinical trials is that our vaccine is doing very well. In fact, one of the companies we're working with, Merck, thinks it's going to be the vaccine to go forward, so we're very proud.

I think it's worth noting that the development of vaccines, from creation to actually using them in people, typically takes 10 to 12 years, the vaccine manufacturers tell us. Because of the Ebola outbreak, because we've worked collaboratively with many organizations around the world, including WHO, CDC, etc., that's been significantly shortened. As a result, we should be able to see some commercialization of this vaccine within the next few months, potentially in the fall, although we actually can use it now.

As you know, the numbers are going down. It may seem a little bit late, but I think we're going to continue to see this disease in the future and next time, thanks to our vaccine, we'll see a very different response and a very different outbreak.

The Chair: Thanks very much.

Ms. McLeod, go ahead.

Mrs. Cathy McLeod: Thank you, Mr. Chair.

I do want to take advantage of having Dr. Taylor here to maybe talk a little bit.... Certainly, Ebola was a significant concern a few months ago. Maybe he could really give us an update in terms of where we are in tackling this particular outbreak.

Dr. Gregory Taylor: I'd be delighted, Mr. Chair. That's an excellent question.

Having just been there, I want to start by saying that the interventions are working. As you've seen, the numbers have gone down consistently. Clearly, if there's not another case by Saturday, Liberia will be declared Ebola-free. Sierra Leone's numbers are going down significantly; Guinea still has some. The interventions and the support, which from Canada I am proud to say with $110 million, our vaccine, our labs on the ground, our Canadian Forces, are making a difference.

I must say, from being on the ground in West Africa, I came back very proud to be a Canadian. It was truly a collaborative mission. I went with some staff from DFATD, as well as the CEO of the Canadian Red Cross, and the CEO of the Canadian Médecins Sans Frontières, or Doctors Without Borders. I was supported by our ambassador on the ground, and our high commissioner on the ground and staff. It was really an excellent mission. It left an indelible impression on me, I must say. You can read about it, you can see the pictures, but it's not the same as being there in person.

I was struck with the question of poverty. I was taken by one of my staff to a slum in Freetown where they had just lifted a quarantine. It was a household-based quarantine for one case. That included 50 to 60 people because they define that as the number of people using one toilet. It was right out of the movies in terms of standing beside a clinic and seeing somebody cooking two feet in front of me, then urine being dumped in the alleyway two feet beyond that.

Clearly, what was striking was the basic public health needs of these people. The needs of clean water and latrines are simply not being met. In Guinea, in that country, what was striking there was the sense of chaos. It was a lot of moving pieces, a lot going on at the same time. I'm left with a vision of goats being transported in a little car and the goats were on the roof racks of the car, just hanging on and barely falling off.

I did see our forces at Freetown. Our forces were working directly with our U.K. colleagues. It was a spectacular experience. They felt like one team and were very proud of what they're doing. I had a chance to speak to some of the young men and women and doctors and nurses who were working there and very proud.

I must say—and I use this word—I “tripped” over Canadians. When we arrived at one of the Ebola treatment centres a nurse who was working there and who I was unaware was from Nova Scotia, took us on the tour. That was one of the MSF treatment centres. Another treatment centre was run by the Red Cross, the French Red Cross. A doctor from B.C. took us on the tour.

Canada has a very high reputation in that country. I think the key message leaving is that it's not over yet. The numbers are going down, but as you probably saw in Liberia, it popped up because it now seems that it's transmitted by sex through intercourse. Seemingly, you can apparently have the virus for up to...it's looking like four to five months potentially, and that's what we think was the case in the one individual in Liberia. So it's not over yet, and long after Ebola is done the public health needs will remain quite high in those countries. There's been some interesting modelling suggesting that because the infrastructure has disappeared and kids weren't getting immunizations, perhaps measles will actually kill more children than Ebola did during the outbreak. That's not to mention, of course, that these countries have some of the highest rates of malaria in the world.

Clearly, it's not over. Clearly, they're going to need the international community's help. Clearly, Canada still has a lot to offer, I think, and I must come back to the fundamental issue of clean water. Sanitation is sorely needed in those countries.

● (1650)

Mrs. Cathy McLeod: Thank you.

My next focus will be with CIHR. I want to hear a little bit more specifically in terms of the patient-oriented research and how you see that. Obviously, that was flagged in the budget as being an important path forward. Could you share some of the details?

Mr. Michel Perron: Thank you, Mr. Chair and committee member, for the question.

Indeed, the Canada strategy for patient-oriented research, SPOR, as we call it, the acronym, is indeed a key platform for collaboration among federal-provincial partners on the ground—patients, as well—in terms of health innovation, with the potential for transformative results. The intention is really about bringing together from the bench side to the bedside, allowing for the research to flow through the system in a manner that allows for, as close as possible, a direct application to patient needs, to policy-maker needs, and the like.

We have developed a series of SUPPORT units, which are being co-funded by the provinces in this sphere, where CIHR, provincial governments, and other partners are investing over $270 million in the first six SUPPORT units, which demonstrates I think a very significant not only attention to but investment by the provinces in terms of this platform for bringing research to the bedside. We were very pleased to note that in budget 2014 we received an additional investment for the SPOR initiative, as we did for 2016-17 for $13 million in SPOR.

Clearly, this is an area that I think will merit continued attention perhaps by this committee, given the potential for its outcomes.

The Chair: Thank you very much.

Next up is Ms. Fry.

Hon. Hedy Fry: Thank you very much.

I am so pleased to be able to ask questions to the bureaucrats because I think I will get answers.

You actually, Mr. Perron, gave an explanation to the question that you were asked earlier by my colleague from the NDP, about the CIHR cuts. Some of us actually know how to read estimates, and we do know that what you put in the main estimates and what you put in the supplementary are what we are looking at, but you did mention the specific area of that transition. The problem, though, is why one recognizes that it is a problem. Something has to be done about it because none of these agencies have the ability to get money back to deal with the transition. I don't know if you have a plan for being able to do that.

● (1655)

Mr. Michel Perron: First and foremost, as you know, CIHR is invested with a significant amount of funds, a billion dollars, which we try to invest as efficiently and accurately as possible with respect to health research. In that regard, the changes we are implementing at CIHR were the result of a very significant consultation that we undertook with the provinces and the academic institutions and health centres on how we can reduce applicant burden, how we can ensure a more efficient application process to streamline the process by which the applications can come in and be peer reviewed.

I should mention that CIHR does have a world-leading peer-review process.

Essentially, the flowthrough of these changes has resulted in a functional program change, which does reflect a small gap, as I mentioned earlier, which possibly will affect 75 to 100 researchers. That's a very small number, notwithstanding an important number—not to dismiss it—of the 13,000 researchers we fund annually. We made every effort to minimize the gap, but the gap is very much a temporary one and one that is reflecting a change in our program approach to respond to the needs of the academic communities.

Hon. Hedy Fry: Thank you. I just wanted to go back to something that to me is an extraordinarily important thing to protect: the health and safety of Canadians.

To the CFIA, if you look at what your actual expenditures were in 2013-14, they were $805.7 million. Then we go to the main estimates for 2014-15 and there is a significant drop from $805 million to $619 million. Albeit in your supplementary you spent $691 million and you've moved that up to $698 million in your main estimates today, there is still a significant shortfall since 2013 of $107 million. For me, the answer that we have the best food safety system in the world doesn't wash, when every time we've heard of a problem it's because the United States refuses to take our food. Recently, this whole XL Foods thing came about because the FDA decided that it didn't want to have the beef that had come in recently.

I just need to know exactly how many meat inspectors were employed in 2013, 2014, and 2015; whether we have positions unfilled; and what the training is that's required for these inspectors. Finally, the last one is that of course it is said that 271 full-time equivalent employees will be eliminated from the meat and poultry program. What does that mean? How is that going to impact food safety?

Dr. Bruce Archibald (President, Canadian Food Inspection Agency): Thank you, Mr. Chair, for the question.

Actually, there are a number of questions there to respond to, so we'll try to work our way through.

I think the first one dealt with the actual issue of the budgets and changes in the budgets year over year. I'm actually going to ask Daniel Paquette, who is our vice-president of corporate affairs and chief financial officer in the agency, to talk about that piece of it.

Mr. Daniel G. Paquette (Chief Financial Officer and Vice-President, Corporate Management Branch, Canadian Food Inspection Agency): Thank you.

When you look at information in the main estimates, the information from year to year is inherently different, so it does make this analysis a little more difficult.

When we look at 2013-14, it truly reflects our actual expenditures and some of the incremental expenditures that were approved during some of the supplementary estimates. One big difference in our case here is also the statutory compensation payments.

If I look at the key difference here between $805 million and $698 million, in 2013-14 we had over 58 million dollars' worth of extra compensation payments, mostly related to infectious salmon anemia. Also, the difference between those two years is that this was the year we had, in budget 2012, the last savings reduction in our appropriations, and that was $45 million.

When you look sometimes a bit more in the future outlaying years, there are a few other reductions that are mainly sunsetters, for which we do expect to go forward and ask for renewal.

Hon. Hedy Fry: On my question about the number of inspectors...?

The Chair: We're over time, but I'll let you finish because I think this is an important point, and then we'll go to Ms. Morin.

Dr. Bruce Archibald: Inspection numbers on a day-to-day basis can fluctuate fairly largely, depending on needs and those types of things. But when you look at inspection numbers in the agency over the last seven years, they've increased by 19%. Almost every year there has been a steady increase in the number of inspectors, and there have always been sufficient inspectors to cover off all the food safety needs.

● (1700)

The Chair: Does that conclude what you want to say? Okay.

Ms. Morin, go ahead.

[*Translation*]

Ms. Isabelle Morin: Thank you, Mr. Chair.

I want to pick up on the question that I tried to ask Minister Ambrose earlier.

The animal health and zoonotics program underwent drastic cuts. In 2012-13, it's budget stood at $175 million but is down to $90 million this year. HR-wise, that represents an annual loss of 400 full-time positions, with the number of positions dropping from 1,199 in 2011-12 to 800 this year.

I'd like to know why the program's budget was cut so significantly. Isn't it an essential program?

Dr. Bruce Archibald: Thank you for the question.

I am going to ask Mr. Mayers, the agency's vice-president of policy and programs, to answer that question.

[*English*]

Mr. Paul Mayers (Vice-President, Policy and Programs, Canadian Food Inspection Agency): Thank you very much, Chair.

On the animal health and zoonosis program, again, as explained by the CFO, when one compares estimates to the report on plans and priorities, you end up with these differences. But the reality is that, in the animal health and zoonosis program, if one looks at it in the context of the RPP, it actually shows an increase in both direct budget and FTEs from the 2014-15 period to the 2015-16 period.

So again, the issue that—

[*Translation*]

Ms. Isabelle Morin: I was comparing the estimates to 2012's. They have decreased by nearly half since then.

Could you explain to me why there are 400 fewer jobs this year than in 2012?

[*English*]

Mr. Paul Mayers: In the agency we take a risk-based approach to the allocation of our resources. When you look from year to year, as the CFO explained, the comparison will depend on issues including, for example, renewal. One of the important renewals in the zoonosis area, for example, is our programming in relation to BSE, which was the sunsetting program that is now renewed.

This is why it's difficult to make those comparisons, because the main estimates are not the only element of the story. The supplementary estimates are also important in understanding the overall framing going forward. As noted, in terms of our front-line inspection activities, the agency's staff has continued to be consistent.

[*Translation*]

Ms. Isabelle Morin: Since you're assuring me that no jobs in that area will be lost, I'm going to move on to another topic.

The Pest Management Regulatory Agency is very concerned about bee colonies. Health Canada is responsible for pesticides. Neonicotinoid insecticide is used on seeds, and that gives rise to many concerns. A report was done—

Mr. Marc-André Morin (Laurentides—Labelle, NDP): The insecticide is banned in Europe.

Ms. Isabelle Morin: Indeed, it's banned in Europe.

The Pest Management Regulatory Agency came out with a report on the subject two or three years ago. Where does the situation stand now? It's quite worrisome given what a vital role bees play. According to the agency's report, changes are necessary. Will any funding be allocated to address those changes? What has been done since the report came out?

Mr. Simon Kennedy: Thank you for the question.

I'm going to answer in English, if you don't mind, just to make sure I give you an accurate answer.

Ms. Isabelle Morin: Very well.

[*English*]

Mr. Simon Kennedy: This is an issue we're looking at very carefully. Health Canada obviously has an important mandate to protect the safety of the public. At the same time we want to make sure we're making decisions based on the best science available.

In the case of the neonic class of pesticides, they are undergoing re-evaluation and reassessment. We are doing this jointly with the United States. The Americans, through the Environmental Protection Agency, are also doing a re-evaluation of neonic pesticides.

Until that work is complete and a final decision can be made, there is a moratorium on expanded usages of this particular class of pesticides, so the uses that are currently there in the marketplace are continuing, but in terms of expanding to new areas or having new applications, new uses, that's awaiting the outcome of the review.

● (1705)

[*Translation*]

Ms. Isabelle Morin: The report I was referring to was released in 2012, so three years ago. How much longer will it take before we see any action on the issue?

[*English*]

The Chair: Ms. Morin, we're way over time.

Mr. Wilks, go ahead.

Mr. David Wilks: Thanks, Chair.

I just have a couple of questions both related to the same topic, one for Health Canada officials and then one to CIHR. They both are with regard to electronic cigarettes. As you know, this committee carried out a study of electronic cigarettes and made a number of recommendations on which the minister is moving forward, including that the Government of Canada establish a new legislative framework for regulating electronic cigarettes and related devices.

Has any of the $26.5 million in planned spending for the tobacco program been identified for developing a legislative framework toward this initiative?

Mr. Simon Kennedy: Mr. Chair, on the issue of electronic cigarettes, this is something the department is looking at quite carefully. We're grateful actually for the work of the committee and all of the consultations that were done and the recommendations. We've been examining those quite carefully.

At this point I would say we have not dedicated specific funds to that work because we have policy staff, and analysts and so on, who are busy doing that work, but there hasn't been a necessity of, for example, hiring additional staff or setting up a dedicated office. We have specialists who look at these kinds of issues all the time who are actually doing that work.

Depending on the ultimate decision of the government in terms of how to move forward on this, it's entirely possible we would need to make budget decisions to reallocate resources. But when it comes to the policy development work, and the assessment of the work of this committee, and to develop a government response, that doesn't require the movement of money budgetarily. We're able to handle that within our existing resources.

Mr. David Wilks: Thank you.

Mr. Simon Kennedy: I want to assure the member there's a lot of work going on to come back with a response.

Mr. David Wilks: I appreciate that. As you know, it's a high priority for the minister. We believe we did provide some very good recommendations back.

To my good friend, Monsieur Perron, welcome back at a different level. As you know, again, this committee's report with regard to electronic cigarettes was brought back to the government. Do you anticipate any of the approximately $1 billion in planned expenditures through CIHR this year will be allocated to projects related to electronic cigarettes?

Mr. Michel Perron: CIHR, as my colleague from the health portfolio indicated, recognizes the importance of this emerging research area. I should indicate CIHR has supported already a number of research projects on various facets of the issue, such as both the harms and possibly the benefits of e-cigarettes, evaluating tobacco control policies, and the efficacy of e-cigarette use for smoking cessation.

By way of more detailed examples, I can indicate that in 2013 CIHR invested approximately $800,000 over five years to a team led by Dr. Eisenberg of the Jewish General Hospital to support the first clinical trial to evaluate the efficacy of e-cigarette use for smoking cessation. We will be awaiting the results of that trial.

With respect to continuing research in this area, clearly CIHR will continue to support research in this field. Our open investigator competition allows for applicants in this particular space, and then more specifically with respect to the report of the committee, CIHR is currently investigating the options that could be pursued in line with this committee's recommendations on the research gaps.

Mr. David Wilks: Thank you very much.

The rest of my time I'll give to Mr. Young.

The Chair: Okay.

You have one minute, sir.

Mr. Terence Young: Okay I'll be fast.

Mr. Kennedy, last year at the Toronto airport I came in one night and there were these advertisements, these big, high signs about eight feet high, in bright colours, you couldn't miss them, and they said, “Humira”. Now, I know disease awareness advertisements are allowed under the current law, but this isn't a disease awareness advertisement, this is a drug advertisement.

It has the name of a very expensive drug that costs about $22,000 a year for treating rheumatoid arthritis, juvenile arthritis, and Crohn's disease. The reason they're not supposed to advertise prescription drugs is that they all have dangers and a doctor should be deciding. No one should make a decision to take a prescription drug without consulting an expert first. The adverse effects from Humira are that it can cause cancer and it can cause tuberculosis. It's definitely not a decision that you want to make while you're walking by with your suitcase in an airport.

What can we do under Vanessa's Law, or what can you do or what do you intend to do to stop drug companies from planting seeds in people's heads to try to get around their doctors so that they decide to take a drug before they know anything about it?

● (1710)

Mr. Simon Kennedy: Thank you very much for the question.

There's a variety of quite powerful provisions that have come into force under Vanessa's Law, and unfortunately I'm not able to cite the specific one with relation to advertising or how it applies, but I could come back to the committee.

For example, under the rules now we're able to have the courts impose penalties including jail time and fines of up to $5 million per day instead of the current $5,000 per day. Drug companies are compelled to revise labels to reflect new risk information, including updates for health warnings for children. Recalls on unsafe products require stronger surveillance. There's a very wide range. This is a law with very strong teeth.

My apologies, I'm trying to remember but I don't have at my fingertips the specific provisions on advertising. I think the general principle is that we're going to look at being a lot tougher on these kinds of violations in the future.

Mr. Terence Young: Thank you.

The Chair: Ms. Fry, go ahead.

Hon. Hedy Fry: Thank you.

I actually wanted to go back to the issue of the Inuit and the aboriginal funding.

I can go back into the estimates and show what was there in 2013-14 and then what was in your main estimates and if you spent more in the supplementary estimates. But the point is that I am very concerned that this whole safe water and waste water action plan that is sunsetting in 2016-17 isn't going to be gone. I want you to reassure me that it won't happen, that it is just on paper, and that when the time comes you will not sunset it. Given that there have been 139 boil-water advisories since February, which is only a tiny space of time, it is obvious that this program is needed.

I just wanted to know if I can have any reassurances from you that this is not going to be allowed to sunset.

Mr. Simon Kennedy: Yes, I can certainly assure the member that the Health Canada funding as regards water and safe water...and in the specific case of Health Canada our role is around testing. There are other elements that belong to Aboriginal Affairs, and so on, but certainly that funding continues and is not lapsing.

If I could just for a moment come back on Vanessa's Law, there is an injunction power under the legislation that would allow us to step in very quickly if there was an issue around advertising. I just wanted to close the loop on that.

Hon. Hedy Fry: I noticed there was going to be a cut in public health again in the area that deals with disease prevention and health promotion. Why is this specific piece of public health action and the needs of public health being cut?

Now more than ever, given that there are all kinds of pandemics that can affect infectious diseases, that we have a huge amount of obesity and type 2 diabetes, that tuberculosis is out there, all of these kinds of problems we are facing in Canada need to be looked at. Health promotion and disease prevention saves money down the road, so why is that being cut? Can you explain that to me, Ms. Outhwaite?

Mrs. Krista Outhwaite: Thank you, to the member, for this question.

If we're only looking at the main estimates in this case, you're quite right in pointing out that there is a reduction in the funding coming to the Public Health Agency. The reduction is a net reduction. Some increases are coming for things like the Ebola virus preparedness—this was mentioned earlier—a bit of money for the Pan American Games, and some genomics research.

On the other hand we are seeing some decreases and the majority, if not most, of the decreases are due to a sunsetting initiative for the hepatitis C health care services program. You may recall that this relates to the earlier restitution that was provided to hep C individuals in Canada by way of compensation programs, a rather substantive program; and a complementary program of funding went to provinces and territories starting in 2001, I think it was, with payments provided to provinces and territories with the specific purpose of ensuring that hepatitis C sufferers would be able to access health care services correctly across the country in all aspects.

We're seeing a bit of a reduction, again, in the sunsetting initiative for a federal aboriginal health program. That is also part of the initiative that's going forward for renewal on the advice of the public service to the government, as was mentioned by my colleague.

Two other declines relate to completed projects. You may recall that we gave some money to the GSK facility in Sainte-Foy, Quebec, to build a new fill line for pandemic vaccine production capacity; that is done. We've also completed a project for automated external defibrillators with Heart and Stroke.

● (1715)

Hon. Hedy Fry: Thank you very much. That explains it all.

How am I doing, Mr. Lobb?

The Chair: You have one minute.

Hon. Hedy Fry: I have one minute to ask a question on transfers. The idea is that the transfers are going to be brought down to possibly 3% by 2017. The point is that they're not going to be increasing exponentially. The Council of the Federation did some estimates and between 2017 and 2024—obviously to 2024, because a review of the transfers is due then—that will represent a $36-billion cut to the transfers they're currently getting. This is going to be a huge loss. Given the increase in aging, given all the demographic and geographic needs, what's going to happen there?

The Chair: Ms. Fry, maybe Mr. Carrie will follow up on that.

Mr. Carrie, go ahead, you have five minutes, sir.

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

I'd like to split my time with Mr. Young. First, I wanted to express my appreciation to Health Canada for all the work you've done over the years for natural health products and the world-class regulatory system.

As you may know, I still work as the minister's...part of the committee for traditional Chinese medicine. With many more Canadians today coming from Asia, looking to have the traditional Chinese medicines they're used to taking, could you explain the work you're doing with traditional Chinese medicine? What approach are you taking with traditional Chinese medicine and what kinds of innovations are you working with to make these products available to Canadians?

Mr. Paul Glover (Associate Deputy Minister, Department of Health): Thank you for the member's question.

It is absolutely correct that, increasingly, Canadians are turning to alternatives like traditional Chinese medicine. There are a number of steps the department is taking. First and foremost among them is that, under the leadership of the minister and others, an advisory committee provides advice to the department on an ongoing basis with respect to the regulation of traditional Chinese medicines, the challenges the community has faced in terms of bringing these products into the country, the practice of traditional Chinese medicine, some of the issues related to that, claims around the products, and all of those sorts of things.

We've been working closely with the Chinese government. It has been very generous in providing traditional pharmacopoeias about the different herbs and substances, and how they have traditionally been used in China, to make sure that practitioners making claims about those herbs are in line with their historic use and use patterns so there is an alignment between what is happening in this country, where these herbs come from—the medicines—and how they have long been used. Those are some examples of the range of things we are doing to work closely with that community to make sure that they understand their obligations when bringing these medicines and herbs into the country. We have a quick and efficient way to understand what it is they're proposing and see if that aligns with the traditional uses from their origins.

● (1720)

Mr. Terence Young: Thank you.

Our work is, by its nature, critical, and that's the way it should be. I don't think we pause often enough to recognize success and celebrate success. The Canadian Food Inspection Agency has had a long run of really good success. I'd like to ask Mr. Archibald if you could take maybe a minute and a half.... I mentioned earlier I thought it was good luck and I suppose there's an element of luck, but it's not just luck, you're doing a lot of things right. Maybe you could tell us how you're succeeding.

Dr. Bruce Archibald: Thank you very much for the question.

I think there are a number of positive things the agency is proud of. Over the last number of years there have been significant investments in the area of food safety, launches of enhanced oversight programs to deal with fresh fruits and vegetables, the creation of inspection verification teams that ensure the high level of integrity within our system, and the adoption of a science-based approach to how we conduct our work and do our evaluations.

As the minister mentioned, we were very pleased to find that the report from the Conference Board of Canada, ranking us against the 17 other OECD countries, placed us in the number one position. There are always opportunities for improvement. We're always looking for ways to continue to strengthen our systems. As the minister mentioned, there was a significant investment to ensure that various food safety laboratories across the country, provincial and federal, are linked together so we can have real-time data sharing.

I know this committee primarily deals on the health space, but I do want to mention a very successful management of outbreak of avian influenza in Canada that occurred at the end of the last calender year. We've had some cases show up again in Ontario this year. Through good cooperation with the provinces and the excellent biosecurity programs that the government has invested in, as well as good cooperation with various producer groups, if you look at that particular challenge, it's had much greater success in Canada than our colleagues in the U.S. have had. In fact, they've sent in folks from the U.S.A. to look at our systems, to understand them and see how we can help them improve their own system. I think there has been a lot of things to talk about.

The final comment is in terms of our staff. Every year the Government of Canada does a public employee survey. We had participation in excess of 82%, which is the highest of any large federal department or agency. Around 90% of our staff indicated that they were proud of the work that they did at CFIA, and 95% said they were prepared to go the extra mile. To me, those are all indicators of a strong staff that does excellent work every day.

Thank you for the opportunity to talk about them.

The Chair: Thank you very much.

This is going to conclude the question and answer portion of our meeting. We have one final task that we need to do. We have to vote on the main estimates. We've received unanimous consent among the three parties. What we're going to be able to do is lump our questions all together in one, and that will save us a little time.

Shall votes 1 and 5 under the Canadian Food Inspection Agency, votes 1 and 5 under the Canadian Institutes of Health Research, votes 1, 5, and 10 under Health, and vote 1 under the Patented Medicine Prices Review Board, less the amount approved in interim supply carry?

Mr. Murray Rankin: Is this a recorded vote?

The Chair: Yes, it's recorded.

CANADIAN FOOD INSPECTION AGENCY

Vote 1—Operating expenditures and contributions.....$537,749,431

Vote 5—Capital expenditures.....$25,783,194

(Votes 1 and 5 agreed to: yeas 5; nays 4)

CANADIAN INSTITUTES OF HEALTH RESEARCH

Vote 1—Operating expenditures.....$47,463,563

Vote 5—The grants listed in the Estimates.....$955,287,128

(Votes 1 and 5 agreed to: yeas 5; nays 4)

HEALTH

Vote 1—Operating expenditures.....$1,777,987,439

Vote 5—Capital expenditures.....$28,035,364

Vote 10—The grants listed in the Estimates and contributions..... $1,678,425,178

(Votes 1, 5, and 10 agreed to: yeas 5; nays 4)

PATENTED MEDICINE PRICES REVIEW BOARD

Vote 1—Program expenditures.....$9,947,595

(Vote 1 agreed to: yeas 5; nays 4)

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

Some hon. members: Agreed.

An hon. member: On division.

The Chair: We'll table those next week.

If there isn't anything else, I think that's it for today. I would like to thank our officials for taking the time and answering all the questions.

I thank our members for their courteous questions.

The meeting is adjourned.