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Chair

Mr. Bill Casey

Standing Committee on Health

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● (0845)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call the meeting to order.

It being 8:45, we will start the proceedings. We are going to hear from an array of witnesses today, and after that we are going to do some committee business.

Our witnesses today are Mr. Ake Blomqvist, health policy scholar from the C.D. Howe Institute, and Victor Elkins and Chandra Pasma from the Canadian Union of Public Employees. Appearing as individuals are Colleen Flood, professor, university research chair, and director of the Centre for Health Law, Policy and Ethics at the University of Ottawa, and Mélanie Bourassa Forcier, professor and director of health law and policy programs at Université de Sherbrooke.

I am going to invite Mr. Blomqvist to have his five-minute opening statement. After that, we'll go to the next ones, and then we'll have questions.

Mr. Ake Blomqvist (Health Policy Scholar, C.D. Howe Institute): Thank you. My name is Ake Blomqvist. I am an adjunct research professor at Carleton University and co-author of the C.D. Howe publication called "Feasible Pharmacare in the Federation", which we have submitted to the committee. I am a part-time health policy scholar at the C.D. Howe Institute, but I am also presenting on behalf of my co-author, Colin Busby, who is an associate director of research at the institute. He is responsible for the work on health care and was supposed to be the main presenter, but he was called away unexpectedly because of a sudden and very serious illness in his family, so I am presenting on his behalf as well.

I have been writing about health policy in Canada for some 35 years and very much support the view that we advance in the paper, which is that the most constructive thing the federal government can do for pharmacare today is focus on things it can do independently and in support of reforms that are already under way in the provinces.

We don't think that an attempt to create a universal public single-payer plan would be helpful at this stage. Obviously we share the view that too many Canadians still report not filling prescriptions or not completing treatment courses for financial reasons and we recognize that the prices of drugs in Canada are still very high by international standards. Also, there are major issues with the quality of prescriptions in various places. We think that the proposals to overcome these problems through a national pharmacare plan would create very major difficulties.

A stand-alone plan managed by the federal government would be unwise, we think, because it would result in less integration in the management of the overall health care system and less incentive to make cost-effective choices among drugs and other inputs in health care. A federal pharmacare plan, for example, could not influence doctors' prescribing behaviour, something that greatly impacts the cost and effectiveness of any pharmacare plan.

We also don't think that using the approach of conditional federal-provincial transfers would be a good idea. Trying to get the provinces to create a set of single-payer public plans would quickly deteriorate, we think, into a federal-provincial standoff about money. It would also be complicated by the fact that the existing public drug plans in different provinces are so different from one another.

Instead of a big push to revamp our mixed public-private system, we think the federal government should work with the provinces to continue developing the pharmacare initiatives that several of them have already started. Ultimately, we believe that provincial reforms are likely to lead to some form of universal pharmacare coverage everywhere in Canada.

To be a bit more specific, we advocate a strategy with several components. There are things that the federal government can do independently of a national plan to lower drug costs in Canada. It should be applauded for joining the pan-Canadian Pharmaceutical Alliance, but it could go further and take a leading role in that alliance. It could also make arrangements to include private insurers in the alliance to bargain jointly with the public plans.

The federal government could also reform the rules according to which the Patented Medicine Prices Review Board regulates prices. It could do so by incorporating the idea of value-based pricing.

Second, the federal government can work jointly with the provinces on strengthening the use of drug formularies that are used in the public plan and strengthening the role of economic evaluation in designing these formularies.

The third strand is that the federal government can ask the provinces, as we propose, to ensure that every citizen has access to a default plan with an upper limit on the percentage of income that a family has to spend on drugs. This idea could be pursued in a way similar to what the federal government currently does with respect to carbon pricing—setting a reasonable minimum standard for provincial plans and offering partial financial support for provinces that meet that standard.

● (0850)

In sum, we think there are several ways the federal government can speed up the process of pharmacare reform that is already happening in the provinces. We think this approach would stand a much better chance of achieving significant progress than the big bang approach that many advocate.

Canada has not done well in recent international rankings in health system performance. My personal view is that many of the shortcomings of our current system are due at least in part to our complicated model of divided federal-provincial jurisdiction over health policy. We think federal-provincial relations in health care are complicated enough already, and an undertaking to tear down and rebuild our system of pharmaceutical financing would just make them more complicated.

Thank you.

The Chair: Thank you very much.

We now go to Ms. Flood for five minutes.

Ms. Colleen Flood (Professor and University Research Chair, Director of the Centre for Health Law, Policy and Ethics, University of Ottawa, As an Individual): Good morning, everybody.

I'm the director of the University of Ottawa Centre for Health Law, Policy and Ethics. I want to thank you for listening to me today. I want to thank you for the work that you're doing here today and for your service generally. My brother-in-law in New Zealand is an MP, so I kind of feel your pain a bit.

I completely disagree with the former speaker, so I guess that's good. Maybe that's why you put us together. I am going to speak on why in fact we do need universal pharmacare—not necessarily national pharmacare, but certainly universal pharmacare.

To cut to the quick of it, essentially in most provinces we have a U.S.-style system for prescription drugs. Poor people are covered, working people are mostly covered through private health insurance, and provinces kind of pick up the elderly. Increasingly, they are de-insuring the elderly, particularly those they describe as the wealthy elderly, so they cover the poor elderly.

Then there is always a gap of people who are uninsured in Canada. That's about 18%. That has been persistent, and it isn't getting any less through provincial reform; it's getting worse. That's the problem that we have to deal with.

I'll give you one piece of research that I think is deep and profound on this issue. It is from the Institute of Clinical Evaluative Sciences in Ontario, probably the best research institute we have in the country. Work by Dr. Gillian Booth on access to prescription drugs for young and middle-aged people under the age of 65 in Ontario found that close to 1,000 young and middle-aged people who are diabetic die every year for want of access to something as basic as insulin, which, by the way, we invented. Banting and Best made one of the great Canadian discoveries, and we can't make sure through our governance system and our insurance systems that people get access to this most basic drug.

We also know that the U.S.-style approach results in U.S.-style costs. Ake has already spoken to the fact that we're a high spender, relatively.

Justice Emmett Hall, a smart man, said back in 1964, “prescribed drugs should be introduced as a benefit” and “its authorization should be an early objective of the Canadian Parliament”. That was 52 years ago. He didn't put it into the basic set of benefits back in the day because he thought it was too expensive and that we should wait for the cost of pharmaceuticals to come down.

Maybe he wasn't as smart as we thought: they haven't come down, and that's because they're not part of a single-payer plan. They're not part of a concerted effort on the part of government to purchase those drugs.

We know that every other developed country around the world that has a universal plan includes prescription drugs in its basic benefit package. We're standing out in the world for not doing that, so I disagree with Ake. I think we are a relatively poor performer these days precisely because we're not doing a good job on insuring pharmaceuticals, community care, and home care, and that's causing all sorts of other problems with our hospitals and physician services.

What can we do about it? I do agree with Ake that it's important that whatever we do is not too much of a burden on the provinces and is respectful of federal-provincial relationships and the Constitution. There are two basic scenarios in my mind.

The first is to expand the Canada Health Act to include community-based pharmaceuticals. Then you say, “You're just going to spend gazillions.” No, not necessarily, if you stipulate as part of the Canada Health Act that the provinces must have a fair process to decide what to include in the basic benefit package. They would be choosing then. For example, they may say that insulin is a higher priority than fixing my bunion. I can go and have my bunion fixed—and actually my doctor organized all of that in a few weeks, free—but people are dying for want of insulin. Surely no rational, reasonable kind of health care system would permit that.

I think if the Canada Health Act could be opened up to include community-based pharmaceuticals and a respectful requirement that provinces have a fair and transparent process to decide what is in and what is out, it would leave them to decide. That leaves them to decide that they'll fund insulin but they won't fund bunions. That's completely doable.

● (0855)

The other way is the kind of bigger bang approach, I guess, which is that the federal government itself would permit this.

Sorry; I should go back and say that the concern we presently have is that we all have private health insurance. We don't want to lose this stream of funding. The Canada Health Act does not necessarily require that everything be tax financed. Provinces charge premiums currently, and you could do this. You could finance this in part through CPP payments.

You could also funnel the funding from the private health insurers into a central plan. The private health insurers would essentially pay a premium to the central plan to do the buying. This is a proposal that Aidan Hollis at the University of Calgary has put forward. I think it's a pretty good one, and I detail it with a bit more specificity.

The final idea is that the federal government do it itself. That's the big bang approach. I actually do have a figure here; we did a bit of a back-of-the-envelope calculation. For about $5 billion, you could cover 150 essential drugs for all Canadians.

I could talk a little about that proposal, but there you have two viable proposals. I don't think either of them would break the bank, and they would put us back on a par with other competitive nations to make sure we deliver health care to the people as they need it.

Thanks for listening to me.

The Chair: Thank you very much.

On the 1,000 people...what was that statistic again?

Ms. Colleen Flood: It was that 1,000 people a year in Ontario under the age of 65 who are diabetic die.

The Chair: In Ontario. Thank you.

Now we are going to Ms. Forcier.

● (0900)

[*Translation*]

Ms. Mélanie Bourassa Forcier (Professor and Director, Health Law and Policy Programs, Université de Sherbrooke-CIRANO, As an Individual): Good morning.

My name is Mélanie Bourassa Forcier and I am a professor in the Faculty of Law at the Université de Sherbrooke, where I direct the master's programs in health law and policy. I would like to thank the committee for inviting me to come and give my impressions on the development of a national pharmacare program.

Am I for or against a national pharmacare program? Basically, I subscribe to the two positions that have been presented to you today. I believe that they can be reconciled to a certain extent. Clearly, I am in favour of access for all to medication. However, assuming that the federal government does not want to revisit the provinces' tax base in order to maintain their autonomy in their areas of jurisdiction, I am in favour of increasing federal transfer payments to the provinces. Those transfer payments would allow the provinces first, to ensure access for all to medications, second, to increase their pharmacare coverage, and third, to ensure the sustainability of their programs that could be threatened by the advent of biological medications that are particularly costly.

In addition, I would add that I am in favour of increasing federal transfers in order to ensure health care services that go beyond the archaic philosophy whereby medically necessary services are those centred on hospitals. It therefore seems important to me to broaden the definition of what can be considered medically necessary. I am likewise in favour of reducing the costs of medications. No one can be against that. However, you will have gathered that I am in favour of respecting federal and provincial areas of jurisdiction.

Let us discuss the savings alleged in contemporary studies on the establishment of a national pharmacare program. Basically, this is all about the savings mentioned in contemporary studies. The oldest studies on the matter, the Hill, Kirby and Romanow reports, focused on the idea of universal access and not on the savings that could result from the establishment of a national pharmacare program. Therefore, the savings alleged in the contemporary studies on the establishment of a national pharmacare program are essentially the result of volume—as Ms. Flood mentioned. Clearly, one single major insurer has much greater negotiating power than a multiplicity of insurers. Such are the laws of the marketplace.

Of course, consolidating power has its advantages: savings are considerable because of bulk buying, because there is a single set of rules, and because all Canadians have equal access. However, consolidation also means setting decision-making autonomy aside, sometimes at a cost. Without that cost, we would long ago have seen the advantage of joining with the United States to increase the volume of our purchases of a variety of goods. If the federal government had not held fast to that autonomy, Health Canada would long ago have accepted medications being put on the market after they had been approved in other jurisdictions, rather than conducting its own health testing. So yes, autonomy comes at a cost, but it also has a value.

Therefore, I am against a national pharmacare program that would be established pursuant to any federal legislation other than the Canada Health Act. I also want to remind you of the 2011 Supreme Court of Canada decision on the Reference re Securities Act. You may recall that the reference dealt with the constitutionality of an act designed to create a fully national program to regulate securities. Section 9 stated that the purposes of the act were to provide investor protection, to foster fair, efficient and competitive capital markets and to contribute to the integrity and stability of Canada's financial system. In a word, the objectives were laudable and difficult to contest.

As the Supreme Court pointed out, the act as worded did not unilaterally impose a unified system of securities regulation. Instead, it permitted provinces and territories to opt into the program if and when they wanted. The court held that the act was unconstitutional because it exceeded the powers of the federal government and represented an interference into provincial areas of jurisdiction. I remind you that the same court, in its 1997 decision in Eldridge, once more confirmed provincial jurisdiction over health.

● (0905)

However, the same court, still in the securities decision, insisted that it was possible for provinces to cooperate contractually to establish a national securities program.

In my opinion, the pan-Canadian Pharmaceutical Alliance is the way to reach such a consensus on the supply and coverage of medications in Canada.

However, I will conclude by insisting that it is important for the federal government to maximize the development of its own jurisdiction, given its clear impact on the costs Canadians pay for medications.

In my opinion, therefore, the federal government should intervene more broadly in the area of public health. With patented medications, the federal government has the power to intervene—as has been mentioned—through the Patented Medicine Prices Review Board. The board is currently in the process of reviewing its mandate, but it is still important to act quickly, especially with a view to regulating the prices of biological medications. There is also the issue of preventing sudden increases in the price of medications.

Unfortunately, as you know, the board does not have the power to regulate the prices of non-patented medications. However, the federal government's jurisdiction over competition may be a factor here. The Competition Bureau's mandate is too limited, in my opinion. A registry of all mergers and acquisitions in the pharmaceutical industry, as well as an examination of the impact of agreements between pharmaceutical companies on competing in the marketplace could certainly ensure greater competition and lower prices.

Thank you for your attention.

[*English*]

The Chair: Thank you very much.

Now we'll move to Mr. Elkins, from the Canadian Union of Public Employees.

Mr. Victor Elkins (Regional Vice-President for British Columbia, Canadian Union of Public Employees): Good morning.

My name is Victor Elkins. I'm the president of the Hospital Employees' Union and a regional vice-president for B.C., sitting on CUPE's national executive board.

It's my pleasure to speak to you this morning on behalf of the 630,000 CUPE members across the country, which includes 150,000 members in the health care sector, working in hospitals, long-term care residences, and community health centres or providing home care.

I want to share with you why CUPE members support a national health care program and why we most certainly do not support simply patching up the status quo.

You have already heard from many witnesses who spoke of the gaps that exist in our current prescription drug regime. Canadians are paying way too much for prescription drugs, and too many people are falling through the cracks, with no coverage or simply inadequate coverage.

Some have suggested that all we need to do in response is extend the current system so that everyone has coverage of some kind, whether public or private. This kind of model exists in Quebec today, but a hybrid model is not the answer, because if we rely on private insurance, drug coverage costs are simply unsustainable. Private coverage is highly inequitable, inadequate, and needlessly expensive.

Let's go over each of these points in more detail.

Private coverage is fundamentally inequitable. The lower a person's income and the more precarious their work, the less likely they are to receive benefits from their employer. In fact, according to an analysis by the Wellesley Institute, nearly all employees in Canada earning $100,000 or more a year receive health benefits, but of those earning $10,000 or less, only 17% get benefits. Since those with lower incomes are also at greater risk of health problems, such as cardiovascular disease, depression, and diabetes, this means that those who are most likely to need prescription drugs are the least likely to have employer-related coverage.

Unionized workers are also more likely than non-unionized workers to receive benefits. However, while CUPE and other labour unions have been highly effective at achieving prescription drug costs and other health-related benefits for our members, that doesn't mean the solution to Canada's prescription drug problem lies at the bargaining table. Obviously, we want to see our members, and all Canadians, have good drug coverage, but ideally decisions about what kind of medications people have access to shouldn't depend on the outcome of negotiations between employers and unions: they should be decisions made by patients and their doctors.

We want medically necessary health care, such as medications, to be available to all Canadians, regardless of where they work or whether they do not work. Prescription drugs should be provided on the same basis as any other form of treatment recommended by a doctor. We are calling for this based on principle, but also because the rising cost of prescription drugs is not sustainable and cannot be addressed without a national drug plan.

Prescription drugs represent the largest portion of employee-paid health benefits, and the rising cost of prescription drugs is placing an increasing burden on employers and employees. The current patchwork system cannot contain these costs. Part of the problem is that the very nature of the system gives it no mechanism or incentive to contain costs. There are 24 separate insurance companies negotiating individually with the large pharmaceutical companies over the price of each individual drug, and the costs of those drugs are simply passed on to employers and employees, so where is the incentive to keep the costs low?

The current system also allows drug companies and pharmaceutical companies to play Canadians against each other. For instance, there is some evidence that cost savings demanded by public drug plans are just being passed along to private plans. In Quebec, documents that were leaked to the media revealed that when the public plan negotiates a decrease in the price of generics, pharmaceutical companies compensate by passing these costs off to the private plans. As a result, the average cost of a public plan for generics decreases by 5.5 %, but the average cost for private drug plans increases by 6.4%.

Private insurance is also more expensive because of high administration costs and the necessity to provide profits to shareholders. Because of these two expenses, there is a significant gap between what Canadians pay in premiums to private insurance companies and what they receive back in benefits. In 2011, this gap was nearly $6.8 billion.

This gap is also growing over time. If the ratio between premiums and benefits had stayed at the same level that it was in 1991, Canadians would have saved $3.2 billion in 2011. This difference in cost is going to administration and the pockets of shareholders, not to better drug coverage for Canadians.

● (0910)

Finally, as costs increase, private plans aren't moving to contain them but are shifting them to workers instead. The number of plans with maximum annual or lifetime limits is growing. Thirty per cent of employers now have a maximum limit of some kind on their drug plans. This just means that people who actually need the drugs the most are the ones who are cut off and forced to either turn to a public plan for catastrophic coverage or pay out of pocket. More employees are now also required to make copayments or to pay dispensing fees.

Some employers are turning to flexible plans, which require workers to guess at their level of need and to pay out of pocket if they had the misfortune of guessing wrong. Some employers have cut off benefits entirely for certain employees or for retirees, as U.S. Steel Canada has recently done to pensioners in Hamilton.

The solution to all these challenges for Canadians, for workers, and for employers is a comprehensive public drug plan that covers all Canadians, regardless of where they live, where they work, their age, or their income.

However, we are concerned that recent trade deals the Canadian government has negotiated, though not yet ratified, will limit the federal government's ability to contain costs and ensure the safety of Canadians. Both the TPP and CETA are projects that could cost Canadians about $850 million to $1.6 billion annually in increased prescription drug costs. The provinces will be reimbursed for the extra costs, but private plans and Canadians who pay out of pocket will have to swallow them.

You can read more about our recommendations in our written submission, but briefly, what CUPE recommends is that the federal government create a national drug plan that provides Canadians with universal, equitable access to prescription drugs with no copays or deductibles. The program should be publicly administered and publicly delivered. We also urge you not to ratify the TPP and CETA trade deals.

We thank you for your time. I look forward to your questions.

The Chair: Thank you very much.

I think we've had 48 presentations up to today, and you are still adding information, new information that we hadn't heard. I just want to thank you for your contributions. They have all been very helpful.

We are going to start questions now. We'll start our first round at seven minutes.

Mr. Kang, go ahead.

● (0915)

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Thank you, Mr. Chair.

I want to thank the panel members for coming here and shedding more light on this big issue that the committee is studying.

My first question is for Professor Bourassa Forcier.

The implementation of medicare in Canada required government to take the patchwork of insurers and create a single-payer system. There have been suggestions by the previous witnesses that a similar process must be used to implement a national single-payer pharmacare strategy.

Respecting the constitutional divisions of power between the federal and provincial governments, what is the federal government's scope of action to implement national pharmacare, which could include a single-payer model and a single formulary?

[*Translation*]

Ms. Mélanie Bourassa Forcier: Actually, I have said that I am in favour of the federal government intervening in order to facilitate access to medications for all. My impression is that, for the intervention to be legitimate constitutionally, it has to be done pursuant to the Canada Health Act. Now, that act must be brought up to date.

As you have already heard or read in the briefs presented to you, when the Canada Health Act was passed, the most expensive medications were provided in hospitals. We now see that situation moving. Most medications, even those for the treatment of cancer, are provided in an out-patient situation, and are therefore excluded from the terms of the Canada Health Act.

Clearly, if the federal government expands transfer payments and broadens the term “medically necessary” that appears in the Canada Health Act, additional conditions will have to be included in the act so that the provinces can obtain the new federal transfers. Those conditions could indicate, for example, that all residents of each and every province are assured of reasonable access to medications. Because of the transferability condition written into the act, we could ensure a degree of consistency in the supply of medications, which is possible to do under the Canada Health Act.

We would then be choosing a flexible program that is acceptable constitutionally. I am sure you are aware of the latest positions of our Minister of Health, Dr. Barrette. That is, that provinces would not automatically agree to abide by new conditions governing medications. But the provinces could still at least take advantage of federal transfers that would allow their pharmacare coverage to be broader.

[*English*]

Ms. Colleen Flood: Can I answer as well?

Mr. Darshan Singh Kang: Yes.

Ms. Colleen Flood: I think the Supreme Court has ruled on several occasions and in recent times that conditionality in transfers between the federal and provincial governments is acceptable. It is, as I said, quite feasible to include community-based pharmaceuticals inside the Canada Health Act and ask the provinces to determine a list of essential medicines. That's not one big national formulary.

If the federal government wished to create one national formulary and one national purchaser, that would require the consent of the provinces, so that's a different ball game. However, the way we've usually done business is through the Canada Health Act or a conditional kind of transfer, and that approach allows the provinces to have flexibility in how they design their health care systems, which could permit, for example, the funnelling of private health insurance premiums or some sort of premium payment through CPP. A model such as you have in Quebec could be okay with this, provided it meets certain conditions, which I would say would be no payment at point of service and no user charges for essential medicines, just as for hospital and physician services. That would be in the spirit of the Canada Health Act. I think it's completely constitutionally permissible.

If the federal government wished to run a big bang federal program, I think that is feasible, but it would have to be voluntary. The provinces would have to agree to participate in it. I would imagine that given their current fiscal situations, most of them would. Quebec may choose not to, but most of them would. I think that would be permissible.

● (0920)

[*Translation*]

Ms. Mélanie Bourassa Forcier: Could I add something?

[*English*]

I'd just relate it to something.

[*Translation*]

We established the pan-Canadian Pharmaceutical Alliance, representing the first ministers of each province and now the federal government. The alliance's function is primarily to negotiate the price of generic medications. With Quebec, and now also the federal government, joining the alliance, we now have much greater bargaining power. With generic medications, the positive effect of volume purchasing can be reflected in the prices we are able to negotiate.

As for the price of innovative medications, negotiating lower prices is difficult, if only because they are patented. It is still possible, by means of confidential product listing agreements. These are becoming more and more common, especially with private insurers.

I agree with Ms. Flood. It has also been suggested that private insurers should join the alliance in order to increase the negotiating power. While still keeping a hybrid, public-private scheme, it is possible to interest private insurers in the negotiations in order to facilitate the purchase of a greater volume at a consequently lower price.

[*English*]

The Chair: Thank you.

Dr. Carrie is next.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Mr. Chair, and thanks to all the witnesses here today.

As the chair rightly pointed out, we're getting new information all the time, and my questioning is to see if you have more information for us.

Madam Flood, you mentioned the provinces would be gung-ho for more money for a national pharmaceutical-type program, but the minister has been very clear that there will be no more money in the transfers. There's nothing in the budget even for the promises they made for $3 billion in palliative care.

We've had credible witnesses who stated quite clearly that if we move toward a monopolistic type of system, the day one costs would be anywhere from $10 billion to $14 billion. We know that private insurance companies in Canada do cover a significant amount of health costs.

Here is one of the challenges. If we hear people saying they want to move to a single payer, there's no real definition of the problem. You have some statistics. You mentioned 18% of Canadians don't have coverage, but for what percentage of those people is the lack of coverage even a problem? You mentioned the thousand people who die in Ontario every year from complications of diabetes. My dad died from complications of diabetes, but he had full coverage, excellent coverage. We're having a problem defining the actual problem. There's no update for statistics.

My question is to C.D. Howe, because many of our witnesses have stated that the statistics are quite old. There have been some suggestions they may not even be recent enough to be relevant, given the shifts in recent years with employment and different coverage.

Do you find it difficult to find recent stats and studies to support investigations? Should the federal government update statistics before we make any final decisions? I ask because this is a huge program, and the government is under constraints; I think there is a $30 billion deficit, and this one line item would be $14 billion.

Beginning with C.D. Howe, what are the statistics that you can glean from, and are they recent?

Mr. Ake Blomqvist: All I'm familiar with is that most of the evidence that is cited on the difficulties that Canadians have accessing health care are based on answers that people gave to questions in various kinds of survey questionnaires. I'm not clear on how reliable that data is and exactly how it should be interpreted.

Colleen is citing evidence on people who died. As to how you attribute the cause of death and to what extent it had to do with lack of access to necessary medications, I don't know. It's a little bit difficult to see what kinds of studies one would have to undertake in order to have a good answer to that question. For example, what are the health consequences of lack of access to medications? Exactly how one would do that, I'm not sure, but obviously one could do it better.

● (0925)

Mr. Colin Carrie: Are you even aware of any studies that provide up-to-date statistics on these things?

Mr. Ake Blomqvist: Being up to date, in my opinion, is not the major issue. The major issue has to do with how you interpret people's responses to survey questions.

All of you, I'm sure, have answered survey questions of various kinds. You're asked on a scale from zero to five whether you have had severe difficulties, some difficulties, whatever, and you know how arbitrary the answers are that people give to questions of that type.

I'm not sure that it would be all that important to get evidence on this issue. There are fairly simply rules that the provinces could implement to make sure that nobody is constrained for financial reasons from getting necessary drugs at the point of service.

One of the few areas where Colleen and I agree has to do with the fact that there probably should be some kind of a guarantee in every province that a person could get access to prescription drugs at no cost at the time they fill the prescription. Where we then disagree is whether at tax time it would be a good idea to recoup some of the payments that have been made.

Mr. Colin Carrie: We've had witnesses quote some statistics that are 30 years old. They said that over the last 30 years we've had a huge demographic shift, with more Canadians moving into the senior category.

Certain patchworks are out there. For example, Ontario has the Trillium bonuses for people to have access. We've also had a shift away from full-time jobs. There are many more part-time jobs. I think the union representatives would be aware of that. I think it's really important that we have updated statistics, because how can you fix a problem if you're not even defining it properly?

My question is to Madame Flood, maybe, and Madame Bourassa Forcier.

Are you aware of any updated studies that would give us statistical analysis to define the problem? There has been a huge shift in the last 20 or 30 years, and there is going to be a huge shift in the next 10 years.

Ms. Colleen Flood: I'm sure that the variety of witnesses you've heard have been bringing various pieces of evidence to you that will need to be synthesized. I have no doubt that the results you will see are that there are significant problems of access for Canadians to essential medications across this country and that this lack of access is causing morbidity and even mortality in some circumstances.

The research study that I referred to is about six years old. It clearly shows the difference between Ontarians who are over the age of 65 and have drug insurance and those under the age of 65. In those situations, we're talking about young and middle-aged people who are suffering morbidity and mortality who are diabetic.

Other work that my colleagues have done shows that people without drug insurance are not going to see their family doctor because they know they will very likely need a prescription, so there's no point in even going to the family doctor in the first place. This is leading to bad health outcomes as well. That study is a few years old.

As the CUPE representative said, we also know from what we see in other countries that the most likely result for the aging population is private insurers seeking to de-insure the elderly. The United States has a plan for the elderly called Medicare. It covered everybody, because of market failure back in the day. Private insurers weren't covering the elderly for the things they needed. Its basic benefit package includes pharmaceuticals for everybody. I mean, we're not even competing with that.

Mr. Colin Carrie: I'm curious, though. You mentioned that the one study you did was six years old, and it was for one chronic condition, diabetes. I'm sure there are similarities between Canada and the U.S., but there are also differences.

Moving toward a monopoly—

Ms. Colleen Flood: There are not really any differences in how private health insurance markets work.

I think any scholar in health policy would tell you that those are how health insurance markets work unless government forces them not to. Unless government regulates private health insurers and forces them not to drop the old and the sick, that is what will happen.

My aunt lives in New Zealand, the country I am from. She bought private health insurance as a school teacher for her entire life. At 80, she's finally in hospital. They asked her the last time that she was in hospital, and she said 1928, when she was born. At this point in her life, when she finally needs her drug insurance coverage and her private health insurance benefits, she can no longer afford them because they are too expensive. She contributed her whole life for nothing.

● (0930)

The Chair: Thank you, Dr. Carrie.

Go ahead. Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chairman.

Thank you to all the witnesses for being here today.

I have some data here before me. One in four Canadians say that they or someone in their household cannot afford to take their prescribed medications, resulting in skipped doses, split pills, or unfilled prescriptions. The source for that is the Angus Reid Institute, which conducted a survey in July 2015, a year ago.

Number two is that on an annual basis, approximately one in 10 Canadians do not fill their prescriptions at all because of cost. My source for that is Michael Law et al. in an article that was published in the Canadian Medical Association Journal in February 2012, four years ago.

Finally, Canadians spend $6 billion a year out of pocket on prescription drugs. That's 22% of total spending on all drugs, and my source for that is Pharma 2020's quite well-known peer-reviewed article that was written in July 2015 by a couple of pre-eminent Canadian health economists.

My question is this: does anybody on this panel doubt that there are Canadians right now in this country who are not able to fill their medication prescriptions because of cost? Does anybody doubt that?

Ms. Pasma, do you doubt that?

Ms. Chandra Pasma (Senior Research Officer, Canadian Union of Public Employees): No, I don't doubt that, but I just want to respond to that point if I can.

Mr. Don Davies: I will come back to you.

Mr. Elkins, do you doubt that?

Mr. Victor Elkins: No, I do not doubt that at all.

Mr. Don Davies: Ms. Forcier? Ms. Flood?

[*Translation*]

Ms. Mélanie Bourassa Forcier: No.

[*English*]

Ms. Colleen Flood: [*Inaudible—Editor*]

Mr. Don Davies: Mr. Blomqvist?

Mr. Ake Blomqvist: No, I'm sure of it.

Mr. Don Davies: Ms. Pasma, I'll let you elaborate a bit if you want.

Ms. Chandra Pasma: Thanks, Mr. Davies.

I appreciate the opportunity to respond, because you raise a good point. We know that there are Canadians who can't afford their prescription medications. We know there are Canadians who are dying because they can't afford their prescription medications. I'm not really sure what difference it makes if we know the exact number and we can put an exact decimal point on that number. If it's 25% or if it's 25.5%, I don't see what difference that makes.

The reality is those people are out there, and that is simply un-Canadian. Our system is based on the concept that if you need health care, you get health care, and right now if you need prescription drugs, you do not necessarily get prescription drugs. You can have surgery because you need surgery, you can see a specialist because you need a specialist, and you can die because you need insulin. That is not Canadian.

Mr. Don Davies: I was picking up on Dr. Carrie's line of questioning.

The best evidence that I've heard at this committee is that 10% of Canadians right now have no coverage in this country. Of that I have no doubt. I have no trouble believing that is true of people who are unemployed, low-income people, people who work for employers who do not provide extended benefits coverage, part-time employees, and young people. I have no issue believing that 3.5 million Canadians are walking around today with no access to medicine if they get sick.

Another bit of evidence we have heard at this committee is that a further 10% have intermittent or unstable coverage. They might have some coverage when they work. They may have high deductibles or copayments, so effectively 20% of Canadians do not have regular, consistent, full coverage for prescriptions. That's based on recent data that I've seen.

I want to pick up on your point, Ms. Pasma, because I want to put this to the panel as well. I'm going to quote from the CUPE submission, which, by the way, is excellent.

It says:

> For nearly 50 years, thanks to Canada's cherished public healthcare system, Canadians have been able to access the medical care they need at no cost, no matter where they live, where they work, or how much money they have. Canada's public healthcare system has delivered high quality care and great outcomes for patients. Canadians are rightfully proud of our system and its values of universality, accessibility and equity.
>
> However, there remains an astonishing exception to these values—access to prescription drugs. When you visit your doctor and receive a diagnosis, all treatments that are deemed "medically necessary"—such as a cast, surgery, hospitalization or referral to a specialist—are publicly funded because they are covered by the Canada Health Act. However, when the treatment prescribed is medication, there is no universal coverage. Instead, access to prescription drugs in Canada is based on a patchwork system that varies depending on where you live, where you work, how old you are, and what your income is.

I'm going to put a simple proposition to you. We have the Canada Health Act that covers medically necessary coverage. Why do we draw a line when the treatment prescribed is not stitching a finger but rather going to the pharmacy and getting a pill? Should we not just extend our Canada Health Act to provide access to medically necessary prescriptions?

● (0935)

Ms. Colleen Flood: I agree with that. I think we should. It has to be clear that it doesn't mean everything is covered. I think it means that some things that are presently covered may not be covered if we have to expand to afford that. I think that's the quid pro quo, and that has to be clear to Canadians and to provinces.

I also think the Canada Health Act does permit a great deal of flexibility within it. It allows, for example, provinces to charge premiums to people. A form CPP is a way of collecting the funding. There is even, as I mentioned, the possibility that private health insurers would pay a premium to a provincial buyer, a provincial insurer. You'd funnel the money through in that way. It would be a way to move forward on this fiscally if there was difficulty in paying for it. Maybe temporarily, but maybe permanently, that could be the arrangement.

Mr. Don Davies: I'm having difficulty understanding why some people have a conceptual difficulty with this.

We talked about the federal-provincial issues, the constitutional issues, and the economic issues. We have the Canada Health Act and we have medicare in this country. If you think this is a tough issue, we got that in the 1960s. Is pharmacare not just a natural measured extension of exactly the system that we have that has solved all of those problems?

The federal government makes money available to the provinces, respecting provincial jurisdiction. The provinces have access to that money as long as they agree to respect the principles set out in the Canada Health Act.

Ms. Colleen Flood: It was the plan back in the 1960s that pharmacare would be included. Unfortunately, we froze in time in 1966, pretty much when we merged the Hospital Insurance and Diagnostic Services Act and the Medical Care Act.

The problem for the provinces is that they're paying up to 50% of their total budgets on health care. That's why they're starting to de-insure the so-called wealthy seniors and put in place copayments and these kinds of things. They need federal support to be able to expand in this way.

Mr. Don Davies: Madam Forcier, can I ask a question directly to you about the Quebec model?

The Chair: Sorry, Mr. Davies; your time is up.

Mr. Oliver is next.

Mr. John Oliver (Oakville, Lib.): Thank you very much.

Thank you very much for your presentation. As others have said, there has been a lot learned again today. It's amazing how complex this topic gets the longer we look at it.

It is regrettable in terms of data and statistics that we lost our Stats Canada comprehensive survey form and don't have reliable data now on some of the key economic situations that our Canadian families are in. That's a regret, but I'm happy to see the long-form census being reinstated.

My first question goes to Mr. Blomqvist.

We've heard from different groups here about big bang versus incremental, and obviously your recommendation is for an incremental approach, with some kind of a default plan for low-income families based on percentage of household income and drug costs exceeding that.

The presentation here from CUPE, to quote a little bit of it, said, “Our current patchwork system also allows drug companies and pharmacies to play individual actors against one another.”

If we do the incremental approach, we simply lock in the current inefficiencies that are there in Canada, along with their cost.

I was curious as to whether you looked at all at what was happening in Europe. There are managed competition models, such as in Sweden. There the people have to have private insurance, but it's a heavily regulated private market. Do you have any thoughts about an incremental model based more on better control of the private market?

● (0940)

Mr. Ake Blomqvist: Our paper gives a menu of areas where we think the federal government does have a major role to play, and the pricing of pharmaceuticals is one of those.

It is true that the patent system is the main reason pharmaceuticals, especially brand-name pharmaceuticals, are so expensive. The patent system is a piece of legislation that we have created to give a monopoly to pharmaceuticals and owners of patents. If you give a legal monopoly to specific sellers, then presumably they have to accept that they will be regulated.

In our opinion, the federal government can take a lead role with respect to the pan-Canadian Pharmaceutical Alliance. They can include private insurers in the negotiations for lower prices and exercise buying power on behalf of not just public plans but also private plans in getting better prices from the pharmaceutical companies.

Furthermore, there are opportunities for the patent PMPRB—

Mr. John Oliver: I'm sorry. I've read through your document. I was curious more about your reaction to what Sweden has done and what some of the other jurisdictions have done around managed competition.

Mr. Ake Blomqvist: I'm all in favour of managed competition with respect to setting certain limits that would provide rules that pharmaceutical companies can follow, including issues of compulsory enrolment in group insurance plans, along the lines that are now the backbone of the system in Holland, for example. It is becoming the backbone of the American system as well.

Mr. John Oliver: Thank you very much.

Ms. Mélanie Bourassa Forcier: I might add a little something.

[*Translation*]

I have just started a project to evaluate the transparency of the private insurance market. The study is not yet complete, but we are realizing that, compared to other western countries, the private insurance market in Canada is the least regulated, even though we have more and more regulation requiring conformity. However, there is no requirement for accountability and the reasons for which premiums increase are not at all transparent.

When employers receive information about their employees' use of health care, they have the expense side, but they have no idea of the profits the insurance companies are making. They do not know what the increases will be for their employees in the future. That means that a number of small employers have to drop their private insurance and push their employees towards the public system, which, if they live in Quebec, is obligatory when there is no access to private insurance, or towards nothing at all, if they live in the other provinces.

[*English*]

Mr. John Oliver: Thank you for that. That goes right to my point concerning the problem with the incremental approach, since we lock in the inefficiencies that are in the marketplace today in terms of getting affordable drugs.

The second question was really around the federal-provincial relationship, so thank you very much for referencing that particular securities act and the Supreme Court decisions on it. It was very helpful, I think.

If I understand correctly, a national formulary would have to be a voluntary agreement at the provincial level. What would the federal government build in then to the Canada Health Act? How far can we go to set the stage for a national...?

Ms. Colleen Flood: In the Canada Health Act, you could say a list of essential medicines would need to be determined by each province, and those essential medicines would be free at point of access, similar to what is currently a basic requirement of the Canada Health Act, so that there would be no cost barrier to accessing medicines that are important.

As to how the provinces decide what's in their basket, the Canada Health Act should demand that they be transparent and evidence-based about what they are going to put in. Then there's some sort of fair process Canadians can get their head around about what will be included and not included, so we're comparing apples and oranges. That would be a fine thing for hospital and physician services as well.

This would provide a lot of flexibility to the provinces. The federal government could offer, as they currently do, the potential to buy in bulk through federal auspices and then perhaps get a better Canadian deal. However, you don't have to be big to negotiate hard. My home country of New Zealand has four million people, and it's known for negotiating hard on prices with pharmaceutical companies. They have the lowest OECD prices in the world.

● (0945)

Mr. John Oliver: Thank you.

Ms. Bourassa Forcier, do you have anything you wanted to add to that in terms of how far we can go in the CHA?

[*Translation*]

Ms. Mélanie Bourassa Forcier: I am in favour of the option proposed. However, we also have to see if it is feasible to base it on the notion of transferability. If residents of another province come into our province, what will they have access to? Do they have the same access as in their home province?

I think we have to evaluate two options in this regard. Setting up a list of essential medications evaluated by each province is one option.

In fact, we have already done that in a quite different context. You will recall Jean Chrétien's commitment to Africa, when we permitted the export of drugs for public health purposes. The WHO had established a general list of what were considered essential medications. In my opinion, that should not give rise to opposition from the provinces; there would be a consensus.

As for establishing a national formulary, we are actually almost there, through the Common Drug Review. Of course, once again, Quebec is not part of that group, but we are still following what is being done very closely. So we are not too far away from a national formulary, albeit not an official one.

[*English*]

The Chair: Ms. Harder, we are down to five-minute questions.

Ms. Rachael Harder (Lethbridge, CPC): Thank you. My first question is going to be for the C.D. Howe Institute.

I am just curious about your reflections. If Canada were to move to a single-payer system, some have suggested that some pharmaceutical companies would simply not sell to our market anymore. Do you think this is possible? Could this be a detriment for us?

Mr. Ake Blomqvist: No, I don't think so. There are presumably some cases of breakthrough drugs that enable people to deal with health problems that previously could not be treated at all, and in this situation pharmaceutical companies are effectively in a position to blackmail the individual buyers, including individual countries. However, in most cases new drugs that are introduced are improvements on existing drugs. The ability of buyers to drive a bargain depends on the extent to which they are dealing with absolutely indispensable drugs that are the only ones available for certain health problems.

Ms. Rachael Harder: If I understood you correctly, during your presentation you said that the provinces would need to put a plan in place. You explained it like a carbon tax, almost—the federal government would put an expectation in place, and then provinces would basically be required to make up anything that fell short from their existing system.

Can you expand on that a little more, in terms of what your plan would be or how you would see it working?

Mr. Ake Blomqvist: When you are talking about mixed public-private systems, the model we favour in general is to have a public default plan so that everybody is automatically insured through the public plan, but people then have the right, if they so desire, to opt for an alternative private plan.

In response to Mr. Oliver's earlier question, in order to be eligible for a subsidy if you opt out from the public default plan, the private plan you choose instead must be approved. The approval would have to consist of things like lists of what drugs must be covered and a prohibition on excluding someone from coverage because of prior illness or conditions and the like.

We are believers in the principle that we need to define, more clearly than at present, which level of politician is responsible for balancing the public's desire for good health care and its desire not to pay exceedingly high taxes. That issue has to be clarified.

In Canada we suffer from a situation in which the burden of paying for an expensive health care system is kicked back and forth between provincial and federal politicians. I don't think Canadians are well served by that kind of a system. To the extent that we favour some degree of conditionality in transfers from the federal government to the provincial governments, it would have to be with maximum flexibility. In the context of pharmacare, we are all fans of the Quebec model, which is based on the idea of a public default plan that enrols everybody unless they have an approved private plan. There are rules that the Quebec government insists on with respect to what the private plan must contain.

What we fail to understand is why, in Canada, we have a belief that provincial politicians, who are elected by the same citizens and taxpayers as federal politicians are, cannot be trusted to resolve the issue of balancing the public's desire for a better health care system and not having to pay through the nose for it.

● (0950)

Ms. Rachael Harder: Ms. Flood, this question goes to you.

You made a comment with regard to what would be in and what would be out. You said it would be up to the provinces to decide. Later you went on to make another comment, which was to the effect that if we cover pharmaceuticals, it may result in other health practices not being included.

It would appear that you are acknowledging that there are in fact limited dollars, that we will have to make some decisions, and that those will be tough decisions. In your estimation, what might not be included, going forward?

Ms. Colleen Flood: I don't think some of it would actually be that tough. I gave you one example. I don't think correcting my bunion is as important as insulin; do you?

Ms. Rachael Harder: That's not my decision to make.

Ms. Colleen Flood: Right.

I think that if we ask provincial governments to have a fair trade-off among hospital services, physician services, and drugs, we would see a better range of care that is covered for everybody. Some things may fall off that list, but I think that in places around the world that have more transparent, evidence-based policies about what is included and not included in medicare, most things the population believes are fair and just are included.

Ms. Rachael Harder: All right.

Ms. Colleen Flood: What happens is that the money that is saved by better negotiation of pharmaceutical prices is used to help other things. We've already talked about evidence that people who aren't able to access their drugs are in emergency rooms and are crowding up emergency wards. We need to fix that problem.

The Chair: Ms. Sidhu, you have five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair.

Thank you to all the presenters. It's an eye-opening presentation. A thousand diabetic people under 65 years old died in Ontario. That's very challenging.

My first question is for Mr. Blomqvist.

Can you elaborate more on the value-based pricing? You mentioned it earlier.

Mr. Ake Blomqvist: Value-based pricing is a somewhat technical concept that health economists like.

One of the few ways we can actually try to quantify better health is through the concept of quality-adjusted life years. In the institutions across the world that make decisions whereby they ultimately may say no to certain expenditures that cover certain procedures or drugs that do have health benefits but for which the incremental health benefits are too small, given the cost, the metric they tend to use is the concept of quality-adjusted life years.

The idea of value-based pricing is simply that when we negotiate with the pharmaceutical companies, they will have submitted evidence already to agencies like the National Institute for Clinical Excellence in the U.K. or the pharmaceutical benefits board in Australia, where they have actually produced numbers that say what the health improvement is relative to the next best alternative in terms of incremental quality-adjusted life years. If countries use that metric and establish that the maximum amount they are willing to pay for an incremental quality-adjusted life year is *x* dollars, that can be the basis for negotiations with pharmaceutical companies about what the maximum prices are that will be acceptable in Canada.

● (0955)

Ms. Sonia Sidhu: Thank you.

My next question is for Professor Flood.

I agree about the importance of access-to-insulin models. Can you think of any international model whereby we can look into this? Do some provinces, for instance, do it better for insulin?

Ms. Colleen Flood: Yes, different provinces have different approaches, and that's part of the problem. Across the country we have a wide variety of approaches, and it does depend on where you live. For example, British Columbia does insure everybody, but it has a 30% copayment for pretty much everybody. That is obviously quite a deterrent to those on a lower income and causes problems of access.

Of great credit to Quebec is that it has a universal prescription drug plan. We might not necessarily like its design, but it does have it; however, there are again significant copayments for people at point of service. To me, that's the basic problem. No matter how you design this health care system or national pharmacare, you've got to make sure that people are not deterred because of financial constraints from getting access to the medications they need.

I disagree with Ake that the way to do this is somehow just to leave the status quo in place. Big bang reform around managed competition, even those models that he's talking about, has involved huge government moves—for example, in the Netherlands it meant regulating the private health insurers so that they compete with each other. The private health insurance plan is the public plan. Everybody's in; it's all risk adjusted. They pay in what they can; they get back from it according to their need. There are very small or no copayments at point of service for needed drugs. That's a totally different idea from just leaving it as it currently is.

It's the same with Obamacare. He's moved forward on this, but it wasn't just from leaving the status quo in place. What we saw year after year was little nibbles around the margins, such as introducing benefits for the under-fives and that kind of thing, but no sustained plan to make sure that people who didn't have private health insurance were covered.

Mr. Ake Blomqvist: I'll mention that I don't think it's fair to say that we are advocating the status quo. We are advocating things like managed competition, for example, in the pharmaceutical sector, but we also advocate managed competition with respect to hospital and physician services.

We think the Canada Health Act at the present time is interpreted in a way that is actually counterproductive with respect to reforms that provinces could undertake if they weren't hamstrung by the desire of the federal government to be visible in the health care field. We don't advocate the status quo; we advocate the system that is status quo in the sense of being mixed private-public, but with integrated reforms in all aspects of the health care system, not just pharmacare.

Ms. Colleen Flood: We have been waiting for 52 years for incrementalism to work. That's quite a long time. That's older than I am.

Mr. Ake Blomqvist: If we didn't have a system that divided federal-provincial jurisdiction over health care, incrementalism might have worked a little better.

The Chair: Go ahead, Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair.

I won't thank the panel here today because you've been thanked by most everyone else. I will pass my thank you on to our analysts and our clerk for the wonderful work that they do. Thank you for all the work you do for us.

I want to talk a little about the pan-Canadian Pharmaceutical Alliance and the fact that the Government of Quebec recently joined. I'm wondering if it's too early to tell whether there has been any impact from this decision in Quebec to join the pCPA. Can anybody answer that?

I'll pass that on to Madame Bourassa Forcier.

● (1000)

[*Translation*]

Ms. Mélanie Bourassa Forcier: Since Quebec joined the pan-Canadian Pharmaceutical Alliance, there have not necessarily been more negotiations that have driven the price of generic medications down. We have followed the schedule of negotiations as planned. However, since Quebec joined, more product listing agreements with innovating companies have been reached. Those agreements are concluded, of course, with the representatives of the various provinces that are part of the alliance. Now Quebec is coming to those agreements too, meaning that more medications are on the reimbursable lists. Without those agreements, the medications would not have been on the lists because they are not considered cost-effective.

When you use quality-adjusted life years, QALYs, an economic mechanism used to determine which medications are reimbursable, you often come to the conclusion that a drug that is too expensive vis-à-vis its accrued effectiveness on the market should not be reimbursed.

I'd like to take this opportunity to mention something about QALYs.

There has been a lot of talk about access to medications for people aged 65 and over. In Quebec, a number of consequences have been threatened. The Government of Quebec uses QALYs, and it has been alleged that this is not fair for older people. You will understand that, with QALYs, they use the gain in the number of life years and the improvement in quality of life after a medication is taken. Of course, the older you are, the fewer life years are gained and the smaller the improvement in quality of life. So the cost-effectiveness ratio can be reduced because QALYs are used. Seniors' representatives allege that this limits their access to the medications.

That is something to bear in mind when you want to focus on a value-based use when listing medications.

[*English*]

Mr. Len Webber: Madam Flood, you mentioned the four million inhabitants in New Zealand and the fact that they negotiate hard on their prices. You were basically saying that bulk numbers don't necessarily mean lower prices. Can you elaborate on that?

I would say that Quebec would beg to differ because of the fact that they've now joined this alliance here in Canada.

Ms. Colleen Flood: If provinces wished to do so, in my view they could negotiate a lot harder than they do with pharmaceutical companies to extract better benefits, but it does help if you have a universal plan that everybody's part of so that you're not shifting the cost from from public to private. The mission of the government, then, is very clear. We're buying pharmaceuticals for our health care system.

My husband actually ran PHARMAC in New Zealand. He was the chief executive officer until I imported him to Canada, and he's just down the road if you need him.

He gave me an example: in 2013, for simvastatin, which is a cholesterol-lowering drug, New Zealand paid 2.4¢ compared to 62.5¢ in Ontario. This is just by hard bargaining, basically commercial bargaining. The New Zealand public insurance plan negotiates hard, just like an HMO in the United States. HMOs in the United States do not pay anywhere near the prices you see as the list prices. They are negotiating hard to get commercial deals for very low prices.

The Canadian way has basically been to cross-subsidize pharmaceutical companies. That gets to your point, because we think we're creating jobs. If we want to subsidize pharmaceutical companies, we should do that in a transparent and open way, and not through high prices that patients have to pay at point of service. If we want to give them transfers, let's do that if we think that's important, but on the same basis we think about automobile companies and all that kind of stuff. It should not be hidden away in prices people have to pay out of pocket to get needed health care.

We can do a lot better. We could do it in a Canadian way, if that was what the provinces wanted to do. I think that's perfectly acceptable. Otherwise, the provinces could do it themselves. There may be a problem with whipsawing, with deals being done between different provinces. That would have to be monitored to watch for drug companies trying to take advantage of that situation. The better way to go would be a Canadian approach, but it would have to have voluntary provincial agreement.

● (1005)

The Chair: Dr. Eyolfson is next.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Mr. Chair, and thank you all for coming. This has all been very informative. I agree with our chair that we've been doing this for a very long time and we're still getting new information.

Mr. Blomqvist, there was something in a statement you made that I wanted to put a wrinkle in. You said that under a large universal plan, there would not be a lot of control over doctors' prescribing practices, but Madame Forcier actually just made a reference to something in that connection.

If you had an evidence-based formulary of drugs that were covered by the plan that stipulated the drugs you could prescribe, would that not apply that measure of control that was needed on prescribing practices?

Mr. Ake Blomqvist: Obviously having formulary restrictions would help, but at the same time, we don't believe formularies are the best way to make doctors take cost-effectiveness more into account when they write prescriptions. Under systems of managed competition, there are ways in which you can, for example, delegate to primary care practices responsibility for part of the cost of the drugs that are prescribed for given patients.

That emphasizes the idea that I referred to: we think that unless you have a system that clearly defines which decision-maker is in charge of all aspects of the health care costs—including physician services, hospital services, and pharmaceuticals—the system is unlikely to work well.

However, of course you are right that formulary involves some partial degree of control over prescription decisions.

Mr. Doug Eyolfson: I'm familiar with how hard it is to tell doctors what to prescribe. I'm a physician myself. I've practised medicine for 20 years. I routinely see children come into the emergency room for an ear infection for which Amoxil would have worked, but they're on some very expensive gorillacillin, and I cannot understand why they are on this drug. I would love to see some sort of control that would have prevented that from being prescribed to this patient.

Mr. Ake Blomqvist: If I may ask, do you sympathize with the idea of drug budgets for primary care practices?

Mr. Doug Eyolfson: I would be more a fan of formularies that simply say what you must prescribe, so that if someone wanted to prescribe this very expensive drug and it wasn't indicated, the formulary would just say no, you can't prescribe that.

I work in a hospital-based practice, and that happens all the time. I write medication orders and the pharmacy says, no, you can't prescribe that; this is what's on our formulary.

Ms. Mélanie Bourassa Forcier: Can I add something, just to complete the answer?

[*Translation*]

I am in favour of establishing a formulary to inform doctors about good prescription practices, as I stated before a parliamentary committee in Quebec that was studying the implementation of Bill 81. However, that must not prevent doctors from prescribing another medication not in the formulary if they consider that a patient must have it. I did not mention it just now but Quebec has just passed a bill that allows tenders for medications.

An administrative stage is doubtless required in order to consider the cost and the value of a medication. However, I am not in favour of reducing doctors' ability to prescribe what they consider the appropriate medication for their patients.

[*English*]

Mr. Doug Eyolfson: I understand, although I will say again, as a doctor familiar with doctors' prescribing practices, that I'm very much in favour of it because there's just not enough education on what doctors prescribe. I think that there needs to be more control on that.

● (1010)

[*Translation*]

Ms. Mélanie Bourassa Forcier: You know that doctors have no training about how the pharmacare programs in their provinces work.

[*English*]

They don't receive any training regarding the coverage that exists in their provinces.

Mr. Doug Eyolfson: I agree.

I only have 30 seconds left and I have a very quick question for Madam Flood.

You mentioned that you had an estimate of $5 billion. Again, that's an estimate. Is that gross expenditure, or would that be a net expenditure that takes into account the potential savings due to improved outcomes, such as not coming to emergency—

Ms. Colleen Flood: That's just gross. That's a back-of-an-envelope thing that a few health economists and physicians and folks who have been talking about public medicare have come up with that they think could cover 150 essential medications. It doesn't include whatever you may be able to extract by thinking about the tax subsidies that go to private health insurers and it doesn't include the other benefits.

On your last question, I would note with respect to integration and controlling or attempting to moderate physicians' prescribing budgets that private health insurers don't have the ability to do that at present.

Mr. Doug Eyolfson: No, I should clarify: it doesn't say what you can prescribe, but it will say what's covered.

Ms. Colleen Flood: Right, and provincial health insurers, I would say, haven't done a very good job on it anyway, so it's not as though we have this perfect nirvana that we're about to wreck in terms of better control of what physicians are doing. I think that expanding coverage to include very vulnerable people who don't have coverage is going to help. Full stop.

Mr. Doug Eyolfson: And I agree. Thank you.

The Chair: Mr. Davies, you have three minutes.

Mr. Don Davies: I want to come back to Quebec, because that is an example of a public-private hybrid system in Canada. I want to quote from an article by Marc-André Gagnon. He said:

> In 1997, Quebec created a drug-coverage system where it is mandatory for workers to enrol in private plans when they are available. Those for whom no private plan is available end up on the mandatory public plan. Thus, all Quebeckers are covered by some form of drug insurance.

Then he said:

> What has been the result of Quebec's hybrid model? Access to medications improved when the plan was implemented, but by keeping a fragmented system based on multiple public and private plans, Quebec has not developed the needed institutional capacity to contain costs. Canada has the world's second-highest per-capita costs for prescription drugs (only after the United States), and Quebec has the highest costs per capita among all provinces.

He said:

> Twenty years ago, Quebec's system was a great step forward, but it is certainly not a model for the 21st century. While it did provide better access to prescription drugs, the system remains inequitable, inefficient and unsustainable, according to a recent official report by the Commissaire à la santé et au bien-être.

He said:

> Inequity persists in the Quebec system because the prices of drugs vary between the public and private plans (...) So who pays? Employers and employees end up paying steep premiums. This increases labour costs and reduces the competitiveness of Quebec's businesses.

And he said: "Mandatory private coverage is also not related to income, so the costs can be substantial for some—especially the working poor."

He points out that a student working part time told him she had to pay $190 of her $514 net monthly income for drug premiums. There's also a systemic issue of institutional skimming between good and bad risks: seniors, people on social assistance, or the unemployed end up on the public plan, while those with a good job—the wealthier and healthier population, generally—end up in the private plans.

I am forming a conclusion that here in Canada we have an example of the hybrid model whose virtues, Mr. Blomqvist, you were extolling, and it's not one that we should copy.

Madame Forcier, do you have an opinion on that?

[*Translation*]

Ms. Mélanie Bourassa Forcier: Yes, exactly.

I find that it is not the hybrid model that is problematic, but what it includes. I feel that we must have a model under which everyone is covered and can take advantage of pharmacare. In my opinion, it is all very well to have a public insurer and private insurers, as long as we are certain that there is positive and effective competition between the private insurers and that there are limits to any inequalities and injustices between those insured by the public sector and the private sector.

I have been making exactly the same case as my colleague Marc-André Gagnon for years. However, I would not go so far as to say that the model is certainly not an example to follow. I feel that it has a lot of things that need to be corrected. At the moment, the fact that the obligations of private insurers are limited under our program gives rise to a number of injustices, and that has to be corrected. However, I am not in favour of the system being completely reformed. We must first proceed with incremental changes. If that turns out not to work, we will have our answer as to whether the system is inefficient. At the moment, I am not at all convinced that it is.

● (1015)

[*English*]

Mr. Don Davies: Ms. Pasma, do you have a quick answer?

Ms. Chandra Pasma: I'm going to respectfully disagree with Madam Bourassa Forcier. I think the Quebec model is actually an example of bad competition. It allows the different players to make their profits by passing the cost on to the public.

The public system negotiated a decrease in the cost of generics. How did the pharmaceutical companies recoup their costs? They did it by passing those prices on to the private insurers. The insurers didn't really care, because they could just pass those costs on to employers and employees who were paying their profits anyway.

I think what we need is a model that gets rid of the profit motive and just focuses on good outcomes for patients. Fifty years of experience with the Canadian health care system shows that public delivery is the model that delivers that.

The Chair: Thanks very much. That completes our time.

I want to thank the panel very much, because we had a couple of firsts today. We had never talked about bunions before on this panel. It's the first time.

It's also the first time I know of, Mr. Blomqvist, that a presenting person asked a member of the panel a question, and he answered. It was very enlightening and very helpful. I learned a lot today; I can tell you that.

I want to ask a quick question of Mr. Elkins.

You stated in your presentation that nearly 94% of employees earning more than $100,00 receive health benefits, compared with 32% of those earning $10,000 to $20,000 and 17% of those earning $10,000 or less. Do you see a trend? Are employers moving away from providing health benefits or adding health benefits?

Mr. Victor Elkins: In my experience at the bargaining table, employers are definitely trying to move away from adding benefits. We're constantly negotiating and fighting for what we have and have had very little chance of trying to improve the benefits at the table for our members. The costs keep skyrocketing, and of course our bargaining skills at the table have to keep improving and sharpening, because we need to fight to protect what those members have.

The Chair: That statistic really strikes me as an unfairness in the system, that's for sure.

Thank you very much. We appreciate your contribution a lot.

We're going to take a short break, and then we have some committee business we have to deal with.

● (1015)

(Pause)

● (1025)

The Chair: We need to do a little committee business.

The first thing on the agenda is that we need to approve a budget for our hearings on the good Samaritan bill. We had six people who came and claimed expenses. We had two video conferences. The total tab was $8,400.

Does the committee agree to pay this bill?

(Motion agreed to)

The Chair: That's done. Thank you very much for that.

Next, we have a motion by Mr. Kang to engage the Parliamentary Budget Officer to study the cost and fiscal impacts of implementing a national pharmacare program.

Mr. Kang, could you present your motion?

Mr. Darshan Singh Kang: Mr. Chair, I move that the committee request the Parliamentary Budget Officer to provide it with an analysis of the following items before the end of the committee's study on pharmacare.

There's a whole list of things here. I think the members have a copy of the motion. If you want me to read all through this, I can. The last paragraph states:

> In carrying out this analysis, the PBO will work with Canadian Institutes for Health Information, Statistics Canada, Canadian Agency for Drugs and Technology in Health, IMS Brogan and other sources to obtain appropriate data and will not rely on analyses prepared by or for a third party. The PBO's report will disclose in detail the sources of data, the quality of the data and the methods of analysis used.

The Chair: Do you have a time frame?

Mr. Darshan Singh Kang: It's to be before the end of our committee's study on pharmacare.

The Chair: Okay.

Mr. Darshan Singh Kang: At the beginning it says, “The committee request the Parliamentary Budget Officer to provide it with an analysis of the following items before the end of our committee's study on pharmacare.”

The Chair: The motion says “by September 9, 2016”.

Mr. Darshan Singh Kang: The motion was amended, Mr. Chair.

The Chair: So now it just says before the end of our study. My copy says “the following items by September 9, 2016”.

Mr. Darshan Singh Kang: The motion is amended, Mr. Chair.

The Chair: To say “by the end of...”?

Mr. Darshan Singh Kang: It says, “by the end of our committee's study on pharmacare”.

The Chair: I wonder if it would be better to give the PBO a date rather than that.

Is there debate?

Mr. Colin Carrie: I like the idea of getting more information.

One of the lines of questioning that I've been using over and over is on whether we can get some updated data to help define exactly what the problem is that we have in front of us and the best way of resolving it. We had some really good information today.

Does this mean that we want to suspend our study right now? We're seeing a whole bunch of witnesses and maybe we should wait, get the Parliamentary Budget Officer to give us some information, and go on to some of the other studies we've identified as priorities. We could suspend this study until we get the information from the Parliamentary Budget Officer so that we can perhaps fine-tune the exact witnesses we need.

I think he could give us some good information. I haven't read through this entire motion; we may even want to expand a little more on the information that he could give us.

I certainly like the idea of where you're going on this.

● (1030)

The Chair: Are there any other comments?

Go ahead, Mr. Davies.

Mr. Don Davies: I want to thank Mr. Kang for this work. I think it's a really good start. Like Dr. Carrie, I'm just reading through it now.

I agree with you, Mr. Chair, that we should have a date. If we say "by the time the study is concluded", nobody knows when that will be. We should have a date.

I'm already starting to sort of do some editing of this. I think it's very helpful to the PBO and I think it would be very helpful to add some very crisp questions to the PBO and have that information.

The Chair: They'll be here at the next meeting.

Mr. Don Davies: I know.

For instance, paragraph a. says "The percentage of Canadians", and you don't break this down. Just to give you an idea of how I'm editing here, I would like the percentage of Canadians who do not have any access to prescription drug coverage and the percentage of Canadians who have intermittent access to prescription drug coverage. I don't think that comes out clearly at a.i. and a.ii., although I think that might be where they're going.

My concern is whether we will have time to put those kinds of questions, the kinds of questions that the committee needs and wants, to the PBO on Thursday. I think this is a really good start, but I think it needs a bit of work.

The Chair: I think we need some meat on the bone, so to speak. We've had all kinds of estimates about the impact and about how much this is going to cost. I think we need this.

Mr. Don Davies: Well, I just may—

The Chair: How are we going to do this? Will we pass this now or will we wait until we hear from the PBO?

Mr. Don Davies: I will illustrate. Paragraph a. says "The percentage of Canadians...who are ineligible for public prescription pharmaceutical coverage". That question is different from finding out who doesn't have access, in a way.

All I'm saying is that I think this motion is probably about 80% there. I think we need some time to massage the questions so that we can give the PBO good questions. I don't know if we can do that by Thursday.

The Chair: Go ahead, Mr. Kang.

Mr. Darshan Singh Kang: We may fine-tune this a bit, but I think this is a starting point. We have lots of data so far from all the stakeholders who appeared before us. It doesn't look as though we will be getting any more data. I think we are just repeating all the data. Every time we get a new witness, they come back with the same data we had before. We can certainly put a time limit to this after the PBO appears. This is giving some direction to the PBO to come back with all the information we need from him.

Thank you, Mr. Chair.

Mr. Doug Eyolfson: I heard Mr. Davies' remark about the first part, "who are ineligible for public prescription pharmaceutical coverage". However, it says at the end of paragraph i., "and who do not have private or employer sponsored coverage". I think that statement on it does expand and, unless I'm mistaken, helps with that greyer definition of who is in need. I find that having those two statements together—the first one and then "and who do not have private or employer sponsored coverage"—adequately answers the question.

I just wanted to put that out there.

The Chair: We have a motion on the floor. I'm going to call—oh, sorry. Go ahead, Mr. Kang.

Mr. Darshan Singh Kang: Mr. Chair, I think we can put it off until Thursday and we can come back....

The Chair: Put it off until Thursday?

Mr. Darshan Singh Kang: Yes. Then we could requestion.

The Chair: Okay.

Go ahead, Mr. Oliver.

Mr. John Oliver: In terms of committee process, instead of the content of the motion, I'm wondering if we could take the first half hour of our committee time on Thursday to make sure we provide feedback and see if we can come to consensus on a motion or vote on a motion. Then we'd have something to give to the PBO maybe half an hour after we start. That would give everybody around the room a chance to come back with some edits.

I'm not sure how we would consolidate it in half an hour of debate. That's my problem.

● (1035)

Mr. Colin Carrie: As Don was saying, I think this is a good start, but one of the things we even heard today from the representative from Quebec was about the jurisdictional issues, the fact that the provinces take the lead in the delivery of health care and use different formularies. This is a lot of information to be asking the PBO to give us within 48 hours.

It's good information and I think it's information that we do need. As I was saying, we need up-to-date statistics, we need the demographics, we need to find out which Canadians are mostly affected, and I think it's a good idea, but perhaps we could ask the PBO to provide a cost estimate and then maybe we would suspend it until we get this information. Then we would start our opioid study immediately, because I know we were able to put in witnesses from last Friday. Pharmacare can be put on hold until this report from the PBO is actually given to committee, and it will help us fine-tune where we're going with the study that we're currently undertaking.

The Chair: That's a good suggestion. We're going to start the opiate study next Tuesday. Later, after this discussion, we're also going to talk about the work plan for pharmacare. There's been a suggestion that we might want to have fewer meetings, and we're going to talk about that.

Also, our travel has been denied. I got a notice as well saying that all travel is denied for all committees from now until well into 2017, so I don't think we can count on going across the street, much less to the places we were thinking to go. The analysts have come up with some alternative witnesses we might bring in to give us the same information, or part of it, that we might get by going to the places. We're going to talk about that work plan in a minute.

Mr. Darshan Singh Kang: Mr. Chair, when the PBO comes here, I don't think we'll be able to ask him all the questions and get all the answers. In this motion, we will get whatever we can from the PBO, and if we need to, we can expand it and get all the information in writing later on.

The Chair: All right. The last suggestion from Mr. Oliver was that after digesting this for a couple of days, we'd take the first half-hour of the next meeting to talk about it and make amendments to it if anybody feels there should be amendments. I detect there's a consensus for the principle of the motion. There may be some things that have to be tweaked, but we'll do that.

Mr. Don Davies: I want to make sure I'm understanding correctly.

I'm not understanding that the PBO will give us any answers next meeting. We're talking about just coming up with a set of questions that we can give to the PBO, maybe discuss the methodology of questions, and then send the PBO away for some period of time.

The Chair: Exactly.

Go ahead, Mr. Oliver.

Mr. John Oliver: I want to go back to process. I'm wondering if we could pass the motion so that we're moving it forward. If amendments need to be made to it, we do those first, though. We could consider amendments first thing Thursday morning. It means the motion has to be reopened, I guess, but we get something on the table.

The Chair: Somebody just advised me that we should probably wait until we hear from the PBO and then make the amendments after that, because there may be some things they can't do and won't do. Maybe they have some ideas too.

Mr. John Oliver: We'd be tabling this as a guideline to him of where we'd like the study to be going. It would indicate a general direction, and we would confirm it after we meet with him.

Mr. Colin Carrie: I don't think this really has to be a motion. To utilize the advice that was given to you, perhaps we could let them come here and see what they're presenting to us. Some of the holes in this motion may be filled. We could certainly have a list of questions that we could give them to go back to after that time. I think the time that they're here is very valuable. I don't think we need to go over modifications at that time. Why don't we just leave this the way it is and take the good advice that you just received?

The Chair: Go ahead, Mr. Davies.

Mr. Don Davies: Thank you, Mr. Chair.

Again, I want to make sure I'm clear. I don't understand the PBO to be coming here to be testifying about anything. The PBO is coming here, at our request, for us to discuss questions and methodology. We're really giving the PBO instructions, I guess in consultation with the PBO, about the information that they can go and study and then come back. If that's the case, then I think the analysts are quite right.

When I think about it, John, maybe the half-hour should come afterward. We pass this motion, we put it to the PBO, and each of us has a chance to talk to the PBO about methodology and questions. I think it gives us a couple of days to see if there's something here that we might want to add. It looks pretty comprehensive to me, but there might be one or two things that we would like to put to the PBO.

Then after the PBO leaves, we can decide if there are any modifications to this that we may want to make, and then we send it off.

● (1040)

The Chair: Are you proposing we pass it now, and then amend it after our meeting with the PBO?

Mr. Don Davies: Yes. Leave half an hour at the end of the PBO meeting, dismiss the PBO, and then, after hearing what the PBO has said, discuss how we might want to modify this list, if at all. It also gives those of us who haven't seen this motion a chance to think about it over the next day or two and figure out what we might want to tweak on it.

The Chair: I'm going to put the question to the committee. We'll vote on the motion under the understanding that after we meet with the PBO, we might want to amend it.

All in favour of the motion, say aye.

(Motion agreed to)

The Chair: We passed the motion, but that's under the understanding that we're going to hear from the PBO. If we need to make amendments...yes, Mr. Davies?

Mr. Don Davies: I didn't mean to interrupt, but I know we're running out of time and I wanted to ask the committee for their feedback on how many meetings we intend to allocate for the opioid overdose study.

I tried to be as crisp as possible and I think we got it down to six, but I could easily add another four or five witnesses. I didn't want to put too many, because I don't know how long the study will go on. I was going to suggest that after talking to my colleagues, it seems we need at least four meetings to hear witnesses.

I'll tell you my idea for a study. I'm not proposing we take time and write a long study summarizing the evidence. What we should do after hearing from the witnesses is take maybe half a meeting, or even do it by writing, and say that the committee hereby recommends the minister take the following steps, and then just list them. I don't think we need big introductions. The purpose should be to give crisp and helpful recommendations to the government as to what they might want to consider doing about the crisis.

If that's the case, we may need a fifth meeting to do that, or only part of a fifth meeting.

The Chair: I have a proposed work plan for the opioid study, but I need unanimous consent to distribute it. It's only in English.

Do I have unanimous consent to distribute it?

Some hon. members: Agreed.

The Chair: Okay, we have a work plan.

I'm going to ask our analysts to outline the features.

Ms. Karin Phillips (Committee Researcher): We have numerous witnesses from all different members. Right now as it stands, I've put—

The Chair: Just one second. Are we going to name witnesses?

Ms. Karin Phillips: I can, but I thought I would talk about it generally and then—

The Chair: Let's talk about it generally with no names, because we're not in camera. If we're going to talk about possible witnesses, whether they come or not, we'll have to go in camera, so no names, please.

Ms. Karin Phillips: There are five meetings listed. It could be more, because we've received the names of numerous witnesses. The witnesses I put on panels were those who were prioritized by members.

Broadly speaking, it starts with federal officials to give a lay of the land as to what the current response is and what's going on. Then it moves into hearing from stakeholders, and that's pretty much it.

As you can see, there are more witnesses here that you could hear from. I tried to make sure there was a balance of perspectives, so I didn't put two of the same kind of witness on the panel. It's up to the committee how many hearings they want to have on this study.

● (1045)

The Chair: This shows five.

Ms. Karin Phillips: Yes, this shows five. I would suggest looking at the alternates, and then you could say if you want to hear from more of them.

The Chair: Is there any discussion?

There's no discussion....

Mr. Len Webber: I'll make a short comment here with regard to some of these possible presenters.

We've all heard stories of families and individuals who are afflicted by this opioid crisis. Do we need to hear more of that at these meetings? I would say not. I would prefer to listen to individuals who possibly could have a solution to this crisis. I'd be pleased to see the Royal Canadian Mounted Police and the Canada Border Services Agency present to us on how to counter these drugs from being smuggled in and such.

As much as it breaks my heart to hear those presentations from individuals who've had afflictions with drug addiction, I think we already know there's a crisis and we should maybe eliminate some of those from of this list.

The Chair: Were these names all provided by members?

Ms. Karin Phillips: Yes. There's only one that was a request to appear, and that's the AFN, the Assembly of First Nations.They're on the list for the last meeting, which will focus on first nations communities.

Mr. Doug Eyolfson: I simply want to confirm what Mr. Webber said. I agree. We know that families have been affected by this and devastated by it. I don't know if there's value added; we need data and solutions. It's not that I'm not interested in their perspective. We know the tragedies they are going through and we're trying to prevent them. I think the best way is, as you say, through objective witnesses with data.

The Chair: Go ahead, Mr. Kang.

Mr. Darshan Singh Kang: I think the more we talk about this, the more confusing it's going to get.

First Mr. Webber wanted to have witnesses here, and we should have been looking at the root cause of the problem very quickly. If we know the solutions, then we shouldn't have gone through the exercise of lining up all these witnesses, so I don't know where Mr. Webber wants to go with this.

I think we should bring in the witnesses and very quickly get to the root cause of the problem so we can give some direction to the minister on how to go about addressing this crisis. I don't know how many members already have the solutions or have the data.

The Chair: Go ahead, Dr. Carrie.

Mr. Colin Carrie: Mr. Chair, first of all, thank you for letting us have a look at this. This is a very complicated issue. Addiction is a hugely complicated issue. I do believe, though, that some of the individuals here and some of the families involved are actually now sitting on boards to give perspective to different boards and stuff. I think their insight is very valuable because they look at how it affects families and communities, and that gives a perspective on what the government can do to help in the future.

We're already past the time for committee business. I have another place that I need to go. Maybe we could end the meeting here and finish our discussions at the end of the meeting next time.

The Chair: I have only one more speaker on the list, Mr. Davies, and then we can do that.

Mr. Don Davies: I would second Dr. Carrie's point. I think we should pick this up and take a look at it. I think it's a very good list, but I think there's some tweaking that should happen. For instance, in meeting three, we have the Canadian Association of Chiefs of Police. We already are going to be hearing from the Royal Canadian Mounted Police in the first meeting, and I would rather hear from the Vancouver firefighters, who are front-line responders. I'd rather substitute them, for instance.

I have a couple of small tweaks to it, so maybe we can pick this up and finalize—

● (1050)

The Chair: We'll do that, and we'll do it in camera so that we can talk about individual names in the next meeting.

In the next meeting, we're going to hear from the PBO. Then after they're done, we're going to talk about Mr. Kang's motion and we'll also talk about this work plan. We have to talk about the pharmacare work plan as well, and there are two private motions, one for Mr. Webber and one for Mr. Davies, that we have to deal with.

Go ahead, Mr. Oliver.

Mr. John Oliver: Following Thursday, we have to hear witnesses on the opioid study, so can we give direction to the clerk to begin to confirm the first and second meetings so that we actually have witnesses lined up who are aware that they're coming to Ottawa next week?

The Chair: Can we have consensus that the first two meetings are okay to book?

Voices: Agreed.

The Chair: Thank you.

Mr. Don Davies: That's the first meeting for sure. In the second meeting, we have this Marie Agioritis, mother of an overdose victim. I don't think we should schedule her—

The Chair: We're not going to talk names. No names.

Mr. Don Davies: Oh, pardon me. I'm sorry about that.

Mr. John Oliver: We will not have any family witnesses in the first two meetings.

Mr. Don Davies: Yes.

The Chair: We can do that. There will be no personal family issues.

The meeting is adjourned.