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Chair

Mr. Bill Casey

Standing Committee on Health

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● (0820)

[*English*]

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

We'll continue our briefing on the opioid summit that just took place.

We're certainly pleased to have the Honourable Jane Philpott, the Minister of Health, with us today. I understand she's here for an hour, and then she has some other duties she has to perform, so we should get right into it.

Also from the Department of Health, we have Simon Kennedy, deputy minister, and Hilary Geller, assistant deputy minister. From the Public Health Agency, we have Dr. Gregory Taylor, chief public health officer, back for another little visit.

I want to thank you all for coming. Would you like to make a statement or would you like to go right to questions?

Hon. Jane Philpott (Minister of Health): I would be happy to make a statement.

Thank you, Mr. Chair, and members of the committee, for the opportunity to come and be with you today to speak to the opioid crisis, which I gather was one of the reasons you wanted me to appear before you today.

Thank you, Chair, for introducing my colleagues from Health Canada and the Public Health Agency of Canada.

I have a few opening remarks, and then, of course, I look forward to your questions.

Before I start, I want to thank this committee for the fantastic work you've been doing on a whole number of fronts and to let you know how much I appreciate the work being done here and how much I look forward to further studies coming out of this committee. In particular, I want to thank you for your study and report related to the opioid crisis.

As you know, this is a serious matter facing our country. Of course, we have differing views on certain strategies, but we know that overall this is an issue that needs to be addressed from a public health perspective. It's not an issue in which partisanship needs to interfere. We need to focus on saving the lives of Canadians.

I think this committee is well aware of the statistics and the fact that hundreds of Canadians have died already this year. If you look at British Columbia alone, up to the end of October there were over 600 deaths related to opioid overdoses. I'm sure that the committee also heard a great deal about addiction as you were doing your study. You heard people talk about the fact that addiction can happen to anyone, that it's a chronic illness, that it affects people of all ages and of all socio-economic groups, and that it impacts communities all across this country.

These matters are urgent. The number of deaths related to opioids has complex roots. It's dimensional, and it requires swift action on behalf of all of us in this vocation.

I have been addressing this matter since the very beginning of my responsibilities as Minister of Health, and I have been making decisions in an attempt to promote health and to save lives. I believe we need to continue to have a health-focused approach to the opioid crisis.

Some of you know that last month I was in British Columbia and visited front-line workers. I was at Fire Hall 2 in downtown Vancouver and met with paramedics and police officers and firefighters as well as many health care providers. Hearing from them about what this means on the ground and the challenges they face every day in trying to save the lives of victims was very moving for me.

Later that month I, along with the Ontario Minister of Health, Mr. Hoskins, hosted a large gathering that some of you were able to attend. It was a conference and then a summit, where we had representatives of government, health care professionals, and community members talking together about how we need to respond.

We have taken many government actions to date on this, including, of course, the work of this committee. We have continued to focus on a public health approach. You have no doubt heard of some of the announcements yesterday, which I'll refer to shortly, but first of all I wanted to make sure you were aware of a number of steps that have been taken so far.

One of the early steps we took was to make sure that naloxone was available in a non-prescription status. We also heard about the need for a naloxone nasal spray, and we were able to expedite an emergency importation mechanism to get nasal spray into the country. We were later able to expedite an approval of naloxone nasal spray for production in Canada.

We realized that one of the things we needed to do was to focus on harm reduction. In that light, early on I approved an exemption for the Dr. Peter AIDS Centre to operate a supervised consumption site in Vancouver. We were also able to give an unprecedented four-year renewal to Insite, which is an extraordinary site based in downtown Vancouver.

We also were asked to reverse the federal prohibition on the use of diacetylmorphine, which is pharmaceutical heroin. It is proven as a medication for the treatment of addiction, and it is now available under a special access program.

Last week we took steps to schedule fentanyl precursors, making it harder to access some of the chemicals used to make illicit fentanyl. Yesterday we introduced amendments to the Controlled Drugs and Substances Act and other acts.

It's important to recognize the big picture of why we did that. It is fundamentally taking a health-based approach to problematic substance use, and the new Canadian drugs and substances strategy replaces the former national anti-drug strategy.

It formalizes the government's approach to drug policy, which is comprehensive, collaborative, compassionate, and evidence-based. The lead for the strategy has now returned to the Minister of Health, and we have reinstated harm reduction as one of the four pillars of drug policy, along with the pillars of prevention, treatment, and law enforcement.

You can ask me more details later, but I wanted to give you a bit of an overview of what's included in some of the details of that bill. One of the things we did was to streamline the approach for communities that feel there is a need to have a supervised consumption site in the community. In order to do that, we removed the 26 criteria that had been in place in the previous legislation, and we replaced those with a requirement for the Minister of Health to demonstrate evidence of public health and public safety benefits.

This comes in part from the 2011 Supreme Court decision, which stated that where the evidence indicates that a supervised injection site will decrease the risk of death and disease and there's little or no evidence that it will have a negative impact on public safety, the minister has a responsibility generally to grant an exemption.

The Supreme Court also gave us guidance on what kinds of things the Minister of Health should take into consideration in making that decision, and there were five factors in particular that were emphasized.

The first is that there has to be a demonstration of community need. Second, there has to be a demonstration of community consultation and support. Third, the minister has to have an understanding of the potential impact on crime rates. Fourth, there need to be regulatory systems in place, and fifth, there needs to be evidence that the site has the appropriate resources in place.

Given all this, we know that there is an abundance of evidence that well-established and well-maintained supervised consumption sites in communities that want and need them will save lives, prevent infection, and introduce people into the health care system in a way that will not increase crime rates and will not increase problematic drug use.

There are a number of other elements in the bill that you may want to ask about. You have probably heard that we will be prohibiting unregistered importation of pill presses and encapsulators to help to address the matter of the illicit supply, production, and distribution of drugs.

We will be removing the exception in the Customs Act that currently prevents border officers from inspecting mail that's 30 grams or less. This will allow us to stop the importation of dangerous substances such as fentanyl, which are often shipped in these very small packets.

There are a number of other amendments to the Controlled Drugs and Substances Act. They're there to help increase the flexibility that we have to address emerging risks. They allow us, for instance, to temporarily add a substance that we believe poses significant risk to public health to a temporary schedule on the Controlled Drugs and Substances Act pending a comprehensive review and a decision on permanent scheduling.

All in all, the response to the opioid crisis requires a comprehensive approach. It requires actions like those we took yesterday to essentially stop people from drowning, as it were, but we also have to take steps to address root causes, the reasons people fall into the water in the first place, if we are to use that water metaphor.

The Canadian Mental Health Association talks about the opioid crisis having multiple roots. Some of those roots are in the health care system. Canada is the second-highest per capita consumer of opioids, and we took steps during the summit to address the roots of the crisis with the role of prescription drugs. We brought together at that meeting seven provincial and territorial health ministers and a broad range of stakeholders, and we developed a very interesting and impressive list of actions that these 42 organizations are committed to taking in a joint statement of action. There's also a commitment on our part to report on the progress quarterly.

I thank you for being here today. Thank you for working alongside us to be able to address this very serious matter that affects some of the most vulnerable Canadians. We need swift action on this. We need a renewed focus on a public health approach that includes harm reduction and addresses root causes. We absolutely have to work collaboratively to save the lives of Canadians and promote their health.

Thank you very much.

● (0825)

The Chair: Thank you very much.

You are right on target at 10 minutes.

We're going to go to questions now. We'll go to our first round of seven minutes, and we're going to start with Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Mr. Chair.

Madam Minister, thank you for being here and for your valuable input on our work, especially as regards the opioid crisis that you have brought to the fore. Yesterday's announcement is very positive and forward looking.

I have a few questions. I will focus on the facts.

The number of criteria for opening supervised injection sites has been reduced to five. There are only two such sites in Canada right now.

How many sites do you expect will be opened in Canada and in what timeframe? Is there a specific objective in this regard or are you waiting to have discussions with the provinces and the communities affected? If there is such an objective, how will it be reached?

● (0830)

[*English*]

Hon. Jane Philpott: Thank you very much for the question. You actually raised a whole series of questions within that one, and I'll try to speak to each of them if I can.

I encourage members to read the Supreme Court decision of 2011, if you haven't already. It was informative for us in coming up with this legislation yesterday and it lays out the criteria as to when and if these kinds of sites should be approved. I think you'll see that it's quite helpful.

You spoke to the matter of the number of sites that there are now, and you're absolutely right: so far there are two that have received an exemption, the Dr. Peter Centre AIDS Foundation and Insite, both of them in Vancouver. A number of applications are in place. I believe there are three from Montreal, if I'm not mistaken—no, four now from Montreal, two from Vancouver, and three from Toronto. Is that it?

A voice: Yes.

Hon. Jane Philpott: Okay. Those are the ones for which we have received the full and entire applications. Several other communities have applications that are in process, and my department has been helping them with some of the steps along the way.

One of the challenges under the current legislation was that we were not able to comment or to even provide feedback or begin a review of an application until it was complete. That requires, in some cases, as in some of the new applications in Vancouver, that they have an almost complete application. They have some work to do on, for example, renovating the space where they want the site to be available, but we can't actually do all of the work until things are complete.

Our commitment now is to have a much different approach, in a number of ways. One is that we intend to be able to post online the progress that sites are making so they can see where they are and which pieces are missing. The federal government actually takes the heat on not approving these sites, when many times the barriers to site approval have nothing to do with federal jurisdiction but have to do with local municipalities or with provincial governments providing support, for example. We want to be more clear on that, so that advocates who are pushing for this are pushing on the right levers to be able to get these sites open. Once this legislation passes through, we're also committed to allowing partial reviews of applications that are in process.

Hilary may have some other things to add, but I want to also address the last question, which I think is really important in terms of where we foresee these going and how many communities will have them. I think it's very important that this committee have a central role in this so as not to cause undue anxiety in communities where it's absolutely not appropriate to have supervised consumption sites. This is a crisis that is spotty in where it affects people. Yes, there are people across the country who die of overdoses, but there are some areas where the crisis is intense, as in southern British Columbia.

In those communities that want and need them and where there's strong community support, we have to be able to make them available to save people's lives, but there are all kinds of communities in the country where it's not appropriate, there's no community desire to have one, and there's no demonstrated need. Clearly the fearmongering around supervised consumption sites on every street corner is not helpful at all. We need to make sure that these will go to the communities that need them, that are crying out for them because people are dying, and we need to support those places.

Do any of you want to fill in any blanks? No? Okay.

[*Translation*]

Mr. Ramez Ayoub: Thank you for your answer. It is very clear.

The number of approval criteria for new sites has been reduced to five. You want approval to be simpler and faster, perhaps for locations where the need is the greatest, as you stated. Some people support this while others are opposed. It is never really 100% clear.

As to one particular criterion, some police services have made certain recommendations. Moreover, you mentioned the decision that clearly shows that crime rates fall when these sites are created, not to mention reducing the number of sudden deaths of people with this problem.

What will you do to influence, educate or inform the police services that appear to be more reluctant? The Ottawa Police Service, for example, already expressed doubts this morning about the approach, whereas, in other parts of the country, people are very open and are anxiously waiting for sites to be approved.

What does Health Canada intend to do to help these municipalities, these cities? Is there a specific approach?

● (0835)

[*English*]

Hon. Jane Philpott: Those are excellent questions, and it gives me an opportunity to clarify that there will still be an application process involved that speaks to how the minister will get information to be able to make sure that those five factors have been appropriately considered. There will be guidance within the application process to show things like whether an impact on crime could be demonstrated. Some of it could be by, for example, having correspondence related to the chief of police in that particular area. There will be ways that we will support communities to be able to demonstrate that they have met the specific factors given by the Supreme Court.

The point that you raise is a very interesting one in terms of sometimes hesitation on behalf of law enforcement as to whether or not this is a helpful mechanism. I would encourage members, if you ever possibly can and you're in Vancouver, to go visit some of these long-standing supervised consumption sites like Insite. It has been established since 2003. You cannot help but be moved by this place, where people are greeted at the door in a non-judgmental way, where they make every effort to reduce the stigma associated with problematic substance use, and where people are welcomed and given an opportunity to be introduced to the health care system at the point that they are ready.

Anyway, I could go on and on about how impressed I was by the work of Insite and how I really see it as being a helpful resource in that community.

The interesting thing that happened in Vancouver is that there was.... You're right, there was not 100% community support at the time that it was originally approved, but all evidence says that many, many people who were initially skeptical about whether or not this would be helpful in terms of decreasing crime rates or decreasing, for instance, the number of dirty needles that were in local parks, etc., have come around. The community support and the support from law enforcement, in particular the Vancouver police, is absolutely stunning. People are convinced that this has been an effective mechanism, and there have been zero deaths despite the fact that there are literally hundreds of people who use these services every day. I would certainly encourage law enforcement officials in other communities who are skeptical to go and see what an effective site can look like.

The Chair: Thank you very much. Your time is up.

Welcome to our committee, Mr. Brown. You have the floor.

Mr. Gordon Brown (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): Thank you very much, Mr. Chairman.

Thank you also to our officials and to the minister for coming today.

I think it's a positive development that they're here for the opioid study. It's a very terrible thing that's happening in our country.

Thank you to the government for making it a priority to address this. However, Minister, as you know, I've asked you three times in the House about thalidomide. We have a December 9 notice of motion by Rachael Harder—I'm subbing in for her today—and that motion is:

> That, pursuant to Standing Order 108(2), the Committee immediately undertake a study on thalidomide that: (a) focuses on the forgotten survivors of thalidomide; and (b) examines the effectiveness of the 2015 Thalidomide Survivors Contribution Program.

Mr. Chairman, that motion is in order, and I'm now going to speak to it.

I'm happy to speak to this motion that is essentially asking the committee to examine the effectiveness of the thalidomide survivors program. From the evidence that I've seen, I believe that at the end of the study, the committee will be calling for fair treatment of, and compensation for, the forgotten thalidomide survivors who cannot produce paperwork or witnesses to prove that their mothers took thalidomide. I believe that with the study the committee will find that these people need to be given a personal interview by a qualified professional and then given whatever tests are required to prove that their physical disabilities are not caused by a genetic anomaly.

I'm aware that there is no test that can prove thalidomide use by their mothers. However, the physical evidence they all display, and genetic testing to prove that it isn't something else, can go a long way to drawing the conclusion that thalidomide is the cause of their disabilities.

I believe that as a result of the study, this committee will recommend that Crawford victim services, the company making the decisions about whether or not to compensate these survivors, try to include people in the compensation package, not exclude them—which I believe, from the evidence I have seen, is their current practice.

On several occasions in the House I have asked the Minister of Health to address this situation, and she has been asked the same question by the media. She continues to refuse to act compassionately for these survivors, so I'm asking this committee to use its independence to undertake a study to determine what can be done to help these folks.

On October 25 a number of the forgotten survivors were here in Ottawa as my guests to address the media about the unfairness of the current compensation process. I want to quote extensively from remarks that were given by Mr. Terry Bolton, who is here in the committee room today, but before I do that, I want to note that Mr. Bolton lives in my community of Gananoque, Ontario, and I have known him since we were both young children.

To see Mr. Bolton, if you know anything at all about thalidomide, you can clearly see that he is a victim, or survivor, of the drug. That is the first thought that crosses your mind when viewing his physical condition. He has phocomelia—from the Greek words *phoke*, meaning “seal”, and *melos*, meaning “limb”—in which the hands or feet, or both, start immediately from the main joint, like the flippers of a seal. This is the limb malformation most traditionally associated with thalidomide. He also has an extra thumb that was amputated at birth, another dead giveaway marker of thalidomide.

Allow me to tell his story in his own words.

He said:

In 2012, I found out that my Mom had taken “the morning sickness” drug: Thalidomide, while pregnant [with] me in 1962. I confirmed this with her two surviving sisters. Up until then I had been led to believe that I was a “gift” from God and made “special”.

I set about to educate myself on everything related to Thalidomide. Upon doing research I discovered that my deformities and internal organ problems were “side-effects” caused by Thalidomide.

I had numerous operations as a child. My intestines were bleeding from somewhere, but they never really determined where “exactly”, but proceeded to remove my appendix as well as my Meckel's diverticulum.

My internal ear organ on the left side is missing parts resulting in tone-deafness since birth. I'm now considered legally deaf in both ears.

I was also born with a left deformed arm and hand and with an extra thumb on my right hand. This was surgically removed at birth.

I was also born with very deformed toes on both feet, which resulted in surgery to remove a “double bone” in one of my toes.

I also had heart surgery to correct what is referred to as Wolff-Parkinson-White syndrome. Basically my heart has an extra valve that was causing it to do more work than needed.

This was believed to be a contributing factor in the 40% mortality rate of Thalidomide babies.

● (0840)

I got lucky and lived with my “murmur” for 49 years.

I tried diligently to obtain my birth records and medical records as requested by Crawford.

I remember my orthopedic Surgeon, Dr. John Hazlett telling me as a child of 8 or 9 that “We have enough x-rays of you to make 6 complete skeletons”.

Well according to my birth Hospital, all records and x-rays have been destroyed due to their “retention policy”.

I researched to find out there was a fire in their records building between 1975-79.

There were also two fires in my hometown of Gananoque that destroyed the Pharmacy that my parents used, as well as my Family Doctor's Office.

I believe [every one of the forgotten survivors] has, as well as the other survivors', similar stories to tell.

This now comes down to why we are here. We, Canada's Forgotten Thalidomide Survivors wish to be recognized and compensated for the tragic mistake the Canadian Government made in 1959 when they allowed Thalidomide into OUR country.

It's time to right a very big wrong.

That is the end of his remarks, and he said that on October 25.

Now, living in Gananoque, I can verify personally that the fires that he mentioned in his presentation occurred as he stated. I do remember both of those fires that happened when I was a teenager. I talked with each and every one of those victims who came here to Ottawa who were here on October 25, and their stories are truly heartbreaking. They have all suffered all of their lives because of their exposure to thalidomide, and now they are being denied even the decency of an in-person interview to see if they have the effects of thalidomide. They've all had extreme health issues, medical issues that continue to this day. These issues have required hospital stays and operations. Many suffered from abuse and cruelty from other kids.

Many, like Mr. Bolton, have taken as much training as possible, but have been unable to work or even find employment. One woman, featured on a recent *W5* report about the forgotten survivors who have survived a lifetime of rejection, lives alone in the backwoods of British Columbia.

As I said, their stories are heartbreaking. The thing that really bothers me—

● (0845)

The Chair: Excuse me, Mr. Brown; your time is up. I have limited time on this motion. Are you moving the motion?

Mr. Gordon Brown: I move the motion, and I—

The Chair: Okay. I just wanted to clarify whether you were going to continue with your seven minutes on this motion.

Mr. Gordon Brown: This motion, Mr. Chair, is in order.

As I said, their stories are heartbreaking. The thing that really bothers me about this is that we are talking about a couple of dozen people.

Mr. John Oliver (Oakville, Lib.): I have a point of order.

The Chair: Go ahead, Mr. Oliver.

Mr. John Oliver: I want to thank the member for his very impassioned statement and the motion he is bringing forward, but we do have the Minister of Health here to discuss the opioid crisis. We stopped our other work to deal with this crisis, so I would move that we suspend further debate on this topic and return to our discussion of the opioid crisis.

Mr. Gordon Brown: Mr. Chairman, my motion is in order, and I am speaking. That's not a point of order.

An hon. member: He's right.

Mr. Gordon Brown: The thing that bothers me about this is that we are talking about a couple of dozen people. In the overall scheme of things, what financial impact will assisting them have on our country? Let's put into perspective the cost in order to make their lives a little bit easier for however long they have remaining. As I said in the House, it is a disgrace to think that we, as members of Parliament, in the greatest country in the world, can't collectively do something to assist a few of our fellow citizens who have suffered since birth as a result of a decision made by their country's federal health department.

Canada offered a compensation package in 1991. It included an in-person examination. Many people, such as Mr. Bolton, were either not aware of the 1991 package or, as in his case, their mothers never admitted to them that thalidomide was the problem. It was only after his mother passed away that he learned the truth from his aunts.

It is important to note that Canada is not alone in its compensation offerings. Countries such as Britain, Germany—where the drug originated—and Australia have also offered compensation packages to their victims. In Britain there was one offering, and then there was a second and greater offering after the victims realized that the first package wasn't enough to compensate them. Victims received the courtesy of an in-person examination.

For those who maybe don't understand thalidomide, let me use information from a website that was organized to provide such background to Canadians. This will explain the history and background to this issue.

Thalidomide was first marketed commercially in West Germany in 1954 by the drug company Chemie Grünenthal. There is some unproven evidence that it may have been developed during the Second World War by Nazi scientists. This stems from the fact that a known Nazi was hired by the drug company shortly before the release of thalidomide. It was available to patients in West Germany into the 1960s. Thalidomide was present in at least 46 countries under many different brand names. Thalidomide became available in simple tablet form in Canada in late 1959. It was given to many pregnant Canadian women to relieve morning sickness and to help them sleep.

Some of the forgotten survivors today were the result of the samples that were given to their mothers. This means that they could not come up with a prescription order even if the pharmacy records still existed. There is unconfirmed evidence that it may have been brought into Canada even earlier than this by doctors who had served in Korea and had come across the drug. It was licensed for prescription use in Canada on April 1, 1961. Although thalidomide was withdrawn from West Germany and the United Kingdom markets by December 2, 1961, it remained legally available in Canada until March 2, 1962, a full three months later. Incredibly, thalidomide was still available in some Canadian pharmacies until mid-May of 1962. Sample packs may have been given beyond this date.

Thalidomide was hailed as a wonder drug that provided a safe, sound sleep. Thalidomide was a sedative that was found to be effective when given to pregnant women to combat many of the symptoms associated with morning sickness. It was not realized that thalidomide molecules could cross the placental wall, affecting the fetus, until it was too late.

Thalidomide was a catastrophic drug with tragic side effects. Not only did a percentage of the population experience the effects of peripheral neuritis, a devastating and sometimes irreversible side effect, but thalidomide became notorious as the killer and disabler of thousands of babies.

When thalidomide was taken during pregnancy, particularly during a specific window of time in the first trimester, it caused startling birth malformations and death to babies. Any part of the fetus that was in development at the time of ingestion could be affected. For those babies who survived, birth defects included deafness, blindness, disfigurement, cleft palate, many other internal disabilities, and of course the disability most associated with thalidomide, phocomelia, as Mr. Bolton displays.

The numbers vary from source to source, as no proper census was ever taken, but it has been claimed that between 10,000 and 20,000 babies worldwide were born disabled as a consequence of the drug thalidomide. There are approximately 5,000 survivors alive today around the world. Never counted, and never to be known, was the number of babies miscarried or stillborn. Also never counted was the number of family members and parents who suffered over the years as they struggled with their conscience and the care of their affected children.

Around the world, in the late 1960s and into the early 1970s, the victims of the drug thalidomide, with their families, entered into class action legal suits or threatened actions against the various drug companies that manufactured and/or distributed the drug. They were eventually awarded settlements. In most countries, these settlements included monthly or annual payments based on the level of disability of the individual.

● (0850)

In Canada, the story was different. Canadian victims of the drug were forced to go it alone, family by family. No case ever reached a trial verdict. Rather, families were forced to settle out of court, with gag orders imposed on them not to discuss the amounts of their settlements.

It is startling to believe, but even today, as compensation is awarded to survivors, they are faced with gag orders on their compensation packages. The earlier gag order settlements resulted in a wide disparity in the compensation amounts, with settlements for individuals with the same levels of disability varying by hundreds of thousands of dollars.

In 1987, the War Amputations of Canada established the thalidomide task force to seek compensation for Canadian-born thalidomide survivors from the Government of Canada. As Canada allowed the drug into Canadian markets when many warnings were already available about side effects associated with thalidomide, and as Canada left the drug on the market a full three months after the majority of the world had withdrawn the drug, it was felt and argued that the Government of Canada had a moral responsibility to ensure that thalidomide survivors were properly compensated.

In 1991, the Department of National Health and Welfare, now Health Canada, through what was called an “extraordinary assistance plan”, awarded small compassionate lump sum financial assistance grants to Canadian-born thalidomide survivors. The lump sum payment was offered *ex gratia*, meaning that Ottawa recognized no legal liability in offering the money. The payout amounted to $8.5 million, which worked out to about $52,000 to $82,000 per victim, depending on the degree of disability. These payments were quickly used by those individuals to cover some of the extraordinary costs of their disabilities, and for most survivors these monies are long gone.

Thalidomide survivors are now in their mid-fifties, and they are experiencing physical deterioration due to stress placed on their different body structures, further limiting their abilities and often resulting in new disabilities as a result of degeneration of joints and limbs. This is compounding the tragedy. The needs and problems of this unique population are many and overwhelming, and that is adding to their day-to-day struggle to adapt and survive.

That is the background that brings us to the government's compensation offer in 2015.

It should be noted that as result of different appeals in Britain, nearly 470,000 thalidomide survivors now receive annual payments of about $88,000 each, from both the British government and the thalidomide drug distributor. In Germany, where the drug was first marketed, the federal government gives its 2,700 survivors pensions that total up to $110,000 a year.

Here in Canada, as a result of the 2015 compensation package offer introduced by then-health minister Rona Ambrose, each thalidomide victim was to receive a lump sum payment of $125,000 and an annual tax-free pension of $25,000, $75,000, or $100,000, depending on the severity of their condition, for the rest of their lives. As well, survivors are able to access a special $500,000 medical assistance fund to defray the cost of mobility devices and other adaptive tools they may need.

The outstanding issue, of course, is “the forgotten survivors”, as they prefer to call themselves. They are a small group of people, probably fewer than two dozen from that period—I'm almost finished, Mr. Chairman—

The Chair: I just want to explain. The minister has to leave now by prior arrangement. We arranged the timing to accommodate her—

Mr. Gordon Brown: The minister was going to be here till 10 o'clock. I have about one minute left, Mr. Chairman.

The Chair: —so she has to leave.

Mr. Gordon Brown: These are people like Mr. Bolton. After months of work trying to prove their case, they were rejected by a form letter sent to their homes. As I stated earlier, this is shameful, disgusting, and, quite frankly, embarrassing to all of us as parliamentarians and to Canada as a caring, compassionate nation.

The minister has refused to address the issue with Crawford, so I'm asking the minister, who is here, to look at this again. I'm also asking the committee to support this motion, use their independence to examine the issue, call these survivors as witnesses, call in the medical experts as witnesses, and decide how we can proceed to assist them. That, I believe, can be accomplished with a simple examination by a qualified professional.

Other countries accomplished this. Why can't Canada? These victims have endured a life of pain, suffering, discrimination, and lost opportunity. Let's not make another unhappy and depressing Christmas for these folks.

Thank you very much.

● (0855)

The Chair: Thanks very much.

Now we have a motion on the floor. Do we have debate?

Madam Minister, if you need to go, you are free to go, because we arranged that.

First is Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Mr. Chairman, I am now going to proceed to take my seven minutes to ask the minister questions on the opioid crisis, the reason for which she is here.

Minister, first of all, I would like to thank you for publicly stating once again that addiction ought to be treated most properly as a health issue—

Mr. Len Webber (Calgary Confederation, CPC): I have a point of order, Mr. Chair.

There's a motion on the floor, is there not, Mr. Chair? Should we be discussing the motion on the floor?

The Chair: He asked to speak. He has chosen to do this, but it is not pertaining to the motion, so would you address the motion? We have to address the motion.

Are you done?

Mr. Don Davies: No, I'm not done, Mr. Chair.

I will address the motion when I get around to the thalidomide issue, but for the moment I'm going to direct my question—

The Chair: No, we have to deal with the motion.

Mr. Don Davies: Well, Mr. Chair, I am not restricted to dealing directly with the matter at hand; I'm allowed to raise peripheral issues.

I will eventually come to make a connection between the devastating impact of opioids and the devastating impact on the thalidomide victims, but I would ask that I be given some latitude to do so.

The Chair: Fire away.

Mr. Don Davies: Thank you.

I'd also like to thank the member for restoring harm reduction as a key pillar of this issue. As my honourable colleague just talked about, there are a number of different conditions that affect Canadians, from the devastating impacts of thalidomide to the current problem of opioid addiction in this country.

Minister, as you know, in 2015 the Liberal Party publicly stated that the Conservative Bill C-2 was a deliberate barrier to opening safe injection sites. Of course, it was, because we know that not a single safe injection site has been opened since that legislation was passed.

Many stakeholders have called on your government to repeal Bill C-2 for over a year now, and this is not purely of academic concern. In the last year alone, over 2,000 Canadians, as you pointed out, died from drug overdoses, mostly from opioids—as people have died from thalidomide.

Now, in the last week of Parliament of 2016, you've introduced legislation to streamline Bill C-2, and I congratulate the government on doing that. Of course, since it is the last week before Parliament adjourns for Christmas, this bill will not be dealt with until February of 2017 and not passed until spring of 2017 at the earliest. That's months from now.

The Minister of Health for British Columbia last night said that the opioid crisis in B.C. is “like a war” and that they can't wait for this legislation to be passed. I think Dr. Perry Kendall, the public health officer in British Columbia, said the same thing—that they're not waiting—and you've pointed out, I think with some power, the impact in my home province of British Columbia of these opioid deaths: almost 700 British Columbians will die this year.

Pop-up clinics are operating right now in British Columbia to provide emergency services, and they're either illegal or operating in a legal grey zone.

As you know, this committee conducted an emergency study into the opioid crisis, and the very first recommendation that this committee made to your government, with all-party support, was to declare this a national public health emergency, as the thalidomide issue was. The reason for this is that it would give the public health officer of Canada extraordinary powers to act immediately while your legislation works through the House over the next three or four or five months, including opening emergency clinics now for safe consumption, for naloxone administration, or for drug testing—whatever these emergency clinics could be used for right now to save lives.

My first question to you, Minister, is why don't you declare a national public health emergency to give the public health officer of Canada these extraordinary powers in the next 90 days so that we can start saving lives now, while your legislation takes time to work through the process?

● (0900)

The Chair: Do you have a point of order?

Mr. John Oliver: It's a bit unusual, but I'm not sure that witnesses are allowed to participate in a debate on a motion.

The Chair: That's a good point. Do we have a decision on that?

It's the option of the witness to comment on the question.

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

I would think it unusual that the Minister of Health could not participate in a debate on an issue concerning a thalidomide or opioid crisis.

Hon. Jane Philpott: Thank you.

Mr. Chair, I gather you would like me to respond to the most recent intervention?

The Chair: It's your option.

Hon. Jane Philpott: Okay. Thank you.

As time is running short in terms of my availability, I will speak very briefly to the motion that was mentioned, but I would also like to comment on what's been brought to me by the first intervenor on the motion. I'll start there.

As members know, I was invited on the basis of a motion to come and speak to the opioid crisis, so I do want to make sure I comment on what's been most recently said. You brought up a number of issues, and I think the one that you were asking most directly for was to declare a national emergency on it. I think it's important to speak to that.

The mechanisms available to the federal government on the declaration of an emergency are somewhat different from the powers that are vested in provincial governments for a declaration of an emergency. British Columbia effectively declared a public health emergency, and I have found it helpful to provide them with tools they didn't already have.

Under federal legislation, there is currently an Emergencies Act. It is a modernization of the previous War Measures Act, which was implemented on three occasions: World War I, World War II, and the October Crisis. The current Emergencies Act has never been implemented. I have asked my department, including the Public Health Agency of Canada, to investigate whether a declaration of an emergency would be appropriate under the Emergencies Act.

To do so, we would have to have exhausted all other possible resources, and it would essentially take over powers that are currently vested in provincial governments to be able to act on public health. The analysis of the department to date has been that it is not deemed to be appropriate under the circumstances.

That in no way is an indication that we don't recognize the seriousness of the opioid crisis. I have continued to say that if we felt that declaration of a national emergency would give us tools we don't already have, then clearly we would have a responsibility to do so. To date we feel that the lack of declaration of an emergency has not impeded us from using all tools at hand. That said, we have looked for other alternatives outside the Emergencies Act to be able to bring further resources and mechanisms to the table.

I know British Columbia used their declaration as a way to be able to get better data and surveillance. One of the things that the chief public health officer would be able to speak to if we had the time would be that he has taken steps to open a new special advisory committee.

We have decided to look at the opioid crisis in the same frame that we would look at an infectious disease epidemic. The special advisory committee tool has been used in things like the H1N1 crisis and the Ebola crisis, and it was also used in response to the Syrian refugee crisis. It gives the chief public health officer the opportunity to work with medical officers of health in the public health network across the country to be able to do a much better job than we're doing now, getting as close as possible to real-time information on data and surveillance.

I don't know whether you want me to take the time, but the chief public health officer could give you information. I believe he is meeting tomorrow with medical officers of health and public health officers across the country to talk about getting that kind of information. Thank you for raising this issue.

The other thing the committee recommended was a task force, and I'm happy to say we do now have a task force within Health Canada, as was recommended by the committee. These are examples of things that we're doing to be able to pursue this issue.

I should respond specifically to the motion on the table, and I'd be very pleased to have a conversation with Mr. Brown about this at another time in recognition of the fact that we're here to talk about opioids. I think he's put forward an interesting motion to essentially evaluate a mechanism that was proposed by the previous health minister, who is now Leader of the Opposition.

The process that is currently in place for people who were potential victims of thalidomide was put in place by the previous government, the mechanisms by which people would be compensated and by which those who didn't meet the criteria would have the opportunity to be able to respond to that.

● (0905)

I am pleased that Crawford & Company has been able to identify, I believe, a further 26 individuals, and there was one who actually met the criteria as recently as last week. It continues to identify new people who have suffered as a result of thalidomide.

Having said that, if the committee feels it's appropriate to examine the process that the previous government put in place and to assess whether in fact that was a fair process, obviously it's completely the committee's jurisdiction to examine that.

The Chair: Okay.

I'm going to to move to Mr. Oliver.

Before I go to Mr. Oliver, I just want to say something to Mr. Brown. Obviously you're really involved with this and have a great deal of compassion and concern about it. One of those last ones who was approved by Crawford & Company was in my riding. There was a lady who had tried to get compensation for decades and couldn't get it, but she did under the new system.

I just want to say that this committee has considered motions by opposition members many times. They've been dealt with really well, I think. I understand how concerned you are and your compassion for this case. We all do. Everybody at this table does. We did want to hear from the minister, but anyway, if there are issues, we'll deal with them. I just want to say that.

Mr. Oliver, you're up.

Mr. John Oliver: I just echo what you said, Mr. Chair. We certainly all heard the very impassioned plea for review of the program and what the issues were, but we have set our committee agenda for this meeting. We have a number of other priorities that we have set as a committee. At this juncture I would move that we suspend the debate on this motion and return to our scheduled committee work. We can discuss this motion at a later date.

The Chair: That's a motion to suspend the motion.

Mr. John Oliver: Sorry. I would adjourn the debate.

The Chair: It is moved that we adjourn the debate on this motion.

I'm going to put that to vote, but I just want to assure you that this will not go away. We'll deal with it again. We'll be glad to hear from you again.

All those in favour of the motion to adjourn the debate on the thalidomide issue at this moment? All opposed?

(Motion agreed to)

The Chair: We're going to return now to the opioid study. Where are we on the speakers list?

Go ahead, Mr. Davies.

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

Thank you, Minister.

Now we'll go back to the opioid crisis.

This committee heard from many witnesses who told us directly that there's a profound lack of detox and addictions treatment facilities for Canadians and that this is a critical piece of helping deal with opioid addiction, and therefore death in Canada. We know that the people dying on the streets are primarily opioid addicts. Therefore, from a preventive point of view, making sure that all Canadians have access to publicly funded, accessible addictions treatment is a key part on the demand side of the question.

Accordingly, this committee made three separate recommendations in our report to your government that calls for significant new funding for public, community-based detox and addictions treatment for Canadians.

In your cover letter to the Canadian drugs and substances strategy issued yesterday, you said, and I quote:

> I am confident that the proposed authorities, combined with the numerous federal and provincial actions and commitments to date, will help us to address the current crisis of opioid overdose and death in a comprehensive, compassionate, and evidence based manner.

Minister, we have not seen a commitment from your government for a substantial investment in addictions treatment in Canada. How can you say that you're strategy is comprehensive, without that?

● (0910)

Hon. Jane Philpott: I thank you for the question. It's an excellent one. You're absolutely right that our response to the opioid crisis has to be comprehensive.

The content of yesterday's bill spoke in large part to one particular mechanism of treatment, that being the possibility of further measures of harm reduction. It was intended to address the currently onerous process that's required by communities who are looking to open supervised consumption sites.

There were other pieces in the legislation, as you know, that contribute to the comprehensive strategy on opioids. It addressed our need to make sure that we reduce access to unnecessary opioids, and in particular illicit substances. There's a large part of the bill that related to that.

I'm glad you brought up the topic of treatment, and I know this has been raised repeatedly here. I can tell you that when I meet with first responders, for example, and when I meet with health providers who are dealing with this, treatment is one of the most pressing matters.

This is an area where I hope we can find ways to work with our partners to do better treatment services that fall largely in the jurisdiction of the provinces and territories. This is an area where I believe provinces and territories need to do work to open more facilities and make those facilities more available.

For instance, you know we are in the process of negotiating a health accord with the provinces and territories. I have made it very clear to them that issues of mental health and addiction are very important to us as a government, that we would actually like to be able to invest to provide further support for them to do better in terms of providing mental health care and addiction.

We could hear more from the provinces and territories about how we can help them and what their plans are to open more treatment services. That would give us an opportunity, hopefully through the health accord and our commitments to mental health, to be able to invest in better supports for people, both in terms of preventing addiction by treating mental illness at its roots, but also by providing addiction services.

I hope you will hear more on that soon.

Mr. Don Davies: Thank you, Minister.

Your government has commendably made a substantial increase in funding to the Global Fund to address HIV and AIDS on the international stage. Unfortunately, your government has recently denied or cut funding to many HIV support organizations that provide services here in Canada, including some that are key players in responding to the opioid overdose crisis.

Will you commit to reversing these cuts and ensure that every group that has historically received funding under the community action fund gets that funding? A short answer would be appreciated.

Hon. Jane Philpott: I think you are aware that we have been working with agencies that were potentially going to have an interruption of their funding through the community action fund. I asked the Public Health Agency of Canada to speak directly to each of those organizations and to continue their funding. We are committed to continuing to support those organizations through to 2018.

In the meantime, I am seeking further resources to be able to expand our federal approach to sexually transmitted and blood-borne infections, including the community action fund. It's my hope that we will find mechanisms to continue to support these excellent agencies.

Mr. Don Davies: Thank you, Minister.

Minister, as you know, increasing home care services to Canadians is a critically essential innovation for our health care system, and I'd like to ask you about it.

I'm going to quote from the 2015 Liberal platform, in chapter 1.

> We will negotiate a new Health Accord with provinces and territories, including a long-term agreement on funding.
>
> As an immediate commitment, we will invest $3 billion, over the next four years, to deliver more and better home care services for all Canadians.

Minister, as is crystal clear from your platform, the Liberals' commitment to $3 billion for home care was entirely separate from the health accord and was promised to commence in year one of your mandate. Here we are entering your second year in office. Canadians have not seen a nickel of federal money for home care, and you have tied the home care funding to the health accord negotiations.

Why have you not kept your election promise?

Hon. Jane Philpott: Thank you for the question.

You know we are committed to making sure that our investments in health will improve health systems across the country. It's well known that investing in home care will allow provinces and territories to get people the care they need in a more effective manner.

We are firmly committed to the $3 billion on home care. We wanted to do that in collaboration, of course, with our partners in the provinces and territories, and therefore we have included that in the negotiations toward a health accord.

I'm still optimistic that we will be able to wrap up those negotiations as quickly as possible, but it's taking some time to come to those arrangements. It's my very firm hope that we will finalize a health accord that will include the home care money. I think it's essential that we get that investment into the next federal budget, and certainly, if all goes well in my discussions with the provinces and territories, it will be there.

● (0915)

The Chair: The time is up.

Dr. Eyolfson, you have the floor.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Minister, for coming.

Hon. Jane Philpott: Sorry, but could we make it a quick question?

Mr. Doug Eyolfson: I'll do a quick question, absolutely.

This question may be hard to answer, but it's not a long question in itself. Previously, when all the provisions of Bill C-2 were in place, there were concerns about an extended timeline to approve supervised consumption sites.

Can you comment in general terms on how removing these barriers is going to change the timeline for approval of a new site? How much time will be saved by these changes?

Hon. Jane Philpott: That's an excellent question. What it speaks to is the fact that the current process is terribly onerous. It has made it very difficult to receive an exemption for the communities that really want these sites, and it takes a number of months.

Having said that, as I indicated earlier, it's generally not because the federal government is opposed to providing that exemption; it's often because the barriers to getting those sites approved rest on, for instance, the municipality getting zoning for the site and getting the work done to provide secure systems and so on. In many of the cases in which there's been a delay, it's because of actions that we are waiting for on behalf of municipalities, or sometimes provinces.

That said, one of our commitments under the new system will be to institute a service standard, an expectation as to the period of time that it will take. I would be happy to give you further information on that, but I think it's very important that we provide some assurance that we will deal with these expeditiously.

Mr. Doug Eyolfson: Thank you, Minister.

Hon. Jane Philpott: I'm sorry that I have to leave.

As you know, I will always be available to respond to members' questions and I thank you for the time today.

The Chair: Well, I want to thank you for your answers. I want to thank you for answering our questions about the opioid crisis, and also for addressing Mr. Brown's questions. I can think of other ministers in the past who might not have been so open-minded as you are on that.

Hon. Jane Philpott: These are important matters. Thank you for working on them.

The Chair: They are. We all agree.

We'll suspend for five minutes while we change tables and witnesses.

● (0915)

(Pause)

● (0925)

The Chair: We'll reconvene our meeting.

I welcome back our guests from the Parliamentary Budget Office. We are certainly looking forward to the testimony. I'm sure it's going to be very interesting.

We have Jean-Denis Fréchette, the Parliamentary Budget Officer; Mostafa Askari, assistant parliamentary budget officer; and Carleigh Malanik, financial analyst. We have Jason Jacques, director of economic and fiscal analysis, and Mark Mahabir, director of costing policy.

The point of the meeting is to get an update on our request to have an analysis of the national pharmacare program. We'd like to hear an opening statement of 10 minutes, and then we'll go to seven-minute questions.

Mr. Jean-Denis Fréchette (Parliamentary Budget Officer, Library of Parliament): Thank you, Mr. Chair.

[*Translation*]

Mr. Chair, deputy chairs, ladies and gentlemen of the committee, thank you for this invitation to appear to report on the work that has been done, at your request, to estimate the cost of creating and administering a national pharmacare program.

[*English*]

Preliminary terms of reference have been sent in advance to your committee, and we will be pleased to answer your questions if you need some clarification about the required resources, the timeline, or the methodology.

I would like to mention that to develop those terms of reference, my colleagues Carleigh and Jason have met and had discussions with many of the stakeholders mentioned in your motion. Mark and Carleigh have negotiated some potential agreements that will be required for obtaining appropriate data and information, and in the terms of reference you may note that the project will require two full-time analysts over an expected six-month period and that the total cost of data from various sources will exceed $100,000.

Although such an amount could be planned in the Office of the PBO's budget, it is worth noting that I do not have the signing authority for any amount exceeding that threshold of $100,000. In those circumstances, the Library of Parliament has to submit a request to the Speakers of the Senate and the House of Commons for their approval in principle to enter into such a procurement process. Of course, I do not know what the outcome of their decision might be, but I will have to take it into consideration for the future of this project.

Thank you, Mr. Chair. I'll stop here. We will be happy to answer all the questions you may have.

The Chair: That's the shortest opening statement we have ever had.

We're going to Dr. Eyolfson. You're up for seven minutes.

Mr. Doug Eyolfson: Thank you.

With regard to what you're talking about, the cost and full-time analysts, could you describe what other information you need from us as instructions at this point for costing the whole framework of the initial assignment?

Mr. Jean-Denis Fréchette: Is your question about what it will cost the PBO?

Mr. Doug Eyolfson: No, what I mean is with the study of—

Mr. Jean-Denis Fréchette: Oh, you mean the study itself.

Mr. Doug Eyolfson: Yes. What other information do you need from the committee at this point to proceed with the study?

Mr. Jean-Denis Fréchette: We don't need any more information for the moment. Those are preliminary terms of reference.

There's a reason that we mentioned preliminary terms of reference. It's that they may change over time, or we may see our methodology change, or the access to information that is required may not be available. The terms of reference that are in front of you are what we plan to do for this committee.

Mr. Doug Eyolfson: All right. You have said it would take two full-time analysts six months. Would you anticipate hat there might need to be an extension of that time, or do you think six months is an adequate time for this? Is that a too-loaded question?

Mr. Jean-Denis Fréchette: It's always the big question. It's the $100,000 question, I guess.

For the moment, that's what we're planning, but as we know, in the course of a project like this, which is complex and will require a lot of discussion with stakeholders and so on—the stakeholders being those who have the data that we need for the study—it may take a little bit more time.

We will certainly debrief you on a regular basis in status reports during the course of the study. For the moment, we're looking at June 2017 as the preliminary deadline.

● (0930)

Mr. Doug Eyolfson: All right.

At what intervals would we be receiving updates? Would it be monthly? Would it be every two months?

Mr. Jean-Denis Fréchette: Mostafa will answer.

Mr. Mostafa Askari (Assistant Parliamentary Budget Officer, Office of the Parliamentary Budget Officer, Library of Parliament): I suppose it depends on the committee's requirements. Typically, when we start a project, we go to work on it, finish it, and then report back to the committee or the member. In the meantime, if the committee required some updates on where we are and what the status of our analysis is, we would be happy to come back and provide that, or we could provide it in writing to the chair.

Mr. Doug Eyolfson: All right. Thank you.

At this point, I'll yield my time to Mr. Oliver.

Mr. John Oliver: I have a question around aggregates.

You're estimating the net cost to the federal government—the net cost—and you say in one of the bullet points that all aggregate costs and projections would account for opportunities for savings.

I just want to confirm something. We know there's a significant spend already happening in the public sector for benefit programs that would no longer be required if a national pharmacare program were created. Also, there's a spend in the private sector to provide private drug plans to employers, which could be converted now and turned into the public system. Are those costs going to be identified and brought forward in the estimates of both offset costs for government and also potential sources of funds?

Ms. Carleigh Malanik (Financial Analyst, Office of the Parliamentary Budget Officer, Library of Parliament): If I can just make sure I understand the question correctly, when we're looking at the aggregate costs to the federal government, you're wondering if we're going to include the portion that's currently spent under public programs as well as the portion that's spent under private programs.

Mr. John Oliver: Correct.

Ms. Carleigh Malanik: Yes, we would.

Mr. John Oliver: Okay. Excellent.

In terms of the cost of the study, the $100,000 includes the cost of data purchases. You note in your material that the data you acquire would be your property, then, and would have continued value. Besides this study, do you see other value from that purchase of data?

Mr. Jean-Denis Fréchette: We hope so. It will exceed $100,000. That's the threshold. It's going to be exceeding the $100,000. We know that for now, in terms of the preliminary discussions we've had so far, we hope it's going to be useful for other studies in the future. That's why we have this condition of being the owner of the data for future use for whatever reason.

Mr. John Oliver: Okay.

Mr. Jean-Denis Fréchette: The problem will be to have access to those data and to pay for them.

Just to be clear, if I may, Mr. Chair, we are facing two situations. We need to negotiate that contract, which will be over, as I said, $100,000. I'm also negotiating with the Quebec government because, as you know, the model that you proposed to the PBO is the Quebec pharmacare system. We need their Excel files to have access to all the lists of not only the drugs covered but also the prices paid—not the prices paid at retail, but the costs paid by the system over there. We're in negotiations with the Quebec government right now in terms of accessing that kind of information. Otherwise, if we don't have that, it's going to be very difficult.

We do have the PDF documents of all these 8,000 or so drugs that are on the Quebec list, but the PDF is thousands and thousands of pages. We need the Excel electronic files for that.

Mr. John Oliver: Okay.

Then in terms of estimating the cost, you'd be using the Quebec cost data, but we know that Canada's currently the second highest payer for pharmaceuticals in the world, or among the nations we compare to. Are you looking at any models of how a national program would be able to negotiate different prices? Are you building in thresholds around negotiations of pharmaceutical prices and providing what the projections might be?

● (0935)

Ms. Carleigh Malanik: I can answer that.

It's certainly in our methodology to attempt to incorporate that, but this is all going to be contingent on what actual data and information are available. It's certainly in the methodology framework currently.

Mr. John Oliver: Thank you.

The Chair: We're going to Dr. Carrie.

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

I want to thank the witnesses for being here.

Mr. Fréchette, I hope you don't mind, but I'm going to push you a little bit more on that word “exceed” $100,000. It seems very low to me. I was wondering if you're looking at that. I always get nervous when we're give a number and then it's expected to be exceeded.

I have a lot of confidence in your predictive abilities, so when I'm looking at six months, two employees, and having to buy all this data, I'm wondering, is it going to be tripled? Is it going to be 10 times the amount? Do you have any general idea? Could you give that information to us?

Mr. Jean-Denis Fréchette: Thank you for the question.

The $100,000 is only for the data. It's not the total cost of the project for this committee. It doesn't include the two full-time equivalents that will be absorbed in the normal operations of the office. It doesn't include any overtime and so on. The $100,000, just to be clear, is to buy the data and the information that will be required to conduct that project. As I said, a single contract with one company will be over $100,000. Mr. Chair, I prefer not to mention exactly the amount.

Mr. Colin Carrie: Oh, for sure.

Mr. Jean-Denis Fréchette: Of course, it could go to $1 million. It will not go to $1 million, but as I said, it's going to be over $100,000, which is a threshold that I cannot sign for, so I will need special authorization if we go there to sign a contract of that sort.

Mr. Colin Carrie: For that process alone, where would that have to go—to the Senate? You said we would have to make application for that. Do you know the length of time the process to okay it would take?

Mr. Jean-Denis Fréchette: I don't know. That's why when I was asked the question about six months.... Essentially, you have all these different factors that will have to be considered. When the Library of Parliament—and we are the PBO at the Library of Parliament—submits this request to the two Speakers, we are in their hands. It really depends on their decision. I don't even know what the outcome of that decision will be. They may decide just to refer it to the Liaison Committee. They may decide to just wait and make an analysis of it. I have no idea how long it can take.

Mr. Colin Carrie: I see that there's a lot of uncertainty out there, even with regard to the quality of the data. I've been trying to make the point that we don't even know what the problem is and what we would be addressing. You mentioned under the data section that there are key assumptions that you would have to make. Can you give us a quick little opinion, now that you've had a few weeks, on what you think of the quality of the data out there? Do you have an opinion on that or thoughts on that?

Ms. Carleigh Malanik: We've only started looking at mock data because we haven't actually purchased the data yet. There are several metrics available from both public and private sources. At this point I can't really comment on the quality, but from what I can tell, several years of analysis have been done on this data and data collection, and several metrics are available as well.

Mr. Colin Carrie: Okay, so we're still unsure even as to the quality of data that's out there.

I'm looking at the cost here. Even if we were able to get it in by your timeline of June 2017, which I don't think we could, because going through government processes usually takes a little bit longer than we all think, or even if we gave it, let's say, a year, do you think once we got that data, we could even come up with some type of program that the government could actually implement in this current mandate?

● (0940)

Mr. Mostafa Askari: If we can stick to the terms of reference that we have, we can provide a framework and a cost for that framework. Now, from a policy perspective, the federal government and the provinces have to decide how they're going to implement that because, as you know, the provinces have their own programs right now. How they're going to fit that within their own program will certainly require discussion and debate and negotiations. This will give an idea to those who are considering this kind of program what the overall cost is. Then from there you can go ahead and design a policy that would provide this kind of service. Once the policy is decided and designed, then we may have to go back and re-evaluate the cost and the different aspects of that.

Mr. Colin Carrie: You brought up a really good point about the provinces, because that's another timeline. If there's going to be any negotiation or discussion with provinces, that could take years.

I've been trying to get the government side to possibly narrow the criteria or get some input from the minister to see what types of ideas would be acceptable to her. It's almost like a chicken-and-egg type of thing, because, as you've said quite correctly, we could do all this work, and then the minister might say, “Well, we're not even sure if we want to go that route, so maybe we'll do this instead. Can you go back to that?”, and we could go back and forth forever.

If we were able to narrow criteria and maybe get some policy direction from the government ahead of time, instead of, as the old saying says, shoot and then aim, would that be helpful towards decreasing some of these timelines, and maybe the costs?

Mr. Mostafa Askari: We normally prefer to cost programs that are already in place or have been proposed by the government. Only the elements of the policy are known at that point, so it would be much easier and more effective to cost a program like that. This is an idea, so the elements of it are not really clear to us. With the directions from the committee, we have come to these terms of reference. Whether the final product or final policy is going to look like this or not, we have no idea. If we have better direction in terms of the actual policy design, it would help us.

Mr. Colin Carrie: I think that would make sense to anybody. Would it make sense to you, maybe, if we suspended the study until we got your information and expense report, or something along those lines? I'm just nervous about going around in circles and what this is going to end up costing us.

Mr. Mostafa Askari: That's obviously up to the committee. It's whatever you decide.

The Chair: Your time's up.

Go ahead, Mr. Davies.

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

Thank you for being here with us today.

I've reviewed the document you prepared for the committee, and there are a couple of things I want to clarify. You do not have to purchase data from the Patented Medicine Prices Review Board, Statistics Canada, or Health Canada. Is that correct?

Ms. Carleigh Malanik: No, we don't.

Mr. Don Davies: Then any data from those three sources will be free.

Ms. Carleigh Malanik: Typically, no. Sometimes Statistics Canada does have a standard fee, as well as the Canadian Institutes for Health Information. It's very low. I believe it's approximately $250 an hour, but this is usually standard for their cost-recovery fees.

Mr. Don Davies: Okay. However, I specifically didn't mention the Canadian Institutes for Health Information because what I'm trying to find out is who you have to purchase data from.

Let me try it that way. Who do you have to purchase data from?

Mr. Jean-Denis Fréchette: The main expense, the $100,000 that we mentioned, is for data from IMS Brogan.

Mr. Don Davies: From whom, sorry?

Mr. Jean-Denis Fréchette: It's now called QuintilesIMS, which is one of the stakeholders that is mentioned in the motion. They are basically the only provider of that kind of data across Canada.

Mr. Don Davies: Sorry; to be clear—

Mr. Jean-Denis Fréchette: It's a private firm.

Mr. Don Davies: That's the only organization that you have to pay for data?

Mr. Jean-Denis Fréchette: That kind of amount, yes. With other organizations, as Carleigh said, such as StatsCan and CIHI and so on, we have some kind of relationship. Some of the data may have to be paid for, but you're not talking about a lot of money.

Mr. Don Davies: I was going to say that one federal department paying another federal department is a wash at the end of the day, isn't it?

Mr. Jean-Denis Fréchette: It is, but that's the way it works.

● (0945)

Mr. Don Davies: In general terms, can you describe what kind of data you need to purchase? What is the category, or what are you looking for?

Ms. Carleigh Malanik: Specifically, we're looking for the drug level pricing information so that we can match any particular formulary, in this case Quebec's formulary. Then as well, because the committee was requesting some statistics on patients and their information, we're also asking for information on those individuals, such as their age, gender, and things like that.

Mr. Don Davies: I wanted to shift a bit to your document. At the top of page 2, you recite the exemptions that this committee had instructed, and I just want to be clear on this too. You say, “The criteria for exemption of the co-payment include...”, and then you listed some criteria there. This may have been the committee's lack of clarity, but I think what we wanted to do was match the exemptions under the U.K. model, which I believe was the instruction, and then I think we gave you some examples.

What I'm concerned about is that these four bullets are not all of the U.K. exemptions, so I want to clarify with you that you are clear in your instructions that you are to apply the U.K. exemptions in their totality.

Mr. Mostafa Askari: I don't think we were clear on that point, but some of these exemptions also.... I think the committee has to know that once we start an analysis and go through the estimations, we may have to modify some of these things because some of them may not be possible to do in a credible way.

For example, the exemption for pregnant women is going to be very difficult. You have to make some assumptions about what percentage of the population is going to be pregnant, and then how are you going to apply that? One issue there, of course, is also whether pregnant women are exempted only for the drugs that are used for their pregnancy or are also exempted for all the drugs that they use for other reasons.

Mr. Don Davies: I will probably leave this to my colleagues, but my assumption was that we would simply, for ease of reference, apply the U.K. exemptions, because obviously the U.K. would have that figured out. The U.K. either exempts pregnant women from the copayment for drugs related to pregnancy or for drugs generally.

My main concern was that this list is not complete. It doesn't include children under 16, as you've recited it here. It should include children under 16. Students are, I'm told, not between 16 and 18 but between 16 and 19. Also, I think veterans are not listed here, or people with long-term illnesses.

Anyway, my point was that if you need clarity on what exactly the exemptions from the copayment are, the committee, I think, should give it to you, but because you said “include”, I wasn't sure whether you were just showing some of them but were aware that there was a broader category or whether you meant that those are your only exemptions. We'll have to clarify that.

Mr. Mostafa Askari: Okay.

Mr. Don Davies: I was going to give a little statement.

I don't have the actual numbers here, but we know we spend tens of billions of dollars a year on pharmaceuticals in this country. We've heard estimates that a national pharmacare program could save between $4 billion and $11 billion a year. To me, then, to spend $100,000 to collect data that would be useful to the government to have in any event is not only, I think, a bargain, but in fact it's our responsibility to do. You mentioned in your report that this data would be retained by the PBO and would be useful not only to the PBO but to the health department. To know how many Canadians don't have coverage has been a concern raised by my Conservative colleagues. They doubt that we have accurate data on how many Canadians do or do not have coverage. To gather the data on what a national formulary would cost is superb information for the government to have in any event, and it may inform public policy.

My question is this: do you regard gathering this data as being of some utility to the health department or other departments in any other respect?

Mr. Mostafa Askari: I'm not 100% sure, but I believe the Department of Health already has access to the data we are trying to purchase. My understanding is that they get—

● (0950)

Mr. Don Davies: Can they not share that data with you, then, for free?

Mr. Mostafa Askari: Probably they cannot, because their contract probably does not allow them to share that data with other organizations. I don't know, but it's something we can—

Mr. Don Davies: Could you check into that? You didn't say 100%, but if you're quite sure that the health department has this data, which the government has already paid for, one would think we wouldn't have to pay for it a second time. I hope not, anyway.

Can you look into that?

Mr. Mostafa Askari: We can certainly check and make sure, but they may have the data in a way not directly useful for us. We may need a certain way of gathering that data or putting the data together that this private provider would do for us. They may have access to the raw data, but not in the way that you want it.

We can certainly check for that.

Mr. Don Davies: Thank you.

The Chair: Time is up.

Before we go to Ms. Sidhu, I just want to ask whether you have had a precedent for a study that you did going over $100,000 and for which you had to seek more funding. Has this happened before?

Mr. Jean-Denis Fréchette: It has not happened for a study. For a court case in 2012-2013 it happened, but not for a study.

Mr. Chair, the member raised a very interesting point concerning access to the department's information, if the department has the information. Of course, we can ask this committee....You have the power to call for papers and people, including data, which is something we do for all the studies we do, either for individual parliamentarians or for a committee. These are our preliminary terms of reference. We debated among ourselves whether we would call them terms of reference, draft terms of reference.... We chose “preliminary”, because this is work in progress with this committee.

At one point, we will present hopefully final terms of reference that will be approved by or will at least satisfy this committee, and they will include the costs and what is and is not encompassed in them. That's the normal procedure. At that point, we can move on.

As to having access to the information, it is still to be debated whether we will be able to have access to the department's data.

The Chair: Thank you.

Go ahead, Ms. Sidhu.

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

Can you talk a little more about the past successes, barriers, and issues with buying data sets for other studies?

Also, again, is there any role for the committee to help you engage with the provinces, or anything our committee or minister can do?

Mr. Jean-Denis Fréchette: In terms of negotiations or discussions with the provinces, it's looking good so far. I had a discussion last week with the Quebec department of health. That looks okay. We are exchanging, and they are quite open in terms of providing some information.

Regarding the other type of specific information owned by the only firm in Canada that holds this kind of data on private-public coverage, Carleigh, as I said, and Mark, who is the legal counsel in the PBO's office, are looking into all the agreements and making sure we're going to get the data that the taxpayers' money will be paying for. We're really careful about that.

That's the answer I can give you. That's the only source right now that we have to negotiate with in terms of purchasing expensive data.

The Chair: Thanks very much.

Mr. Webber is next.

Mr. Len Webber: I don't have a whole lot of questions here either. I think everything was covered.

I do want to ask our committee how we went about choosing Quebec as the formulary to study. Was it just a random thing, or is Quebec one of the more generous formularies out there? Do you recall at all why we chose Quebec?

Ms. Karin Phillips (Analyst, Library of Parliament): As you recall, we had a meeting, and there were several options. Quebec was one of the provinces put forth because it was on the more generous side.

There was some potential for.... It was my understanding that there had been some work done on what is referred to as an implicit formulary, as a working national formulary. If the PBO could have access to that, they could use it, but if it was not available or feasible, they could use an existing provincial formulary. When the committee made its decision, it chose Quebec because it had a more comprehensive formulary.

● (0955)

Mr. Len Webber: I see. Thank you.

Do you have any idea of whether it would be easier to get data from another province? Is Quebec maybe more difficult to get that information from? I'm just throwing that out there. I know it's a question you probably can't answer, but I thought about it anyway, especially for $100,000. It seems a lot of money for collecting a list, a formulary, and I would think what is on that list and also the cost would be quite well known.

I have a question about the cost. Are there some confidentiality issues with respect to letting Canadians know exactly how much they're paying for these drugs? I know a lot of negotiated pricing goes on, and a lot of it is confidential.

Will there be issues with respect to confidentiality on pricing with the drug companies that they've negotiated deals with?

Mr. Jean-Denis Fréchette: Thank you for the question.

Just to be clear, the Quebec government will provide, according to my latest discussion on Friday, the information we need for free. There's no cost there. It's only a matter of having the proper support. As I said, we need electronic files, which are easier to work with, and so on, for the model. The cost doesn't come from the Quebec government.

On your question about anything that has to do with federal-provincial issues these days, particularly last week because of the negotiations on the health program and so on, of course it's always a sensitive issue. For the moment, it doesn't seem to be a problem.

Let me ask Mark about confidentiality. Mark, as legal counsel, will give you all the information about that.

Mr. Mark Mahabir (Director of Policy (Costing) and General Counsel, Office of the Parliamentary Budget Officer, Library of Parliament): Thank you for the question.

We will be using a composite price. The price will consider all the provinces' costs but will not identify the cost for specific provinces.

Mr. Len Webber: Great.

That's about it for me. I don't know if I can share some time if a colleague....

Ms. Rachael Harder (Lethbridge, CPC): I have a point of clarification. You're saying that the database we're seeking already exists, just in another department. Am I understanding that correctly?

Mr. Mostafa Askari: I said I believe the Department of Health has access to these kinds of data for their own purposes, their own research and regulation of drugs. They always have access to all kinds of information about pharmaceuticals, so I'm assuming they have access to these data, but, as I said, we can check with them to make sure that if they have it, it's in a form that would be useful to us, a form they could share with us.

Do you want to add to that?

Mr. Mark Mahabir: Yes, the data Health Canada has may be old. It may not be recent data. What we're getting from the provider would be recent data.

Ms. Rachael Harder: These questions need to be clarified for us before we can make an educated decision with regard to going ahead with this study or not. Is it possible to have you come back to the committee with an update on whether this data is accessible and what year it's from?

Mr. Mostafa Askari: We can certainly check with the Department of Health and see what data they have and whether they can legally share it with us—they may be under contractual obligations not to share the data—as well as whether it's up to date. Certainly we can inform the committee of the results.

Ms. Rachael Harder: Thank you.

The Chair: Thank you.

Go ahead, Mr. Oliver.

Mr. John Oliver: Following up on Ms. Harder's point, would the committee have the capacity to require this information to be provided from the Quebec government? Is that part of our authorities?

The Chair: We have that power.

Mr. John Oliver: Would that be an appropriate exercise, or is it mostly done through contractual....

The Chair: I assume the request would come from the PBO and we would get the information you need.

Mr. John Oliver: I'm wondering how we move from preliminary to final terms of reference. Mr. Davies identified some changes to the exemptions, just to make sure we had the same list of exemptions as the U.K. Are there any other specific items that need further input from the committee, besides the decision on the cost, to move this from preliminary to final terms of reference? What else are you looking for?

● (1000)

Ms. Carleigh Malanik: I guess it's all in this discussion, basically. Mr. Davies pointed out some changes to the exemptions, but we presented this to the committee to incorporate what we thought we could from your letters detailing some of the parameters and also based on our research on which data are available and what is out there and what our stakeholders believe we can do with these data. Now it's presented back to the committee, and I suppose it will be up to you to agree to this so we can continue on this path of continuing this research.

Mr. John Oliver: I'll just ask again: other than the list of exemptions, I'm not hearing anything from around the committee that disagrees with these terms of reference, so if we get back to you with that, can we view the terms of reference as finalized?

Ms. Carleigh Malanik: If that is your wish.

Mr. John Oliver: If the decision is made in the end that we need to spend $100,000 and need to purchase it, would a letter from the committee chair to the deciding body that would allocate resources be of benefit to you in seeking funding for the study?

Mr. Jean-Denis Fréchette: That's an excellent question. As I mentioned, the approval in principle must be done by the two Speakers, the Senate Speaker and the House of Commons Speaker, so I refer to the clerk of this committee and the administration of this committee to decide whether or not they want to send something. I assume there is no problem to send a letter to the Speaker of the House of Commons. I'm not sure about the procedure on sending something from this committee to the Senate side.

If I may, I want to come back to what you mentioned about the department. What we can do is put an information request to the department about whether or not they have the information, which is a normal procedure. We often mention the committee for which we are doing an analysis and for which we need that kind of information, and then we wait for the reply from the department.

The difficulty would be to see if the department is willing to share in advance, or at least to look at the data they have to see whether it is too old or whether it's appropriate for the kind of study we're doing for this committee. There will be, I'm pretty sure, some negotiation in regard to looking at the information in advance.

Mr. John Oliver: Are you going to be the lead to sort through these questions? If we can bring the price tag below $100,000, then we can proceed with the study, and we're moving forward. I'm not sure how it comes back to the committee to make sure we're ensuring that the study is getting done.

Mr. Jean-Denis Fréchette: I assume the best approach will be to keep this committee informed of our most recent developments, to go ahead with the request for information to the department to cover your request, to continue our negotiations about having access and paying for the data from IMS Brogan to see how much that could cost, and to provide that information to the committee.

Of course a contractor would prefer that it remain between the committee and the PBO, because I'm not sure a private company would want how much they sell the data for to be known, and so on.

That would be the process. We will keep the committee informed of all the developments and maybe provide a status report when Parliament comes back.

Mr. John Oliver: Thank you.

The Chair: We have Ms. Harder, from the Conservatives.

Ms. Rachael Harder: Thank you. I have a question I'm hoping that someone here can answer.

With regard to a cost for a study, who goes about approving that? Do we just have money at our disposal and we can just say "Yes, go ahead, make the study happen", or do we have to go back and get approval for financing?

The Clerk of the Committee (Mr. David Gagnon): Normally when we do committee studies, it goes to the Liaison Committee. If it's under $40,000, then usually it's approved. If it's not under $40,000, then it's a different process. The chair usually has to present the budget to the Liaison Committee for approval, and that's the usual process for studies that we follow.

Ms. Rachael Harder: Okay. How long a process is that?

The Clerk: Do you mean the one that I just described?

Ms. Rachael Harder: Yes.

● (1005)

The Clerk: If it's a study under $40,000, then it's usually very quick. The committee has to adopt the budget we present, and then usually it's approved, so it could take a couple of days, but—

Ms. Rachael Harder: In this case it's over $40,000, so the chair will have to take this and present it.

The Clerk: I think this one is different, as the PBO has explained. From what I could understand, right now it's more in their court, and he described the process. Maybe the PBO can answer that better than I can, because it's part of their mandate. They have a different process than we have.

Ms. Rachael Harder: If we say that we want this study done, then the PBO eats that cost without any further discussion necessary or approval required?

Mr. Jean-Denis Fréchette: It's the plan and we will absorb it—of course we cannot absorb, you know, half a million dollars—but if it's something a little over $100,000, for example, then we plan to absorb the costs, do the study, and own the data, eventually.

There is this threshold at which I don't have the authority to sign for this kind of contract. The contract will have to be presented to the Speakers of the Senate and the House of Commons—

Ms. Rachael Harder: Okay.

Mr. Jean-Denis Fréchette: —which is the normal procedure. The PBO has never done it for a study for a committee, as I mentioned before. The library did, in the past, have some contracts. I believe it was IT contracts or something that they had to send for approval in principle, which is part of the briefing book that the library prepares and that I prepare for the Speaker every time there is a new Speaker. Approval in principle means we have to review it. It's part of the normal procedure of my signing authorities.

Ms. Rachael Harder: Okay. I'll speak to my colleagues now.

Given that this study could cost definitely $100,000 and up, would it not make sense to bring the minister in at this point and ask for further direction with regard to the formulary, so that we're giving her information that her department would seek to know? Would it be possible to bring her to the table or to request that she write us a letter with some further direction? I'm not opposed to spending money, but I'd like to spend money in the right direction, so that we come up with a product that her department is going to find useful.

The Chair: I think that she would respond to any request like that. She's very interested in this. It was our choice to make this study, but she's interested in it, I know. I think there will be a very co-operative attitude in the department and in the government to see where this goes, because we've had estimates from zero to an $11-billion saving per year. If you talk about saving an average of $5 billion, $6 billion, or $7 billion a year, this is a very small amount of money.

Ms. Rachael Harder: Thank you, Bill.

I'm looking for some action on this. We can all leave here today, but then nothing will have been accomplished, so could we agree to write a letter to the minister asking for some information with regard to where she'd like to see this study go, on the type of formulary that she would like to see followed?

The Chair: I'd suggest we write a letter to her explaining what the PBO has proposed and see if she agrees with that.

Ms. Rachael Harder: Normally that letter would be written by the chair and submitted through the chair, but it would need the recognition of this committee to move forward with that.

The Chair: That's fine with me.

Now we still have Ms. Harder's time.

Mr. Don Davies: I have a point of order. With all due respect to Ms. Harder's time, which she can continue if she wants, I'm unclear where we're at in this. Ms. Harder seems to be asking a question of our colleagues to discuss. Do you want to have that discussion now, or do we want to have that maybe in committee business afterward?

The Chair: It's actually committee business.

Mr. Don Davies: Can we defer that question, then, until committee business? I'm asking because I have some views on that on what the question is.

The Chair: Yes, we'll defer it until committee business.

Now your time is up, Ms. Harder.

Go ahead, Mr. Kang.

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

My question is around the cost of $100,000. You want to get the data, and there were some other costs. Were there any problems you had in deciding what data to get, or was there any pushback not to get the data?

Ms. Carleigh Malanik: In our discussions with the data holders, QuintilesIMS, it hasn't been really so much pushback as a dialogue around what data is available and how we could receive that data.

I would just like to put out a general statement there that the data that we're requesting does allow for some flexibility around sensitivities. Right now we are moving forward with applying a Quebec formulary, but there would be potential to actually use a different formulary, so I just thought I'd add that.

● (1010)

Mr. Darshan Singh Kang: I hear that some of the data is old. How reliable will the data be that you are getting? Is it pretty up to snuff, or...?

Ms. Carleigh Malanik: Right now it's our understanding that we would have data available for a full calendar year for 2015. If we wished, we could get partial 2016 data, but I think we're going to look towards the 2015 calendar year. This would include data from the Canadian Institute for Health Information for the same year as well.

Mr. Darshan Singh Kang: Okay.

My understanding is that you'll be basing this on the Quebec formulary. Is the Quebec formulary the Cadillac model or the middle or lower model? Will it be implementable? If we use their model, cost-wise, is the Quebec model covering all the drugs in general that Canadians will need? That's my concern on the Quebec model. Will we have to add drugs to that formulary or maybe take some drugs off the formulary?

Ms. Carleigh Malanik: We haven't started the detailed analysis comparing the different provincial formularies. We're right now just running with a Quebec formulary, but again, the data that we're purchasing will allow for application of additional formularies, and it's in the plan for a sensitivity analysis to at least understand what Quebec's formulary is compared to other formularies with the list of drugs and things like that.

Mr. Darshan Singh Kang: So this will be a kind of step in the right direction and not the final approach?

Ms. Carleigh Malanik: No. Our project will be based on using a Quebec formulary. We will of course look at what that formulary means in terms of how many drugs are being covered compared to how many are being sold in Canada and things like that, but we based all of the calculations on the Quebec formulary.

Mr. Darshan Singh Kang: Okay.

Can you make the technical methods available to the committee—for example, the methods for the estimates—once this is decided? Can you share all that information with the committee?

Ms. Carleigh Malanik: I'm sorry. Could you repeat the question?

Mr. Darshan Singh Kang: In terms of all the methods you will use to come to certain formularies and costs, will they be shared with the committee before the final document comes out?

Mr. Mostafa Askari: To be clear, our reports, whenever we do a costing, have a section at the end, normally in an annex, which explains the methodology we have used, the data sources, and any other thing that is related to the report. We do not typically provide a daily update or monthly updates on those kinds of things. Once we have a clear direction through the terms of reference, we do our report and then submit the final report to the committee.

Mr. Darshan Singh Kang: Okay.

We talk about jurisdictional issues with provinces and territories. What kinds of challenges do you think we're going to face when we come out with pharmacare? Have you given it any thought?

Mr. Mostafa Askari: Jurisdictional issues in terms of the provincial jurisdictions, do you mean?

Mr. Darshan Singh Kang: Yes.

Mr. Mostafa Askari: What we are doing right now really has nothing to do with the provinces in general. The only thing we need from the provinces is from Quebec, which is to get the list of their formularies in a digital form so we can use it.

This cost is a national pharmacare program cost. How it is going to be structured and managed as a policy remains to be seen. This is not dealing with that issue at all. This is just saying that if the federal government wants to establish a national pharmacare program, with the coverage we have mentioned here, this is what the overall cost cost would be, now and over time. Then obviously the next step for the federal government and the provinces would be to negotiate and establish some kind of structure to deal with that and to deal with the current programs that the provinces and territories have.

● (1015)

The Chair: Your time is up, Mr. Kang.

Mr. Davies is next.

Mr. Don Davies: Thank you.

I think most of my questions have been covered. I'm not sure that I fully understood the answers to Mr. Oliver's questions about trying to keep this under $100,000 and whether that's possible. If I understand correctly, though, if it is under $100,000, you don't need the special authorization.

Mr. Mostafa Askari: That's correct.

Mr. Don Davies: Could this committee give you direction to request that you spend up to $99,000 collecting the data?

Mr. Jean-Denis Fréchette: That's included—always.

Mr. Don Davies: Always, and then we see where we're at or...?

Mr. Jean-Denis Fréchette: We're back to this question about the quality of the information and the required information to use for the model and the projections. I'm in the hands of the committee. Of course, the committee can ask the PBO to do whatever and spend only $9. It doesn't matter; you're going to have the quality or the availability of data for that amount of money.

Mr. Don Davies: Do you have to purchase the data in one fell swoop, which would be over $100,000, or can it be done in an incremental way? For instance, if we said to spend up to $99,000 and see where that takes you, then you could always come back to the committee, say, in three months from now or four months from now, and then purchase additional data—or do you need to purchase it in one fell swoop at the beginning?

Mr. Jean-Denis Fréchette: It depends on the contract. With some companies it is possible to split, for example, over two fiscal years. It's not always possible. In this case, we don't know.

As I said, we are negotiating. We're still negotiating the contract. Sometimes.... I'll go back to this procedure or these signing authorities. It's very difficult for me to say that I'm going to spend $98,000 in fiscal year 2016-17, and then I'm going to spend another $1,000 on April 2, just at the beginning of the fiscal year. You see the problem. You see the situation. I will be looked at. In terms of my signing authorities, even though I would technically respect these signing authorities, it will not be perceived as being totally fair.

Mr. Don Davies: I'm not asking, assuming you spend over $100,000, how you split it into two fiscal years. I'm trying to ask if we can keep the global amount under $100,000. I'm just wondering if it is possible to go to the company, say that you want to purchase data for $95,000, get that data, see if that's sufficient, and then, if not, come back to the committee for additional money. Is that possible?

Mr. Jean-Denis Fréchette: Additional money from the committee? The committee will not provide.... For the moment, the agreement is not that the committee will provide any money. The cost will be....

Why doesn't the PBO ask for money from this committee? If we have to spend that amount of money—$50,000, $90,000, or over $100,000—we plan it within our budget, which is what I did so far. It's planned in the budget.

We certainly can do incremental...I say “certainly”, but I'm looking at Mark at the same time. We may try to negotiate a series of contracts over time, but then the limit of six months will not be respected.

Mr. Don Davies: Mr. Fréchette, when do you think you can come back with a more finalized terms of reference?

Mr. Jean-Denis Fréchette: Can I get back to the committee on this? Can we discuss that in the office and then—

The Chair: Yes.

Time is up.

Mr. Don Davies: Thank you.

The Chair: That concludes our session for questions.

I have one question, though. When you say it has to go to the Speaker, is it the Speaker who decides? Is there a committee, or is it just the Speaker?

Mr. Jean-Denis Fréchette: This is the process. We, the Library of Parliament, have a contract. Before signing the contract, we send it to the two Speakers. In their procedures, it's written, “for approval in principle”. This is the wording that I'm quoting. Then they make a decision on it.

The Chair: Okay.

Mr. Jean-Denis Fréchette: The decision can be no. The decision can be yes. The decision can be that the two Speakers refer it to the Liaison Committee. I don't know. I have no control over the decision, of course. It's their decision.

● (1020)

The Chair: Thanks very much.

This is just to put it into perspective. I read a headline this morning in the *The Hill Times* that we spent $134,000 to have dinner with Mexican officials. We're talking about a health care issue that could possibly—we don't know yet—save billions of dollars every year. I think we should have a proper study and fund it properly. We'll decide that, I guess, later.

Thank you very much for the update. I appreciate your contribution. We'll probably seek your advice again soon in the new year.

Mr. Jean-Denis Fréchette: Thank you.

The Chair: We're going to adjourn for a few moments, and then we'll go into committee business in camera.

[*Proceedings continue in camera*]