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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1105)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): We'll call to order this meeting of our Standing Committee on Health.

We welcome our witnesses today. We have a plethora of witnesses so we're going to propose that we just have the minister make an opening statement and then go directly to questions.

Does the committee agree that we'll just have an opening statement by the minister?

I guess that's approved.

First of all, I'll introduce our guests, starting with Mr. Michel Perron from the Canadian Institutes of Health Research. He is vice-president of external affairs and business development.

We have Mr. Paul Glover, president of the Canadian Food Inspection Agency.

From the Department of Health we have deputy minister Simon Kennedy.

From the Public Health Agency of Canada we have Siddika Mithani, president and Theresa Tam, interim chief public health officer.

Finally, we have the Honourable Jane Philpott, Minister of Health.

Minister, if you'd like to open with an opening statement.

Hon. Jane Philpott (Minister of Health): Thank you, Mr. Chair.

I appreciate being invited here today to discuss Health Canada's 2017-18 main estimates and our proposed spending, which has been identified as part of budget 2017.

Since I was here last year presenting the main estimates, I've had the opportunity to travel the country, and to visit and hear from Canadians about the health issues that concern them. I know that you, as a committee, have also heard from many Canadians, including those in indigenous communities in this country.

[*Translation*]

My career as a medical doctor made me realize how necessary it is to improve health outcomes for Canadians. My experiences as a minister over the past year have confirmed that.

[*English*]

I'm very pleased to have this opportunity to discuss the resources that we, as a federal government, are putting towards making these kinds of improvements.

Thank you, Mr. Chair, for announcing those who are accompanying me today. I will not repeat their names. I'm pleased that they are here.

[*Translation*]

I will first say a few words, and then I would be pleased to answer your questions.

[*English*]

As you'll see reflected in the 2017-18 main estimates, Health Canada is delivering on many priority initiatives for our government. These are going to result in approximately $4 billion in spending authorities for 2017-18. This is a net increase of more than $500 million from 2016-17, and there will be significant additional investments that were outlined in budget 2017 and will be identified through future supplementary and main estimates exercises.

[*Translation*]

I would like to highlight some of our government's priorities and the actions my department is taking to address them.

[*English*]

Canada's publicly funded health care system, as you well know, is a great source of pride for Canadians. The federal government along with our provincial and territorial partners recognize the need to strengthen the health care system so that it adapts, innovates, and addresses the many new challenges that Canadians are facing every day.

I'm pleased that almost all jurisdictions now have accepted our federal offer of new investments in health care with significant new money, in particular for shared priorities including mental health and home care.

You will note that over the next five years, the Canada health transfer amounts provided to provinces and territories are expected to total approximately $200 billion, providing long-term, predictable, and growing funding to our provincial and territorial partners.

This year's funding, for example, will be approximately $1.1 billion higher than it was last year.

As part of our deliberations with the provinces and territories, we identified some particular health care priorities, specifically, mental health and home care.

One thing I learned as a doctor, and no doubt you all understand as well, is that there is no health without mental health.

[*Translation*]

Over the past few months, I have had meetings in eastern Canada and I participated in a roundtable in Toronto. Stakeholders talked to me about what we could do to improve mental health services, especially when it comes to young people, and the need to monitor those improvements.

[*English*]

There's a growing awareness in Canada about both the importance of mental health and the large number of Canadians who are affected by it. Indeed, most Canadians are affected, either directly or indirectly, by matters of mental illness.

There's a recognition, as well, about the tremendous importance of and the rising need for home care. As we may have discussed before, some 15% of hospital beds are currently occupied by patients who would prefer to receive their care at home or who would be better off in some kind of community-based setting.

Budget 2017 proposes to provide $6 billion over 10 years for home care and $5 billion over 10 years to support better access to mental health care. These initiatives will make Canada's health care systems more responsive to the needs and expectations of all Canadians.

[*Translation*]

Two other priorities were identified during discussions leading to a renewed health accord—making prescription drugs more affordable and ensuring that our health care is more focused on innovation.

● (1110)

[*English*]

To improve access to prescription medicines and lower drug prices, budget 2017 proposes to invest $140 million over the next five years. This will support important work by Health Canada, the Patented Medicine Prices Review Board, and the Canadian Agency for Drugs and Technologies in Health. To expand e-prescribing, virtual care initiatives, and the adoption and use of electronic medical records, we propose $300 million over the next five years to support the Canada Health Infoway.

We also propose to invest $51 million over three years in the Canadian Foundation for Healthcare Improvement, to help accelerate innovation in our health care system. We plan to invest $53 million over the next five years for the Canadian Institute for Health Information to improve decision-making and strengthen reporting of health-related principles and outcomes.

Based on observations from my own travels to first nations and Inuit communities across the country, I believe very strongly that improving the health of indigenous peoples in Canada must be a priority for our government.

[*Translation*]

The Truth and Reconciliation Commission of Canada has asked the federal government to close the gaps in health outcomes between aboriginal communities and non-aboriginal communities. That is exactly what we are currently doing.

[*English*]

Through budget 2017, we're proposing to invest $813 million in new money for health services for first nations and Inuit. This includes new money to increase community-based infectious disease programming, to expand access to nurse practitioners as well as physician services, to increase access to mental health and wellness services, and to increase home and community care services on reserve.

As you'll note in the main estimates, Health Canada's funding for first nations and Inuit health programs will increase by approximately $440 million this year. This will include $82 million for major repairs, expansions, and new construction of health infrastructure such as nursing stations, health centres, acute care facilities, as well as drug and alcohol treatment centres.

The estimates also include support for three other related matters: $58 million to continue implementing our legal obligations under the Indian Residential Schools Settlement Agreement; $27 million to provide first nations communities on reserve with access to safe, reliable water and waste-water systems; and $25 million to address urgent mental health needs in these communities.

Finally, we will also invest this year $137 million in interim reforms related to Jordan's principle. This will ensure that first nations children on reserve have access to the same publicly funded health and social services as other Canadians, and that no child falls through the cracks. The need for this action is obvious. In July 2016, we announced funding of $382 million over three years. Since then, more than 3,300 requests for services and supports related to Jordan's principle have been approved for first nations children.

Another health priority we're addressing is our country's opioid crisis.

[*Translation*]

I went to British Columbia and met with those who have to deal with the crisis—first responders who are repeatedly called upon to deal with overdoses, as well as families and friends who are suffering the loss of a loved one.

I also want to thank the committee for the work it has done thus far, especially its effort to accelerate the passing of Bill C-37 by Parliament.

[*English*]

Addiction rates and overdose rates are on the rise, and our response must be comprehensive, collaborative, compassionate, and evidence-based.

[*Translation*]

Last December, I announced the Canadian drugs and substances strategy, which will replace the current national anti-drug strategy. It re-establishes harm reduction as one of the key pillars of our policy along with prevention, treatment and law enforcement.

[*English*]

In February of this year, we announced $65 million over five years for national measures to respond to the crisis, and budget 2017 proposes an additional $35 million, for a total of new investments of more than $100 million over the next five years.

Our government is well on track toward legalizing, strictly regulating, and restricting access to cannabis.

● (1115)

On the matter of CFIA, the health of Canadian families depends on access to safe and nutritious foods. To help strengthen Canada's world-class food safety system, budget 2016, you'll recall, provided $38.5 million over two years to invest in systems that focus on high-risk domestic and imported foods. Budget 2017 continues this direction, proposing to provide up to $149 million over the next five years to the Canadian Food Inspection Agency to carry out this work.

[*Translation*]

That funding enables the CFIA to develop more stringent and consistent food safety regulations, and to modernize core food safety inspection programs. As a result, Canada will be better able to prevent, identify and address food safety risks.

[*English*]

In addition, several of the priorities of budget 2017 will require that agencies across the health portfolio continue to collaborate on many health priorities. For example, budget 2017 proposes to allocate $47 million over five years to Health Canada, the Public Health Agency of Canada, and the Canadian Institutes of Health Research to develop and implement a national action plan to address the broad range of health risks associated with climate change.

I am confident that the amounts noted in our main estimates and the funds identified in budget 2017 are going to help us to continue to support better health outcomes for all Canadians and to build a healthier country.

Thank you to the committee once again for inviting us to join you today. We are grateful for your contributions. I am certainly looking forward to your questions.

The Chair: Thank you very much for your presentation.

My understanding is that you have to leave at 12:00. Is that correct?

Hon. Jane Philpott: Yes.

The Chair: Just so the members know, the minister is leaving at 12:00. The officials will stay later for more questions.

The other piece of news is that the thalidomide information will be here by Monday, April 10. We'll have that and we'll distribute it. The clerk has been notified that we'll have that.

All right. We are going to start our seven-minute round of questions with Mr. Kang.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Mr. Chair, I want to share my time with Ms. Sidhu. Thank you.

Thank you, Minister, for the broad and detailed testimony. In a short time, I think you really gave us the whole plan. Thanks for that.

Minister, my question is about first nations and Inuit health programming. Priority III of the 2017-18 departmental plan for Health Canada is to “strengthen First Nations and Inuit health programming.” One of the key initiatives to support that priority is to “[a]ddress the Truth and Reconciliation Commission health recommendations, including mental wellness programming.”

In its “Report and Recommendations on the Opioid Crisis in Canada”, this committee recommended:

> That the Government of Canada commit to providing stable needs-based funding for First Nations in order for them to implement the First Nations Mental Wellness Continuum Framework.

What consideration has Health Canada given to providing funding to first nations in order to implement the first nations mental wellness continuum framework? What mental wellness programming is being considered by Health Canada, and will this programming be available to all indigenous people or restricted to status Indians and Inuit? Thank you.

Hon. Jane Philpott: Thank you for an excellent question. This is an important one. In fact, I think there is much good news in budget 2017 as it relates to this matter.

As you indicated, there are a variety of reasons why this needs to be a priority for our government. One that you pointed to is the fact that the Truth and Reconciliation Commission made a number of recommendations to which we are obligated to respond, and 11 of those specifically speak to health issues. I think it should be no surprise to this committee to recognize the fact that, on any broad range of metrics, there are unacceptable disparities between the health outcomes enjoyed by indigenous Canadians as compared to those of non-indigenous Canadians, so it is of the utmost urgency that we work to address those disparities.

To that end, I believe that the investments in this budget will be very helpful. There is, as I indicated, $813 million of new investment in a whole range of areas. We have worked with our indigenous partners, with leadership in first nations and Inuit communities, to specifically clarify where their needs and priorities are. This is the largest single investment in first nations and Inuit health overall in well over a decade. In the area of home care, which we know is a priority that has been identified by Canadians, this is the largest investment increase in Canadian history for first nations and Inuit. This is good news, but there is a tremendous amount of work to be done.

You spoke to the matter of mental wellness. I am glad that you noted in particular the mental wellness continuum framework, which has been established by first nations. Certainly the budget's investments in mental health will be incredibly important in allowing that continuum framework to be implemented fully. We look forward to working with our partners in first nations communities, specifically to address that framework. We believe that the investments made last year to augment mental health resources, in addition to the new investments coming this year, will go a long way to responding.

I would be happy to provide any further specific details that you would like.

● (1120)

Mr. Darshan Singh Kang: Thank you, Minister.

The Chair: Ms. Sidhu.

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

Thank you, Minister. Thank you for coming today to talk to us as a committee.

I know that our government's historical investment in home care will make a big difference in our communities.

Can you please explain what this adjustment means to the communities across Canada, the over almost $2 billion in Ontario for home care? I know it's the territories' and provinces' responsibility to deliver that, but how do you foresee that being delivered?

Hon. Jane Philpott: You're absolutely right. The investments in home care are very important for the long-term sustainability of health care systems across the country. We all know that health care is the largest single budget item on the books of our provincial and territorial colleagues and that there are ways we need to make sure, as Canadians, that public funds are used for home care and that they are used in a way that there is good value for money. We know, for instance, that some of the most expensive ways to deliver care are in hospitals and by physicians.

Health experts, as you well know, will say that one of the ways we can do better is to be able to get care into the communities, so we're very pleased that, as we worked with our provincial and territorial counterparts, they agreed this is an area of priority, and that we were able to offer additional resources, on top of the growing Canada health transfer, specifically for home care, which will allow that transformation of the health system to get people out of hospitals and to get the care they need at home.

To date I've had really excellent opportunities across the country to meet with home care providers and to meet with provincial officials and experts on this to see the kinds of ideas that provinces have about how they want to use this money. We expect to come together in the near future with all provinces and territories to talk about specifics as to how they will use those new investments in care and also, importantly, to agree upon a series of metrics or national standards as to what Canadians will expect so that we will be accountable to Canadians for making sure that the investments we make in home care will in fact go to improved access to care.

Ms. Sonia Sidhu: When will the funds provided under these agreements begin to flow?

Hon. Jane Philpott: There are specific arrangements that are being made as we speak in that regard. In terms of how quickly the funds flow, I know it is important that it be done as quickly as possible. I don't know whether we have a specific date on that. Do we?

Mr. Simon Kennedy (Deputy Minister, Department of Health): We have further conversations we have to have with the provinces and territories, but to have the first year of funding flow fairly quickly, we're looking at what the mechanisms would be to do that. The idea would be to get going and put some of that money out fairly quickly in year one without having the conversations we need to have on the details slowing that down. We've already told the provinces and territories that is the intention, and we're working with the government to figure out what the best mechanism is to do that.

The Chair: Time is up.

Dr. Carrie.

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

Thanks to the minister for being here for the estimates. I almost feel bad for you, though, having to defend your government's irresponsible fiscal management, but I only have seven minutes so I'm going to get right into the questions. I have three to start, and if you don't mind, I'd like to ask them all.

The first one is, in the budget there was a mention of public education, programming, and surveillance activities for marijuana. Given your government's priority, I was wondering if you could define that for us.

The second one is with regard to vulnerable Canadians who depend on medical marijuana. They trusted you and your government to ensure that what they were using was regulated and, more importantly, safe. That was the promise; however, we found out that dangerous carcinogenic fungicides were being used in medical marijuana. Obviously the current inspection system isn't working, so this leads to the second question. Is more money being allocated for inspection following the recall of medical marijuana products that were putting vulnerable users at risk?

The third question is, are proper inspections actually now taking place? If so, how many have been done?

● (1125)

Hon. Jane Philpott: I'm very pleased that you identified investments in public education in the budget. As you know, when it comes to cannabis our government has made a commitment to work toward legislation that will legalize cannabis, regulate it, and restrict access for the purpose of keeping cannabis out of the hands of kids and the profits of this industry out of the hands of criminal organizations. To that end, one of the very important recommendations we received from the task force is to make sure there is a broad public education campaign. I believe $9.6 million has been identified in the budget to begin that.

Some very important work has been done by the department in developing what that public education campaign will look like. The very beginnings of it have started to roll out but I know people will look forward to seeing an expansion of that. There is ongoing funding in that and, of course, when the legislation is tabled it will be important that we appropriately resource this important aspect of public education.

Mr. Colin Carrie: You have no details yet.

Hon. Jane Philpott: I'm not sure we're at liberty to give a whole lot of details. Of course, some of it relates to things like social media campaigns, making sure we get the right information to the right audiences. We know that young people are those who are often most at risk. But of course their parents are also very interested. So we're looking at different kinds of platforms to make sure the message gets out to the right audiences in that regard.

Do you want me to move on to the other parts of your questions for the sake of time? Or I can ask for some clarification.

Mr. Colin Carrie: Yes, please because your officials will be here. We can get that detail.

Hon. Jane Philpott: I'm glad you raised the matter of inspection. The regulations around security and safety of the medical cannabis industry in Canada are extremely rigorous. Other countries look to our program as they look to regulating a similar type of industry. Health Canada does conduct regular and unannounced inspections of the licensed producers who are given authority under federal regulation to produce medical cannabis. We have announced that, as a result of the information that you described, we will now do random testing as well, in addition to the regular inspections of licensed producers. I don't know whether my deputy wants to elaborate on that but in terms of the rigour we want to certainly assure you that work is being continued to be sure we have all the right inspection processes.

Mr. Colin Carrie: It's important that resources are set aside, because this is not only for medical marijuana. Your government has promised, in a very tight timeline, to roll it out for legalization for all Canadians. We're seeing that the inspections, obviously, weren't working if you're getting these fungicides. Are more funds being allocated for it? Are proper inspections now taking place and, if so, how many have been done since we found out about this problem?

Hon. Jane Philpott: Thank you. Obviously, I can't give details right now on what the legislation is going to look like, and the process by which....

Mr. Colin Carrie: Is there more money?

Hon. Jane Philpott: I'm not at liberty to be able to share the specifics of the legislation until it's tabled. But I want to remind the committee that in any production, whether it be the production of toothpaste or lettuce or pharmaceutical products, part of the strength of Canada's regulatory system, when it comes to consumer products, when it comes to food safety, when it comes to pharmaceutical products is to make sure we have strict systems in place to identify contamination. Contaminations do happen from time to time, and that's why we have systems in place to recall immediately, as was done in these circumstances, to make sure that people are aware if something has been identified and then to be sure that the systems are in place so we will always be able to make those identifications as quickly as possible and inform people who might be at risk.

Perhaps you would be reassured by some comments from my deputy in that regard.

● (1130)

Mr. Simon Kennedy: To reinforce what the minister said, we certainly have been taking very seriously these recent violations around pesticides. We have begun a program of randomized sampling to keep the industry on its toes. Right now, there is a very strict list of which pesticides are authorized for use in the cannabis sector. That random program is going to be looking at that. Generally, certainly in the last number of years, we have found a very high rate of compliance in the industry. Generally speaking, as the minister indicated, a fairly heavy schedule of inspections and oversight takes place now. Obviously, we've had these incidents. We've adjusted the program to add this as a new dimension

Without in any way wanting to minimize what was discovered, the other thing I would point out—and we are taking action—is the department did do a risk assessment when these breaches were discovered.

Mr. Colin Carrie: Did you make the testing mandatory? Because, understanding from the article, you didn't. Is it mandatory that these companies are all going to be inspected? Random is good, you know, keep them on their toes, as you said. Are you inspecting these companies, and is it mandatory, yes or no?

Mr. Simon Kennedy: We want to see what the results of the randomized program indicate before we make a decision about what a final regime would look like. To date, we have not seen any information to suggest we need to have a program of inspecting every batch lot of every company.

Mr. Colin Carrie: No, no, but mandatory at each company.

Mr. Simon Kennedy: Right now, we have mandatory requirements around pesticide use, and the randomized inspections are designed to determine whether or not the companies are actually following that protocol. That's frankly pretty typical in the way in which inspection regimes function. In many regimes, you're not actually looking at every single lot, you're pulling them randomly to get a sense of whether people are following the rules or not.

Mr. Colin Carrie: How many inspections have you done?

Mr. Simon Kennedy: I'd have to get back to you with that. At this point I don't have it.

The Chair: Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Chair, and thank you to all for being with us.

Minister, I want to start by congratulating your government for increasing funding to the Global Fund to combat HIV and other maladies internationally. However, I want to ask you about funding for organizations here in Canada.

Last year, it emerged that the Public Health Agency of Canada had expanded the number of agencies deemed eligible for support under the HIV and hepatitis C community action fund, but that the fund itself would remain fixed at $26.4 million. Under this new allocation, many established community-based organizations either lost funding, or had it significantly reduced. I know you have pledged to address this for this current fiscal year.

Can you confirm that the previously funded organizations, all of them, have in fact been made whole with full transitional funding for this year? More importantly, will you commit to providing these organizations the same funding in the years ahead, and to expand funding for the federal initiative on HIV/AIDS?

Hon. Jane Philpott: Thank you for highlighting this important issue. You're absolutely right, it's an issue that has global relevance and, like you, I am pleased that our country is supporting further investments in the Global Fund.

In Canada, we have a tremendous amount of work to do on these issues like HIV and hepatitis C. Like you, I'm recognizing there's more work to be done. One of the things we have increasingly done in the health portfolio is to bring together all partners, to recognize the important role that each of the members of the health portfolio have on the matter of HIV. We've increasingly made sure that the Public Health Agency of Canada is working closely with the first nations and Inuit health branch and the Canadian Institutes of Health Research, because all of the groups within the portfolio have a role to play.

In fact, we did get new investments in the budget to expand the federal initiative on HIV in the order of $30 million of new funding that will support this. That will allow us to look at the very questions that you're asking in terms of these groups that had concerns about potential funding cutbacks.

I will ask the president of Public Health Agency or Dr. Tam to clarify whether, in fact, every single organization was able to get bridge funding to make sure it continued right through until March 2018. With this new funding that came in the budget, we will of course be looking at all of those groups to make sure that we provide good, smart investments going forward to the groups that are delivering well on the ground.

● (1135)

Mr. Don Davies: Minister, I want to talk about the opioid crisis. As you may be aware, Vancouver Fire and Rescue Services reported 162 overdose response calls for the week of March 20, just a few weeks ago. That's a 56% increase over the previous week, where 104 calls were responded to. To date, in 2017, there have been 100 overdose deaths in Vancouver. There were 215 in all of 2016. In the first quarter, we're almost halfway there. If rates of overdose deaths continue at this pace, Vancouver will see nearly 400 deaths in 2017, double the number recorded in 2016. We know fentanyl is spreading across Canada to many communities, and that carfentanil is ever-present.

When I looked in the budget, which the government tabled a couple of weeks ago, on page 193 there is a line item that says, “Emergency Funding to Address Opioid-Related Public Health Emergencies” and it has an allocation of $16 million. This is what was allocated in 2016 to B.C. and Alberta, $10 million to B.C. and $6 million to Alberta, and nothing but zeros thereafter.

Given that the opioid crisis is not under control, and given that we have reason to believe it may even flare up, can you explain if you think it's prudent not to set aside emergency funds to deal with the opioid emergency over the years ahead? Is that a prudent way to budget?

Hon. Jane Philpott: Thank you for the opportunity to clarify the significant investments that are in budget 2017 related to the opioid crisis. You and I were both involved in the very important policy forum that took place over the last couple of days here in Ottawa to discuss this. There's no question that this is a crisis of unprecedented proportions, requiring all of our efforts to be able to address the realities that you've eloquently described in terms of the number of people who are dying.

In the time that remains, what I can say to you is yes, we provided that $16 million of emergency funding directly to those provinces that are facing the crisis in the most severe ways, but in fact there are significant new investments. The Canadian drugs and substances strategy has ongoing funding in the budget. We did not take anything away that was previously there, and it had been allocated to the level of $570 million over the next five years just for that strategy alone. We were able to bring a 20% increase to that, bringing the total investments in the Canadian drugs and substances strategy an additional more than $100 million to be able to amplify that.

I also need to make sure that you know that this is a problem that has widespread implications and requires a comprehensive response, and that's why we did things like the $5-billion investment in mental health. You know the links between mental health and the opioid overdose crisis. You also know that investments in things like housing—$11 billion to our national housing strategy—will go a long way. This is not a crisis that's going to be fixed overnight, and it requires all those social determinants of health to make sure people have access to employment, that they have access to safe housing, and that we get good health care.

I will work with you. This is not a political or a partisan issue. This is one of the most serious public health crises that we have faced in this country; we are determined to turn it around, and I look forward to working with the committee.

Mr. Don Davies: Thank you, Minister.

I agree with all that, but the question was on emergency funding. The budget line is there. I'm just surprised the government hasn't allocated any to emergency. We could have a flare-up on this crisis next week, and the fact that there's no emergency funding budget for it is an omission.

I want to move to pharmacare and pharmaceuticals. Your mandate letter tasked you to improve access to necessary prescription medicines, and it went on to talk about looking to join in bulk buying to reduce the cost that Canadian governments pay for these drugs. You well know that one in five Canadians reports not taking medicine because they can't afford it. It has been estimated that 20% of Canadians—seven and a half million Canadians—do not have stable access to medicine they need when they need it.

So my question is this. I know you're only 18 months into your mandate, but that's a year and a half. Has access to prescription medications improved for Canadians since you have taken office?

● (1140)

Hon. Jane Philpott: Thank you. I know I probably don't have very much time.

I first of all want to thank the committee for your work on the pharmacare study. I'm very much looking forward to the results of that. I know the interests of you and others around the table in the matter of making sure Canadians get access to care.

What I can tell you for sure is that there has been progress made in ensuring that prescription medications are more affordable and therefore accessible, and appropriately prescribed. One of the things I can point to is the bulk purchasing plan, which we joined with the provinces and territories. That is on track to save something in the order of $700 million or $800 million a year now, bringing down the prices of those drugs and therefore bringing down the cost to the public.

I look forward to giving you more information about how we're bringing down the cost of medication overall and working with provinces and territories around things like a national formulary. These are all absolutely essential steps in making sure that prescription medications are available to Canadians.

The Chair: Thank you very much.

Now we have Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you very much, Mr. Chair, and thank you very much for the leadership you've been providing for a very important file for all Canadians. It's great to have you as our Minister of Health.

My first question is around the opioid crisis that we've been dealing with, and fentanyl. It is wonderful in Bill C-37 to see a return to evidence-based harm reduction approaches to this crisis, which is a big change from what we had in place before. So with Bill C-37 coming forward, can you tell the committee, are we seeing easier access to safe consumption sites, and are we starting to see prescription changes in naloxone availability? Are you sensing a turn here?

Hon. Jane Philpott: The circumstances are a sobering reality, and Mr. Davies has highlighted some of what's actually happening. I think we are seeing good progress

However, this is a crisis that has been bubbling up for some time. To manage people's expectations, while I would like to be able to say it's going to turn around immediately, we have to realize that it's taken years to get to where we are and it's going to take some time to turn this around. I am pleased with the progress that's been made.

You asked specifically around Bill C-37, and I once again want to reiterate my thanks to this committee for your expeditious work on that. You had already studied the matter and were able to move it through. We look forward to the passage of that bill, and I hope it will be very soon. I met with the Senate committee last week, and they are still taking hearings, but I hope we will see that moved through very quickly.

A few weeks ago, I was able to announce three new supervised consumption sites in Montreal that were working under the previous legislation, but it had taken them 18 months in the application process to get to that point. We now have another 11 sites in the queue. If we can get that bill through quickly, that really changes the landscape in terms of what it requires, not only for those who are in the queue but for others who will come after them. We hope to be able to announce new sites in the future.

Also, I want to once again remind the committee that while access to supervised consumption sites in communities that want and need them will be effective in saving lives and reducing suffering associated with substance use, this is one of a whole range of measures. We always need to keep our eye on the comprehensive response to this crisis.

Mr. John Oliver: We heard testimony from one of the witnesses —because we did our study on this and released our 38 recommendations—about the importance of distinguishing treatment and addiction treatment. It's often lumped under mental health, and too often the funds for addiction end up in general mental health pools. There was a very strong appeal from a couple of physicians to make sure that we address addictions and have good treatment centres available across Canada.

One of the biggest barriers right now, when people identify themselves as ready to look for treatment, is whether we can get them quickly into centres.

Hon. Jane Philpott: I'm very pleased you raised that matter.

Mr. John Oliver: I know it's provincial.

Hon. Jane Philpott: Well, it is provincial, but I think there are ways that we can signal our support to encourage expanded access to treatment for people with problematic substance use. There's no question that the matters of mental health and addiction are very closely related, and it makes sense to talk about them together. You're right, though, that the fact that we link those together because they have interrelated themes can mean that sometimes resources don't get to addictions or problematic substance use in the way that they should.

One of the things I am certainly trying to do is to indicate that we need to do far better in this country on treatment, both the mental health support treatment and social support treatment that people need, but also on the medical support for people with problematic substance use, including access to medication-assisted therapies, opioid substitution therapies, for example.

There are ways we can do it, including, I'm thinking, in terms of working with our partners in research who are helping us to look at expanded access to treatment. There are ways within our federal leadership that we can try to move that along and make sure there's better access, which there certainly is a big challenge on right now.

● (1145)

Mr. John Oliver: Thank you.

In the estimates, there is an increase of about 30% for first nations and Inuit primary health care.

I'm wondering if you can share any recent success stories in this area. I heard there were some changes in the maternal accompaniment plan. Are there any other things like that? I know there are a lot of challenges but that you're making progress.

Hon. Jane Philpott: Again, that's a great question, because sometimes I think we don't do a good enough job talking about the good-news stories of things that have happened.

There was money in the budget last year, as you may recall, around health infrastructure on reserve. There were some good-news stories. I had the opportunity to go out to Cross Lake in Manitoba and talk to them about being able to support an expansion of the nursing station there, which they were ecstatic about. It was long overdue.

You asked about other things within the broad range of health services. I would like to take this opportunity to highlight one. You referred to prenatal issues. I have become increasingly aware of the importance of wellness at the time of birth. This goes for all Canadians, but in particular there are real challenges for indigenous Canadians. Many of them live in very remote communities and are forced to leave their communities to give birth, with essentially lifelong implications for the mothers and the children. There are two things in the budget that I am beside myself with happiness over. Number one, we were able to change the policy on prenatal escorts. Some of these young women are teenagers who have to leave their communities and give birth in a faraway city. Unless they had a medical reason for it, they couldn't bring someone with them. As they have to leave five weeks before the baby is due and stay for a number of weeks after, this was not a healthy policy. We were able to change that. Now every woman who has to leave her community to give birth is able to bring an escort with her. It's incredibly good news.

The chair is looking at me because my time is about to run out. But the other thing you need to know is that one of our longer-term goals is to be able to restore the cries of birth to remote communities in Canada—to use the words of a first nations leader—and find ways that we can expand midwifery and expand access to allow people to give birth in their homes, in their lands, surrounded by their families.

The Chair: Thank you very much.

Now we go to our five-minute rounds, starting with Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Minister and staff, for being here today.

Minister, as you are likely well aware, there are hundreds if not thousands of Canadians suffering daily from Lyme disease. We know that many are more likely to have been misdiagnosed or are not getting the treatment they need. We've had conferences. We've had experts provide their opinions and recommendations. We've had public consultations. The Lyme disease community believes that enough talking has happened and now action needs to take place. We know that action is not possible without adequate funding.

Minister, can you tell us how much funding over and above previous funding has been allocated to implement a Lyme disease action plan?

Hon. Jane Philpott: You're right that this is an important issue. Certainly many of us hear from...and in certain parts of Canada in particular it's a real challenge. I'm pleased that we were able to host a conference recently to develop a federal framework on Lyme disease. The draft report associated with that has recently been proposed.

There are many things that we as a federal government can do, of course, and we will work toward those. I'll ask my public health colleagues to expand on that, to a certain extent. A great deal of work needs to be done in public education and making people aware of the risks. There are ways that we're doing that through the Public Health Agency, but we're also working with provincial and territorial partners to get the message out to Canadians on how to prevent Lyme disease. A lot of work also needs to be done with health care providers, to make sure they recognize it early, get the diagnosis, and get the treatment to people.

● (1150)

Mr. Len Webber: Absolutely. Minister, I don't mean to cut you off, but I want to know about the actual funding. I only have a little bit of time here. Can you give us any detail on the funding that will be allocated and spent on Lyme disease?

Hon. Jane Philpott: Theresa, perhaps you can give us some specifics.

Dr. Theresa Tam (Interim Chief Public Health Officer, Public Health Agency of Canada): Within the Public Health Agency of Canada we are strengthening surveillance, education, and awareness. We're looking at where more information or knowledge is needed. We are leveraging, essentially, on any funding we may have under climate change, because we're looking at the expansion of mosquitoes, ticks, and vectors, and the expansion of Lyme disease.

We'll be trying to look at how we can leverage that funding. As the minister said, there's additional funding. We will be looking at some of that. That includes grants and contributions as well.

Mr. Len Webber: Thank you. I appreciate that. Obviously, I'm not getting any numbers here.

Hon. Jane Philpott: If I may, I just want to clarify what the actual number is. What Dr. Tam was referring to is $47 million of investment for health risks associated with climate change, and, of course, Lyme disease is one of the priority areas in that regard.

Mr. Len Webber: Okay. Will it go only to federal spending, or will it be targeted funding given to provinces? Will that money flow in this fiscal year, or is it subject to a lengthy application program that actually means funding will be re-profiled for future years? Exactly what part of the battle against Lyme disease will see extra funding this year, and in what amounts? That's what I'm asking. I just need numbers.

Hon. Jane Philpott: I'm happy to get you the breakdown on that $47 million. I don't have it at my fingertips, but we'll be happy to get that to you.

Mr. Len Webber: Thank you. I appreciate that.

Hon. Jane Philpott: That's a federal investment. I think it's also really important to recognize, as you have alluded to, that a large part of the diagnosis and treatment of this is provincial and territorial, and obviously is up to their discretion.

Mr. Len Webber: All right. Thank you, Minister.

I'm sorry. I don't mean to cut you off. I have only a minute here.

I do want to bring up another topic that I am deeply passionate about. Last year one of my colleagues, MP for Edmonton Manning, Mr. Ziad Aboultaif, brought forward a legislative proposal for a national organ and tissue donation registry. The concept was well received by many Canadians, but his efforts were voted down by the Liberal government. That vote did see a few Liberals, including our chair—thank you, Mr. Chair—voting in favour, but it was defeated.

Of those who opposed this life-saving idea, were you, Minister, and also MP Judy Sgro, the member for Humber River—Black Creek. Imagine my surprise, Minister, when I saw a few months later, on November 28, 2016, that Ms. Sgro tabled Motion No.98, which reads as follows:

> That the House underscore its desire and commitment to establish a national organ donor registry, and call upon the government to engage with provinces, territories, and other relevant stakeholders in an effort to devise and enact the legislative and regulatory framework necessary to establish the same.

I'm just asking, Minister, if you can explain this. How can the Liberals vote against a national organ and tissue donor registry in June and then propose one in November? Is the government admitting that it made a mistake and is now willing to support such a great initiative, or is this a case of the government being determined not to vote in favour of a Conservative bill just to be able to say that it passed a Liberal motion instead?

I sure hope this is not the case, because people are dying, Minister. Can you explain this to me?

Hon. Jane Philpott: Let me preface it with two comments. First of all, I will say that I hope you and the committee are very well aware of the fact that health, of all issues that governments face, is not a partisan issue, and I will not make decisions on the basis of partisanship. My priority is the health of Canadians, and it is on that basis that I make decisions.

Second, I need to thank you for your leadership on the matter of organ and tissue donation, which is incredibly important. I will agree with you that there is a tremendous amount more work to be done, particularly in the area of encouraging Canadians to participate. I think you and I would both agree there is much more work to be done in terms of the donor community being increased.

One of the challenges around the motion and indeed any of the areas on this is that when we wade into provincial and territorial jurisdiction, it gets complicated. I would look forward to the opportunity to work with you, because I know this matters to you so much and to many of our other parliamentary colleagues, to find better ways to figure out where our federal role lies and how far we can push it without invading provincial and territorial space, with the ultimate goal of making sure that we increase the donor base.

● (1155)

The Chair: Thank you.

Now we're going to Mr. Ayoub.

[*Translation*]

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

Thank you, Minister. It is always a privilege to give you an opportunity to explain to Canadians the leadership you provide in the negotiations with the many provinces, especially Quebec, on home care and mental health, topics I will now focus on.

In my former life, I was a mayor, and constituents came to see me to get some suggestions to help them stay at home. Those seniors have a family that supports them, and they want to stay at home. They don't really want to go into institutions, unless they are forced to do so because of the nature of the care they must receive.

Canada is a federation, and the federal government negotiates with the provinces. I would like you to explain the leadership you have provided in the negotiations to give Quebec in particular, but also the rest of Canada, the notion of home care and mental health. In the latest federal budget, investments in those areas are of a truly historic nature.

Hon. Jane Philpott: Thank you very much. I will try to answer in French.

Mr. Ramez Ayoub: I congratulate you on the quality of your French. I see a nice improvement. It is to your credit.

Hon. Jane Philpott: Thank you.

As you know, we have had some very good discussions with all the provinces and territories, including Quebec. I know that Minister Barrette said very clearly that mental health and home care are among our shared priorities. I have seen several good examples of that, including a palliative care facility in Montreal. That is a great example of the good work being done in Quebec.

During the discussions, it was clear that the elements you mentioned were priorities for Minister Barrette and his government. We discussed how they could increase services. They have some very good ideas on mental health services for young people.

[*English*]

Maybe I'll just continue in English for the sake of time.

Minister Barrette has identified some excellent programs that they're very interested in for youth. They have, in fact, looked to international communities. I don't want to presuppose what their plans will look like, but just to give you a bit of an idea of the things that they are looking at there. We know that when we get care to young people, it can have a lifelong impact on them. We know that young people are not often identified as having mental illness early enough and don't have access to care. I know that Minister Barrette and his government are looking at expanding programs for young people to get access to cognitive behavioural therapy and using some of the very best world-class models in that regard.

They will make decisions on the basis of how the funding that we gave to them is spent. However, I know that you can assure your constituents that they should see improved access to mental health care as well as home care in the years to come as a result of our investments.

[*Translation*]

Mr. Ramez Ayoub: I am fully aware of that and I am very confident. Thank you.

We are also talking about the opioid crisis, which is much more prevalent in western Canada, but it is worsening in the eastern part of the country, especially in Montreal.

Lately, I was reading some information on the solid relationship with Minister Charlebois in terms of the incentive to open new sites. Montreal was able to benefit from that.

Could you tell us where the reconciliation stands and how far along the process to open those sites is?

● (1200)

Hon. Jane Philpott: I recently announced that three supervised consumption sites in Montreal were ready to resume. They have received an exemption.

[*English*]

They've also said I've had a good working relationship with Minister Charlebois who's determined to address this. I'd also say that I had a conversation with the Mayor of Montreal not very long ago about his concerns about the opioid crisis in Montreal. I would say that they have been highly proactive, and this is good news. It has not reached Quebec to the extent that it has in other provinces, for a variety of reasons, but it's good that this is very much on their radar. There's a lot of good work being done there.

[*Translation*]

Mr. Ramez Ayoub: That's what we call team work and leadership. I congratulate you on that.

Thank you.

[*English*]

The Chair: Time is up.

Dr. Carrie, you are up.

Mr. Colin Carrie: Minister, in March, you refused to delay implementing the ban on neonicotinoids despite the agriculture committee's signal that the decision to ban the pesticide was not based on the best available science. In fact, nowhere in your mandate letter does it say you're required to ensure decisions are based on science, facts, and evidence and serve the public's interest. However, your decision to stick with the implementation of the ban, despite the lack of science, sets a dangerous precedent. With the upcoming legalization of marijuana, we know that the science is very clear. It says the brain develops until the age of 25. Minister, will you forego science in favour of special interest groups in this case too? What are you doing to ensure that your decisions are science-based?

Hon. Jane Philpott: Thank you.

I'm concerned that perhaps you've conflated a few issues that aren't necessarily fitting together nicely.

Mr. Colin Carrie: Well, it's based on science, and the reality is—

Hon. Jane Philpott: The reality is that decisions have to be made based on science. You referred to pesticides on a couple of different matters. One is the matter of imidacloprid, which is a neonicotinoid. A draft recommendation has been tabled. A final decision has not been made on that, but the decision related to that was based on science.

Then you talked about other pesticides related to cannabis, which is an entirely separate issue. But the principle—

Mr. Colin Carrie: No, I did not. Could I please clarify? I think you're misunderstanding.

The question is on marijuana. The science is very clear and I think we all know that the brain develops until age 25. There have been all kinds of leaks coming out of your caucus that you're bringing legislation forth soon. Canadians expect the Minister of Health and Health Canada to be looking at the health and safety side of it, not ease of delivery or access.

On the neonicotinoid issue, the agriculture committee was clear, saying that it wasn't based on the best available science, but you still upheld that ban. The concern is whether you are going to be basing the age of access to marijuana on science or special interest groups, and I think Canadians need to know where you stand on that.

Hon. Jane Philpott: Okay. Thank you for clarifying. I think I understand your question a little better now. Your question is in terms of the concerns about young adults' brains and cannabis and whether we will use science as a guide. Is that right?

Mr. Colin Carrie: Yes.

Hon. Jane Philpott: One of the things that I think all colleagues have to understand is the science as it relates to the data that we have around the use of cannabis amongst Canadians. You know that we have the highest rates of use in the world.

The most recent data that has just come out, scientific data, is that the group with the highest use in the country is the 18- to 24-year-old population, in which case, 30% of Canadians in that age group currently use cannabis. Here's where the science is important to us: to recognize that these young Canadians are using cannabis to a very large extent.

Of course, our legislation is not tabled yet, but we need to recognize that reality and that truth. When you see the legislation come forward, I'll think it's important to recognize that when we take a public health approach to a matter such as cannabis, we need to not confuse the legalization of products with whether products are completely without risk.

A whole range of products available to Canadians, including tobacco and alcohol, are substances that are absolutely not without risks, and in the case of tobacco, in fact, have well documented risks associated with them. One in two users of tobacco will die because of that.

Because a product is legal does not necessarily mean that it's without risk. That, taken together with the information we have about the high rates of use, means that sometimes in the smart, science-based public health approach we have to say to Canadians that there are products available, but science says there may be risks associated with them and we have a responsibility to educate Canadians and make sure they're kept safe.

● (1205)

The Chair: Mr. Carrie, very quickly, please.

Mr. Colin Carrie: There is still a lot to be learned, and just as I said, from the point of view of health and safety of Canadians, I think if you look at the statistics over the last 10 years, the use has gone down for that age group. I think it was 40%, down to 33% now. Perhaps what we were doing in the last decade has helped to decrease the numbers.

The concern, Minister, is that if you are going to be putting legislation out, you can compare it to alcohol, you can compare it to cigarettes that are already out there, but why would we want to start a new product where we're very sure that up to age 25 it can have devastating health effects? Why would we choose an age that is perhaps seven years earlier than that?

Hon. Jane Philpott: Well, as I say, I don't want to presuppose what the legislation is going to look like. I'd be happy to give you some more details on that once the legislation is available.

The Chair: Madam Minister, I understand you have to leave, but if you had eight more minutes, we could complete a whole round of questioning. If you don't have that time, we understand.

Hon. Jane Philpott: Where is my team? Do we have to go? Yes?

If you'll forgive me, I'm a few minutes late already for my next meeting. You know I will be happy to come back.

The Chair: Okay. Thank you very much. We'll look forward to that.

Hon. Jane Philpott: Thank you.

The Chair: Dr. Eyolfson, you're up.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Minister, for coming. I'll start asking my questions of the board, since you have to leave, but again, thank you.

This is in regard to the increased funding for mental health. Dr. Philpott and I share the same profession. Mental health is a very important predisposing factor for a number of other issues. We know that, for a lot of people with substance addiction problems, in fact, it comes down to a mental health problem. A large proportion of the homeless have an inadequately treated mental illness. There are a lot of people whose untreated mental illness puts them in the justice system.

This is a bit of an assumption, but I think we can reasonably make the assumption that these investments in mental health would have some savings on these other services, like the justice system, drug abuse and addictions, and homelessness. Is there any estimation of the projected savings to these systems from these investments in mental health?

Mr. Simon Kennedy: I don't have immediate access to the information. There is a presumption that there will be downstream savings to the health care system and elsewhere, but we still have to do some work with the provinces and territories to determine exactly where the funds will go. The government has indicated—and certainly there's been a lot of support among the provinces and territories for investments in youth, in particular, so we have a sense that will be an area of priority. We still have some work to do to figure out exactly, jurisdiction by jurisdiction, where the funds will go. We'll probably need to do some of that before we can get a better handle on exactly what it might mean in each jurisdiction.

I don't know...maybe the Public Health Agency wants to talk a little more broadly about this issue.

Dr. Theresa Tam: I cannot speak to specific figures. Obviously, if we were on the upstream side—taking a public health perspective and looking more at prevention and promotion, particularly in the young—the lifetime savings are going to be quite significant for sure.

Mr. Doug Eyolfson: All right. Thank you.

This is going to be a similar question in regard to investments in harm reduction. Perhaps there's some data because we've had some limited experience with this. We do know and we've talked a lot about supervised consumption sites and the prevention of fatalities when people overdose. We also know that there is a harm reduction aspect in the supply of clean injection equipment, which means that this would prevent the transmission of blood-borne diseases. We know that a single infection of HIV is going to cost several hundred thousand dollars in the life of a patient, while a single case of hepatitis C, if adequately treated, is going to cost several hundred thousand dollars a year per patient.

In the supervised consumption sites that have existed, is there any data on the decrease in the rates of transmission of blood-borne diseases in these centres?

● (1210)

Mr. Simon Kennedy: I don't have immediate access to the detailed figures, but there is a substantial body of evidence that shows the efficacy of these kinds of facilities when they're properly set up and run. That would include the Insite facility here in Canada. Obviously, there's been work done over the last 10 years or so to look at the impact of that facility.

I'd be happy to do it again, but I had been asked a similar question some time ago by the committee. We've actually tabled a fairly substantial amount of the empirical evidence here, so I'd be happy to share that again directly. There's a large body of academic and other research studies that show pretty definitively that supervised consumption sites lower crime, reduce rates of infection, and reduce rates of overdose. As a ministry, we're confident that the data shows that these are effective facilities.

Mr. Doug Eyolfson: Thank you.

Is there a figure, even just ballpark, on the annual costs of operating Insite? Do we have an estimate somewhere in that?

Mr. Simon Kennedy: I'm sorry, but I don't have that immediately available. We may be able to get that to the committee.

Mr. Doug Eyolfson: Okay.

I'm hoping to see, at some point in the future, whether we have data to show that we are saving the costs of each of these cases of HIV or hepatitis C and how much this offsets the costs of running these centres.

Thank you.

How much time do I have?

The Chair: You're about a minute over.

Mr. Davies, you have three minutes.

Mr. Don Davies: Thank you.

In response to a 2015 Auditor General's report, Health Canada pledged to develop an internal report by July 2016 to analyze clinical care access in remote and isolated first nations communities in comparison to access to health services by non-first nations communities in similar geographic locations.

I'm wondering if you'll give an undertaking to provide a copy of that report to this committee?

Mr. Simon Kennedy: Yes, what I can say is there has been active work under way to respond to the Auditor General's report, so I can certainly give you an update on where we're at with that.

Mr. Don Davies: I just want an undertaking that, when the report is done, the committee will get it. Can you give us that undertaking?

Mr. Simon Kennedy: Can I take that back and come back to the committee? I don't know what state that report might be in at the moment, but I can assure the member that we are working very diligently on the AG's recommendations, and I'd be happy to provide whatever we can.

Mr. Don Davies: I understand that. I know you're working on it. That's why I want to know if, when it's done, we can get a copy of it. That's my question.

Mr. Simon Kennedy: I'll get back to the chair on that.

Mr. Don Davies: Thank you.

Second, in the minister's mandate letter, she was tasked with producing plain packaged tobacco legislation. We know that every month young Canadians start smoking and that many of those people will develop serious illnesses and die. We know that. We also know that plain packaging for tobacco products is effective in preventing people from starting smoking.

Can you tell us when we're going to see plain packaged tobacco legislation introduced in the House?

Mr. Simon Kennedy: Just by looking at my latest notes on this, I believe our plan is to move ahead on plain packaging relatively expeditiously. We have legislation before the House now, in BillS-5, that will give us some additional authorities needed to take action on plain packaging. We would be doing this largely through regulation, so I don't think you're going to be seeing a plain packaging bill as a stand-alone. The legislation we've already brought into the House will give us some extra oomph that will be needed, but we would be looking at probably, largely, regulatory measures to move ahead.

I just want to underline that we are entirely dedicated to getting this done and getting it done as quickly as possible, but we would not envisage another bill that would need to be brought forward for that.

● (1215)

Mr. Don Davies: What I'm looking for is when this will be enforced in Canada. It's been 18 months since the mandate letter was given. That's a year and a half. People are starting smoking, and they're dying. When are we going to see actual action taken?

Mr. Simon Kennedy: I'll come back with what the proposed timetable is. I don't have it immediately at my fingertips.

Mr. Don Davies: Okay.

My final question is on overdose prevention sites. As you know, in Vancouver there's been at least two supervised consumption sites that have popped up, and they're operating illegally. It's only through the courage of the people who are staffing those, at great risk to themselves, sometimes their professional credentials, but they're doing it because they know that these are saving lives.

Has there been any consideration given to the health minister's granting an emergency exemption to those overdose prevention sites that we know are operating, that we know are saving lives, but that you're forcing to act illegally without that exemption?

Mr. Simon Kennedy: What I can say is that we are in receipt of a number of applications for these supervised consumption facilities, including a number in B.C. As I think the minister indicated, we made a commitment to process those as expeditiously as possible within the confines of the law. In a lot of cases, we're actually kind of waiting on things from the proponents in order to be able to move forward with our review. We're very hopeful, in the coming weeks, to be able to put in place some additional transparency measures to give people a sense of where various applications are in the queue.

Mr. Don Davies: Mr. Kennedy, can I just interrupt you?

These are unique cases. These are operating now. I'm not talking about people who want to open them and who are under the current application process. I'm talking about two sites that you know are operating right now in Canada. Does the minister have the power to grant an exemption, if she wanted to, to those sites that are operating right now?

Mr. Simon Kennedy: I think what the government has been pretty clear on is its willingness to move as expeditiously as possible to approve new supervised consumption facilities. That's what we're working on, and that's the conversation we're having with British Columbia.

The Chair: Time's up.

That completes our official round of questions, but in the past, when we had the same circumstance of excellent witnesses and time left, we established another round of four questions at five minutes each.

Is that the consensus of the committee? Is that all right with everybody?

Mr. Don Davies: I'm sorry, could you repeat that?

The Chair: The last time this happened we took another round of four questions in the order of the original round, but for five minutes each, not seven.

Mr. Don Davies: Do we not have time to do seven?

The Chair: I think we have time to do seven, but we don't have time to do a full round. We could, then, do another round of seven.

Mr. Don Davies: Could we just do another first round, of four times seven minutes?

The Chair: Yes, we can.

Is that the consensus?

All right.

We'll start our questioning with the Liberal Party. Do we have an interested questioner?

Mr. Oliver.

Mr. John Oliver: If anyone else wants to share with me, let me know.

First of all, it's great to see health accords being reintroduced in Canada. I think it was in 2004 that we last had health accords in place. There was a lapse. It's good to see the provincial and federal and territorial governments working together again to get agreements.

To start with mental health, a significant amount of funding has flowed. There's always a worry that money flows out that is intended for mental health, but it is redirected and can be used in areas other than the health profile.

Are you working on measures to ensure that provinces and territories use the mental health funding specifically for mental health programs? Have you put in place any metrics, measures, or performance indicators that would track to see whether the investment has helped people who are suffering from mental illness?

Mr. Simon Kennedy: As the government indicated in the various news releases announcing the achievement of an agreement on funding with each jurisdiction, you may have noticed that there was language in them about the next step being to work on targets and indicators and so on. That is exactly the conversation we are having with the provinces and territories.

The minister and the government generally have been pretty clear right from the outset that there's a desire to put money in to help transform the system, but that as part of it, doing so is going to require that there be agreement on what the funds are spent on and that there be some accounting to Canadians for the results achieved. That's the conversation we're having now.

Indeed the hope—or more than a hope, the objective—is to have a good sense of where the money will go, measures that we can report on publicly, and mechanisms that everybody is comfortable with to allow that reporting to take place. That's the conversation we're engaged in right now.

● (1220)

Mr. John Oliver: That's great.

Could you give some examples of what those measures or indicators might be? I know they're under negotiation, but could you share with the committee some of the specifics from your ministry?

Mr. Simon Kennedy: As I said, I don't want to prejudge what the provinces and territories might wish to see in the conversations we're having, but I can indicate, for example, that we've been pretty clear with our partners—and they seem pretty open-minded about it—that we would like to see an important investment in mental health services aimed at young people. There's a lot of research indicating that getting to young people with mild to moderate symptoms early on has a really beneficial impact later in life, whereas if they continue with their difficulties they become progressively worse. That's something the provinces and territories have indicated they are interested in.

You could imagine an indicator, for example, about how long it takes for young people under the age of 25 or something to get access to basic mental health service, or how widespread the access is. Those are the kinds of conversations we're having now.

Mr. John Oliver: Mr. Chair, Mr. Kang would like to have 30 seconds of my time. Could you let me know when I have about 30 seconds left?

The Chair: Okay.

Mr. John Oliver: My second question is for CIHR.

There's been an investment of about $1 million over five years to do research into gender and sex effects of opioid use.

How is it progressing? How many studies have been identified? Where does this stand?

Mr. Michel Perron (Vice-President, External Affairs and Business Development, Canadian Institutes of Health Research): Indeed the issue of gender, sex, and opiate use is an important one for CIHR. Our institute of gender and health is looking at this matter on a regular basis and investing in a significant number of areas.

Most recently we attended the opiate summit co-hosted by the minister, at which we committed to launching synthesis grants in the area of opiate addiction, specifically to have a better understanding of some of the emerging science around the issue of opiates addiction, particularly concerning the way the elements of gender and sex affect opiate use and its treatment. These are commitments we have made that we are launching shortly as part of a broader package of initiatives that we're working on in this space.

Mr. John Oliver: Over the last number of years, I think before the current government, there were a lot of reductions to research funding. There were cutbacks to CIHR support, there was a slow degradation of research capacities at universities, health science centres, and across Canada.

Do you have any sense of where we're at now? Do you track the number of Ph.D.s we have, the number of Ph.D. students on track? Are we recovering as a centre of health research here in Canada, or are we still in that area where we were losing more than we were gaining?

Mr. Michel Perron: Thank you for your question, an important one indeed for us in the research community. You're quite correct that since approximately 2007 and 2008, the CIHR's budget has been effectively stable at approximately a billion dollars. This has resulted in a loss of purchasing power in terms of inflation.

That said, we've been able to offset some of these shortcomings by leveraging significant investment from many of our external partners. For instance, the investment levels from non-federal partners have grown by more than 50% to approximately $96 million in the fiscal year 2014-15.

As you know, federal budget 2017 also addressed two significant issues, climate change adaptation and the substance abuse area, for which there are investments of funds. Of course, we are waiting for the soon-to-be-announced review of fundamental science, and will be working with the minister and the government in terms of the information there.

If there are specific questions around the number of Ph.D. graduates and the like, we'd be happy, through the chair, to provide that information to you at a—

Mr. John Oliver: It would be great just to get a report on the status of the health of the human resources we have at the academic level in health science research.

Mr. Michel Perron: If you permit, Mr. Chair, a follow-up, I should mention that in budget 2016 we also allocated a specific.... I'm going to back up. It's important that as we look at the research enterprise we understand the entirety of the continuum of researchers and the importance that we continually invest on a year-to-year basis to ensure these young graduates make their way into the health research community.

We have committed a specific amount, $30 million, to ensure that early career investigators are particularly focused for ensuring granting around health research to ensure that pipeline maintains its growth going forward. We are doing that, along with other initiatives, whether it be in our post-graduate programs or working with the institutions there.

I'm happy to provide additional information—

● (1225)

The Chair: Thank you.

Mr. Kang, very quickly.

Mr. Darshan Singh Kang: Thank you, Mr. Chair.

I just want to ask of the federal government, the Minister of Health, that funding designated for mental health and home care should only go to mental health and home care initiatives. I can speak from experience, and mental health clinics and home care in Calgary do a great job. They're doing a wonderful job to keep the patients out of the hospitals. I'm speaking from personal experience. That funding should be designated to mental health care and home care, and that's where that funding should go.

Thank you very much.

The Chair: Thank you very much.

Dr. Carrie, you're going to split your time with Mr. Webber, I understand.

Mr. Colin Carrie: Yes, I am. Thank you very much.

Mr. Kennedy, could you clarify something for us. My colleague talked about the change for the health accord, the collaborative approach.

Could you confirm if all the provinces have signed on to the health accord?

Mr. Simon Kennedy: At this point, there are still ongoing discussions with Manitoba on this issue.

Mr. Colin Carrie: Okay. I just wanted to clarify that collaborative approach.

I was questioning the minister about mandatory testing, and I just wanted to clarify because I didn't quite understand your answer on it. The question is this. Is the testing of medical marijuana mandatory, yes or no? The reason I'm asking is it actually says in the article that Health Canada gave no clear answer in its brief as to why it wouldn't make testing mandatory for licensed producers. One reason given by the senior official was that he believed there are only about three labs in Canada that could perform such testing, and there would be a backlog.

Given the ramping up of the medical marijuana field, is it mandatory now? If it's not, is it because you're worried about a backlog?

Mr. Simon Kennedy: It is mandatory that licensed producers who wish to use pesticides on their crop only use of one of the 14 chemicals available. There is a short list. The rules require that if they wish to use pesticides, those are the only ones they're allowed to use. That's a condition of their licence. We do regular inspections to make sure they're doing things as appropriate.

We have not, until recently, had a program as the inspection kind of agent to be specifically testing lots of the product to ascertain whether or not they are staying within that legal requirement. We have started randomized—

Mr. Colin Carrie: So the answer is no?

Mr. Simon Kennedy: No, the answer is that we've started randomized testing to determine whether people are complying with the rules as they exist.

As I mentioned earlier, we've had a very good track record of compliance with the rules generally. We've had a couple of incidents recently involving pesticides. I would note that in each of those cases there were recalls initiated, all of the clients were contacted, and the department did a risk assessment. The risk assessment determined that the risk presented by these breaches was actually very low.

The pesticide involved—the one that you're referring to from the media article—is called myclobutanil, which is actually used on food crops. We did an assessment about one of the concerns that had been raised, which has been in the press and is about what happens if you burn this. We looked at that, because obviously people inhale—

Mr. Colin Carrie: Yes. It turns into hydrogen cyanide, which is extremely dangerous—

Mr. Simon Kennedy: Yes, but—

Mr. Colin Carrie: —and that's why I'm asking. From your answer—

Mr. Simon Kennedy: But—

Mr. Colin Carrie: If I can clarify, because I have some more questions I'd like to ask you, I asked if you do mandatory testing, and you said that the companies have a list of things they can use—

Mr. Simon Kennedy: That's right.

Mr. Colin Carrie: —but you haven't required it. Health Canada does not go in there and "mandatory-test" these companies. If they have, how often have you done the random testing? I'm just wondering. If you don't have those numbers for me, I'm okay with that. You can get back to us.

Mr. Simon Kennedy: We agreed that we would certainly provide those numbers.

I think what I would say, though, is that if you were to ask about the inspection regime and the regulatory regime of not just Health Canada but indeed most regulatory agencies, there's a risk-based element to it. You focus your resources, because obviously you can't do everything at all times everywhere. It would be prohibitive. You focus on where you see risk.

Mr. Colin Carrie: With pharmaceuticals, for example—

Mr. Simon Kennedy: If I could—

Mr. Colin Carrie: —I believe there is certain testing done, and—

Mr. Simon Kennedy: Right.

Mr. Colin Carrie: —these patients, many of them, have cancer. They have AIDS. My concern is that the demand has increased exponentially in the last few years.

I don't want to give you a hard time because I know it's all about the priorities of the government and how much money.... I didn't notice in the estimates any extra money that you're given to do these inspections, but I think that if we're mandating Health Canada for the health and safety of Canadians and we know that this is being given to patients who have cancer, who have AIDS, and who are immunosuppressed, it behooves us to ensure that those products are being tested, and not just randomly. If they are, I'm just curious: how many times have you actually tested them?

● (1230)

Mr. Simon Kennedy: I would be very happy to provide the stats. I don't have them immediately available.

With regard to the issue of hydrogen cyanide, though, and the presence of that, just by way of illustration, the amount of hydrogen cyanide you get from burning and inhaling marijuana smoke—which is what there is if you're smoking it—is in the order of 500 to 1,000 times higher than the levels that were present as a result of the pesticide residue. When you look at what's the risk presented in terms of things like hydrogen cyanide, there is actually quite a bit more just from smoking marijuana than was actually in the residue.

We are concerned, as you and others are, about whether producers are complying with the rules, so we're doing this regime to get a better handle on whether this is a more systemic problem or an isolated incident, but we are very confident that in this case there has been limited evidence to date that it's anything more than an isolated incident. The risk to Canadians was extremely low. There were recalls initiated, we know, because the licensed producers have lists of clients. We were able to reach everybody.

From a material point of view, does this present a serious risk to Canadians? All of the evidence would suggest no. In terms of where we would put additional resources at this point, we want to start with the randomized testing to get a better handle on whether or not it's a broader problem.

Mr. Colin Carrie: I appreciate the answer, but the last time we asked Health Canada to get back to us, I think it took about six months or something, right?

The Chair: You're down to a minute. Do you want to share with Mr. Webber?

An hon. member: Go ahead.

Mr. Colin Carrie: My colleague wanted to know if it's going to be six months before we get those numbers.

Mr. Simon Kennedy: I'll certainly try to get back to you as quickly as possible. I can make that commitment now.

Mr. Colin Carrie: Yes, please, if you could.

With the couple of seconds I have left, for the funding used as a bargaining tool to encourage provinces to sign on to the health accord, I was wondering what the federal government does to ensure that the funds designated to support mental health and home care initiatives will not be used for other health care priorities.

We realize that this budget has totally moved things to the back end, but as we work with the provinces and territories, are there things you have in there that will ensure the funds designated for health care and home care get used for health care and home care?

Mr. Simon Kennedy: Certainly, the government has been pretty clear about that in its public statements and in what the minister has said publicly and with her colleagues, and certainly the instruction I would be operating under as an official is that this is the objective that we want to see achieved.

We have been talking to the provinces and territories around how they wish to spend the money in those priority areas, and then how we would account for that publicly: what kinds of indicators would we use to demonstrate that this was happening? That is certainly the objective, and we'll be trying to pursue that.

Mr. Colin Carrie: Okay.

The Chair: Time is up.

Mr. Davies.

Mr. Don Davies: In June 2016, Mr. Paul Mayers, the vice-president of policy and programs of CFIA, testified to this committee that CFIA inspectors are present every day and during every shift in federally regulated meat slaughter plants. He said, “CFIA inspectors visit those plants every day, every shift but they are not present 100% of the time. It is an inspection done every single shift.”

In June of 2016, Mr. Bob Kingston, president of the Agriculture Union, indicated to this committee that the statement made by Mr. Mayers was false. Now in response, CFIA clarified that:

> ...while its targets are not met in all cases 100% of the time, it operates at or close to target a significant majority of the time. The nature of CFIA's operations is impacted by fluctuations in demand for service, response to emergent events and occasional challenges in filling vacancies promptly.

Leaving aside the question of the discrepancy in testimony, in the 2017 departmental plan, CFIA indicates that it intends to reduce full-time-equivalent positions in the food safety program over the next three years. Given that it's recognized that inspection staff have already been scratched and are certainly not present in all shifts for meat inspections at slaughter plants, how do you anticipate this cut will affect the delivery of program direction?

● (1235)

Mr. Paul Glover (President, Canadian Food Inspection Agency): It's very important, and I appreciate the opportunity to follow up on my response to the committee and to provide further insight into this important issue. I have two parts to the answer if I may.

Inspector numbers do fluctuate. I'm happy to be more transparent about them. We intend to put those up on our website on a regular basis. Seasonal activities, summertime, are more intense. We'll have more seasonal inspectors for cash crops, those sorts of things. Most recently over the winter months with the bovine tuberculosis outbreak there was a need to reassign resources to deal with that emerging issue. So the numbers do move. That is part of the reality and an expectation of this committee that we are nimble and moving to where the risks are to best protect and serve Canadians. So we will do that absolutely moving forward in as transparent a way as we can to make sure that people are confident about what risks they are seeing and where we are deploying our resources.

With respect to adjustments to our budget, I can assure the committee that all of them are related to sunsetting programs, to time-limited initiatives like the introduction of electronic service delivery platforms. Where we used to manually do import and export certificates, those are now being automated, done online. People are able to self-serve so that we don't have to have people doing that. We have a number of resources dedicated to standing up of those sorts of infrastructure. There was also money to invest in our labs. The reductions are planned. They are related to sunsetting programming, and we are making every effort to preserve our inspection resources and prioritize them and not touch them with any of the reductions moving forward.

Mr. Don Davies: Mr. Glover, are you saying there will be no reductions in FTEs for meat inspectors?

Mr. Paul Glover: As I said earlier, those number will fluctuate. We do see retirements. In some instances there will be difficult-to-staff areas. We're happy to to be accountable, show you where those numbers are moving. Our objective is to prioritize and not reduce front-line inspection activities, absolutely.

Mr. Don Davies: Thank you.

Mr. Kennedy, I think you may be the right person to ask about the health accord. The minister made reference to several billion dollars of federal money being transferred to the provinces for mental health. Are there any conditions attached to ensure that the provinces will spend that money on mental health?

Mr. Simon Kennedy: That's the conversation we're having right now with the provinces and territories. In the announcement the government made as it reached funding agreements with each province and territory you would have seen, perhaps, a discussion about how the next step is to sit down and—this is my paraphrasing—figure out how we're going to spend the money, what the targets and indicators will be. The objective is to ensure that those funds go toward mental health and home care. We will be working on a multilateral agreement with the provinces and territories to put down how we would see reporting working collectively as governments and how we will set priorities. Then the objective is, with each jurisdiction, to have a kind of bilateral agreement, almost an annex to the broader, multilateral document that specifies, let's say in B.C., how B.C. is going to spend that money on home care, on mental health, and have that level of specificity.

Mr. Don Davies: Mr. Kennedy, it sounds as though the agreements are not done yet. What if you can't reach agreement on that? The minister has announced that we've come to an agreement with nine provinces, so we've done the agreement; we get the fanfare and the media, and here's the amount of money that we're giving to them. But if one of the provinces says it's not committing to spending that money for mental health or mental health necessarily, what happens to the agreement?

Mr. Simon Kennedy: What I can say is that to date, frankly, there has been very good collaboration with the provinces and territories. I can speak only as an official, but at the level of deputy minister and senior officials, there have been lots of conversations over the last 14 or 15 months. Indeed, we've had great suggestions and great discussions with the provinces and territories about what they'd like to see, for example, in the area of mental health.

Focusing on youth is something the provinces and territories actually said was a big priority for them.

Mr. Don Davies: Could you envision them coming to an agreement?

Mr. Simon Kennedy: I think so. Yes. Obviously, there is more water to go under the bridge, but we've had great discussions to date. I think every signal was that the provinces and territories were anxious to get moving.

Mr. Don Davies: Are there actually written documents, written agreements with each province, that exist now? Is there anything that has been signed by each province as a condition of signing on to the health accord? Also, could we get a copy of those?

Mr. Simon Kennedy: There are the announcements that have been made jointly with the various provinces and territories on the funding issue, which is an agreement on the funding levels.

We are now working on what you might call the documents related to the content. For example, just to take things province by province, our objective is that we will have a signed agreement with B.C., an annex to the kind of broader framework that would say, “here's what we're going to do in B.C.” We're working on that.

I'm not going directly from here to a meeting with B.C., but we've been working on that all along, and the objective would be that in the next short order we would have those signed.

Mr. Don Davies: Have any been completed between the federal government and any province to date?

Mr. Simon Kennedy: None have been yet, and that's been a function of the discussions that have been ongoing about the money, leading up to the budget. We've been waiting until the budget step was done. We're now actively going back and having that conversation.

● (1240)

The Chair: Your time's up.

Dr. Eyolfson.

Mr. Doug Eyolfson: Thank you. I'll be sharing my time with Ms. Sidhu.

With the 2017-2018 departmental plan, one of the priorities is an initiative relating to the action plan on opioid misuse. It emphasizes harm reduction and public health, including consideration of the Controlled Drugs and Substances Act. The amount is going to be just under $89 million for 2017-18.

Can you comment on what aspects of the action plan the spending increase will be used to implement? It's an increase of 1.3%.

Mr. Simon Kennedy: There's a lot of work on opioids under way in the health portfolio right now. I could give you a catalogue of the areas that we're working on, the priorities.

With regard to the money in the budget, the government has not to date come out and publicly said this is the specific breakdown of how the new funds will be spent, but my understanding is that will be happening shortly. I wouldn't want to pre-empt the minister or the government in that regard.

Some areas are priorities for us. For example, we have laboratories across the country that do analysis of drug samples seized in raids by the police and that sort of thing. Obviously, because of the rise of synthetic opioids, the demand for those laboratory services has gone up significantly. The provinces have asked for additional assistance from our laboratories. So one area of priority for us going forward with some of the resources we received is going to be a substantial increase in the ability of our labs to respond to the opioid crisis, as well as an ability to analyze substances more quickly, and perhaps more public reporting, better assistance to provinces, and so on. That would be one example.

When Bill C-37 goes through, we want to be able to more expeditiously process requests for things like supervised consumption facilities. That's an area we want to beef up.

We have been doing a lot of work on the regulatory side to try to support provinces in enabling access to new therapies as an example. That's another area that we've been prioritizing.

I know the Public Health Agency has been doing a lot of work as well. I'm sure it could speak to some of the things it's doing. There's a long catalogue of initiatives we're working on. We would use the new resources to support those kinds of activities.

Mr. Doug Eyolfson: Thank you.

Mr. Simon Kennedy: I have one more example, and I think it's powerful. We have been working with an expert panel over the last number of months, and one of the things we're looking at is the monographs for all opioid drugs right now. As you would know, these are the labels that effectively tell practitioners what a drug can and can't be used for.

We're looking at whether it would be wise to add additional contraindications to monographs, which obviously would cause physicians, even for off-label use, to think twice about whether to use an opioid where doing so is definitely contraindicated. We'll be getting that expert advice shortly.

If we were to update product monographs for a large number of opioids, that obviously would involve a lot of work and a lot of expense, so again this is an area in which we might want to prioritize some of the funds the federal government receives for our regulatory system to actually have better labelling and better guidance to practitioners.

Mr. Doug Eyolfson: All right.

Do you anticipate that these funds will be sufficient to fully implement that plan, or do you anticipate that we might need more funds for this than what have been allocated in the increase?

Mr. Simon Kennedy: I wouldn't want to prejudge what we may advise the minister for the next budget round and so on. We think that the resources that have been provided are substantial and are going to be very helpful in our ability to advance the priorities that the government set out.

This is a top priority, so where we may feel additional resources are needed, we will do our best to reallocate internally. I think we're pretty comfortable that we're seeing a significant increase in funding.

● (1245)

Mr. Doug Eyolfson: All right, thank you.

I'll hand the floor over to Ms. Sidhu.

Ms. Sonia Sidhu: Thank you.

My questions are to the Public Health Agency of Canada.

In 2017-18, I know that $2 million is being transferred to CIHR to support the Canadian Immunization Research Network. What steps is the Public Health Agency of Canada taking to improve immunization coverage to reduce vaccine-preventable disease rates?

Dr. Theresa Tam: We have received $25 million over five years to improve vaccine coverage rates. There are several different components to that. One is to reset those targets to make sure they are still where we want to hit, have better ways of methodology for estimating vaccine coverage. We're also supporting up to $1.2 million, up to six research teams for two years, to look at identifying where those underimmunized populations are and why they are underimmunized, the reasons behind that.

We are transferring $2 million to partner with the CIHR to leverage on an existing network, the Canadian Immunization Research Network. That research network has a lot of great scientists collaborating across Canada. It already exists. They will look, from a scientific evidence perspective, at behavioural characteristics of vaccine acceptance and methodologies to improve uptake.

Finally, we will have an immunization partnership fund. That fund will leverage provinces, NGOs, and other stakeholders to look at implementing interventions that would work to increase immunization coverage rates.

Ms. Sonia Sidhu: Also, can you explain the action to address antimicrobial resistance in Canada? What role does the Public Health Agency of Canada play in both the development and implementation of this framework? Can you explain the action plan, what steps you are taking?

Dr. Theresa Tam: We already have in place a federal framework and action plan. I've been playing some leadership role in putting together a cross-sectoral agriculture, animal health, human health, pan-Canadian framework. That involves all of the people, the health portfolios sitting here—CIHR, Health Canada, CFIA—as well as other government departments that will come up with the pan-Canadian framework. We're targeting that to be ready around May, which is our commitment to the World Health Assembly to deliver that.

After that, we will have a more precise look at specific actions. They are in the areas of better data and surveillance on the agriculture and human health side, looking at how we improve the appropriate use of this very important resource, what we call stewardship. It's to improve infection control practices, and also research and innovation, looking at diagnostics, at new tools to combat antimicrobial resistance.

The Chair: Okay, thank you. The time is up.

That concludes our questions. We want to thank the witnesses for their attendance today and their patience with us. I want to thank the members of the committee for their questions.

I have a couple of little committee issues....

Yes?

Mr. Len Webber: Just very quickly, there were a number of questions asked today to our guests regarding follow-up. I'm wondering if we can agree on an appropriate time for that to come back to us, and to have it come through you, Mr. Chair, so you can get it to us.

I know that in the past it's taken quite long to get information on questions we've asked. We're hoping to get at least something decent in a time frame.... Perhaps in two weeks you can come back to us with the question and the figures that we've asked for, specifically on Lyme disease.

The Chair: Is two weeks a reasonable deadline? We've recorded all the questions and all the information that's required.

Mr. Simon Kennedy: Our suggestion, from conferring with colleagues, is that there's a lot of material. Certainly in my area we could do this in two weeks, I think, fairly easily. Dr. Mithani was saying that there may be some data that might take a little longer to get.

We could commit to trying to get everything in two weeks, and if not, to deliver what we can and then do a second follow-up tranche if that's acceptable to the committee.

● (1250)

The Chair: Is that acceptable?

That works.

Mr. Len Webber: Should there be a motion put down with regard to times?

The Chair: That's all right. We have a commitment, and we'll follow up on it.

Thanks very much again.

On committee business, we have cancelled our meeting for April 13—I want to make sure everybody knows that—but we need a deadline for witness lists for the thalidomide study, which is on May 9 and 11. I'm going to propose that we make that deadline as of next Thursday. That's the last sitting day of next week before the two-week break.

Could I have a motion that April 13 be the deadline for the thalidomide study witnesses?

An hon. member: I so move.

(Motion agreed to [See *Minutes of Proceedings*])

The Chair: That's it. Thanks very much, everybody.

The meeting is adjourned.

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