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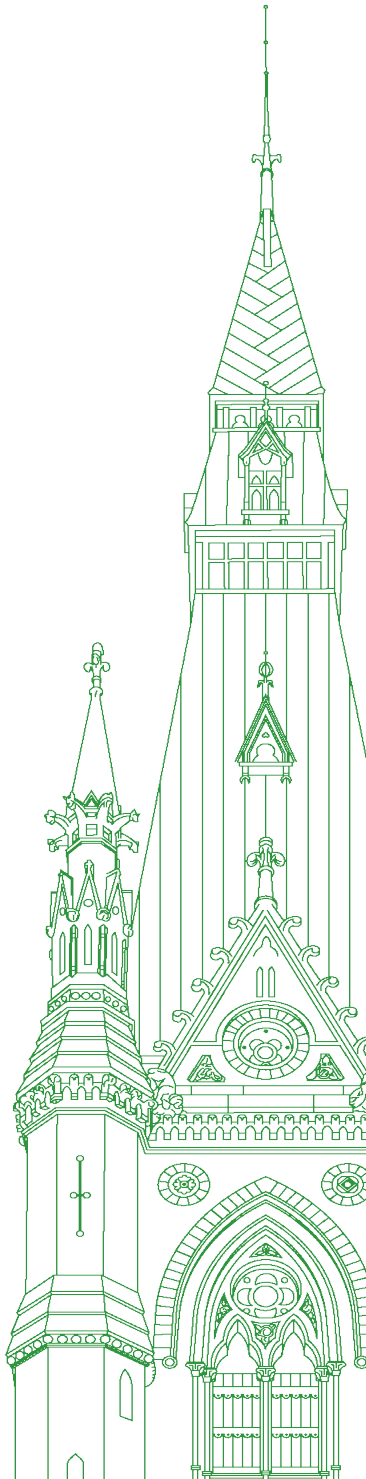

Chair: Mr. Ron McKinnon

Standing Committee on Health

Friday, December 11, 2020

● (1300)

[*English*]

The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)): I call this meeting to order.

Welcome, everyone, to meeting number 13 of the House of Commons Standing Committee on Health. The committee is meeting today to study the Patented Medicine Prices Review Board's guidelines. Then we will proceed to the clause-by-clause consideration of Bill C-210, an act to amend the Canada Revenue Agency Act, regarding organ and tissue donors.

I thank the witnesses for appearing today. From Best Medicines Coalition, we have John Adams, who is the board chair. From Boehringer Ingelheim Canada Limited, we have Mehmood Alibhai, director, national policy and patient access, and Annie Beauchemin, executive director, patient access, pricing, health care affairs solutions. From Canadian Life and Health Insurance Association, we have Stephen Frank, president and chief executive officer, and from Independent Voices for Safe and Effective Drugs, we have Colleen Fuller.

I will start the meeting by providing you with some information, following the motion that was adopted in the House on Wednesday, September 13, 2020. The committee is now sitting in a hybrid format, meaning that members can participate either in person or by video conference. All members, regardless of their method of participation, will be counted for the purpose of quorum. The committee's power to sit is, however, limited by the priority use of House resources, which is determined by the whips. All questions must be decided by recorded vote unless the committee disposes of them with unanimous consent or on division. Finally, the committee may deliberate in camera, provided that it takes into account the potential risks to confidentiality inherent to such deliberations with remote participants.

The proceedings will be made available via the House of Commons website and, so you are aware, the webcast will always show the person speaking rather than the entirety of the committee.

To ensure an orderly meeting, I will outline a few rules to follow. Members and witnesses may speak in the official language of their choice. Interpretation services are available for this meeting. You have the choice at the bottom of your screen of floor, English or French. Before speaking, click on the microphone icon to activate your own mike, and when you have finished speaking, please put your mike on mute to minimize any interference.

As a reminder, all comments by members and witnesses should be addressed through the chair. Should members need to request the floor outside their designated time for questions, they should activate their mike and state that they have a point of order. Members should do likewise if they wish to intervene on a point of order that has been raised by another member. In the event that a debate ensues, members should use the "raise hand" function, which will signal to the chair your interest to speak and create a speakers list. In order to do so, you should click on "Participants" at the bottom of the screen. When the list pops up, you will see next to your name that you can click "raise hand".

When speaking, please speak slowly and clearly. Unless there are exceptional circumstances, the use of headsets with a boom microphone is mandatory for everyone participating remotely. Should any technical challenges arise, please advise the chair. Please note that we might need to suspend a few minutes, as we need to ensure that all members are able to participate fully.

For those who are participating in person, proceed as you usually would when the whole committee is meeting in person in a committee room, keeping in mind the directives from the Board of Internal Economy regarding masking and health protocols. Should you wish to get my attention, signal me with a hand gesture, or at an appropriate time, call out my name. Should you wish to raise a point of order, wait for an appropriate time and indicate to me clearly that you wish to raise a point of order.

With regard to a speaking list, the committee clerk and I will do the best we can to maintain a consolidated order of speaking for all members, whether they are participating virtually or in person.

Thank you all for listening to that long housekeeping speech one more time.

Before I ask the witnesses to make their statements, I will advise the committee that we have received a letter from the law clerk indicating the status of the document production order. I would ask the committee for authorization to make this letter and its addendum public.

Do I have the approval of the committee to do this?

Some hon. members: Agreed.

The Chair: Thank you. The letter will be made public.

We will now continue with the witnesses.

Witnesses will have up to 10 minutes to make their statements. I will be using cards, a red card and a yellow card. The yellow card means there's one minute before your time is up. When you see the red card your time is up, so please try to wrap up fairly quickly. Thank you, all.

We'll start with the Best Medicines Coalition.

Mr. Adams, board chair, please go ahead for 10 minutes.

Mr. John Adams (Board Chair, Best Medicines Coalition): Chair and members, we appreciate your invitation to be here today, and we thank the committee and staff for their work throughout the pandemic challenges.

I represent a coalition of 30 patient organizations, national and regional, working together through the Best Medicines Coalition to support patients and advocate for better access to life-saving medicines. I volunteer as the chair of the board of directors of BMC.

Our non-profit supports any actions by governments, public or private insurers and civil society that can deliver greater access to medicines for Canadian patients. We're a small but mighty organization made up of broad-based charities and grassroots groups, including the one I lead, Canadian PKU and Allied Disorders, which involves rare brain-threatening diseases. These groups involve patients and caregivers to improve care and are active in research, patient services, education and issue advocacy.

BMC member organizations include diverse conditions, including mental illness, arthritis, asthma, blindness, Parkinson's, psoriasis and cancers, including breast, kidney, lymphoma and ovarian, and their survivors.

I am here today as a patient advocate, because when our youngest child arrived, the miracle of universal newborn screening discovered his rare genetic condition, enabling immediate therapy. As an adult, he volunteered for a clinical trial for its first drug, and that drug transforms his brain and life. His mother, my wife, died in 2014 of two neurodegenerative diseases, ALS and FTD, which still do not have effective treatments. It is a big deal when we can move lethal diseases like ALS from untreatable to treatable, and it is a big deal when we can permanently fix genetic problems, such as my son's, in the new era of cell and gene therapies.

Let me address the important question of real, perceived or imagined conflicts of interest. I happily completed the committee's disclosure form and want to address how the Best Medicines Coalition funds and governs its activities. We do not sell a service. We do not have union or other dues. We don't have university tenure or other job security. We don't charge patients to advocate on their behalf.

If governments establish a means to fund our efforts to support patients in the public interest, we will apply for that funding. This is not without precedent, as it exists in the context of climate change advocacy, telecommunications regulation or legal challenges for human or charter rights. We ask HESA to recommend such public interest funding.

BMC accepts funding from the pharmaceutical industry for our patient support activities. We make no secret of this and are aware of possible perceptions. It is why this funding is received with an explicit agreement that funding does not influence our policies, advocacies or operations in any manner. All activities and interactions are pursued within a framework of integrity. BMC and its member organizations adhere to a code of conduct regarding funding, which is publicly available on our website. All initiatives are conceived and developed in and by the organization, aligned with its missions and goals, without influence from any funder on content, messaging or execution. I'd be pleased to answer questions on this, and I trust that we all must be transparent about all our conflicts, perceived or otherwise.

The matter at hand today is the government's approach on drug prices and the critical risk this poses to some Canadian patients. Our focus is ensuring that all Canadians have access to medicines needed when needed. Medical necessity is paramount for all patients. We support the need to make medicines more affordable for all patients, especially those who pay out of pocket, and we support the goal of actual prices in line with similar countries. We also believe regulations and guidelines must encourage, not deter, new medicines and vaccines plus those clinical trials sponsored by drug developers, which are important to patient volunteers in providing early access to promising new therapies, as was the case for my son.

There's a natural tension between how much insurers are willing to pay and patient access to medicine. Whether we like it or not, pharmaceuticals are a global market and Canada is competing globally to be an attractive market. This is clear in terms of medicines, vaccines and PPE.

If Canada regulates prices too low, the patients we represent will not gain access to life-altering or life-saving medications. If prices go too high, public insurance systems could become overwhelmed and unsustainable. This would be disastrous for patients and taxpayers alike. The challenge for Parliament, government and PMPRB is to balance those interests. It's not an easy task.

The government and PMPRB decided to move forward with their approach despite uncertainties on patient impacts. This is at the core of our concern. At this committee, PMPRB was unable to tell when certain conditions in the guidelines will come into effect. Consider that a global entity is deciding on the sequence of product launches and Canada's processes and pricing rules lack clarity for the foreseeable future, why would it be a surprise that a new medication or indication would not be launched in Canada?

● (1305)

This government is unwisely taking on significant risks and the consequences will be borne by patients. We are not willing to provide informed consent. As written, the PMPRB regulations and guidelines have not balanced price and access. Specifically, anticipated price reductions go beyond original intent, and initial evidence shows significant negative impact: a decline in new drug introductions and reductions in new clinical trials.

This government confirmed the legitimacy of these concerns and, in my view, lost the moral high ground when it exempted COVID vaccines and drugs from the PMPRB rules. Why exempt COVID and not other lethal diseases?

A frequent criticism is that few new drugs provide significant additional benefits to patients. COVID vaccines reveal this but also show that it's not helpful. We have one approved vaccine today. It is a breakthrough. Other vaccines may be approved, but the others will not likely offer a substantial clinical benefit over that first approved vaccine. It's clear that our health systems and individuals will benefit substantially from access to many approved vaccines, even if only the very first one is a breakthrough. That is how innovation works.

A key marker for patient communities is whether medicines will be available to Canadians both affordably and in a timely manner. Since the announcement of the new rules, applications for new drugs have declined compared to similar countries. This is troubling.

Health Canada and PMPRB want to lower drug prices to reflect what the public health system is willing to pay or able to pay. Nothing in these changes makes it certain that health systems will deliver patient access to medicines at these prices. There could be a double whammy for patients. Price regulations might mean new drugs will not come and, if they do finally come, the system still may not cover them.

We wish to express four recommendations for this committee to consider.

First, the Best Medicines Coalition supports step-by-step implementation to lower drug prices. PMPRB indicated some phasing. They did not articulate when and what would be phased. We ask for clarity and decisions based on best evidence. We urge this committee to recommend that the federal government, through cabinet, direct a stay of implementation of parts of the regulations and guidelines, deferring the novel economic factors to a second stage pending further study and consultation. The new basket of comparator countries should proceed to bring down list prices immediately, especially for those patients who pay out of pocket, which, I point out, represents 21% of all drug spending in Canada.

Second, BMC recommends that this committee call for greater policy-making disclosure, and we support any efforts of the committee to bring about that transparency. The government should disclose inputs provided as part of formal consultations and otherwise, including analysis of the nature and breadth of concerns and how concerns have been addressed or will be mitigated. Further, it is important that the government and PMPRB disclose correspondence and other inputs from provinces and territories.

Third, the Best Medicines Coalition asks that this committee recommend that the government develop and publish comprehensive evidence, including initial impacts on critical markers of policy success or failure; that is, key metrics of introductions of new medicines and initiation of clinical trials sponsored by drug developers. There is a need for disclosure regarding the government's and PMPRB's assumptions, which the regulations and guidelines rely upon. We urge this committee to request that the PMPRB case studies on specific drugs back in 2018, prepared to show the impact of possible proposals, be updated and published based on the final regulations and guidelines.

Fourth, the Best Medicines Coalition asks that this committee recommend that the government study and provide public interest funding so that the voices of patients and their needs and interests can be more adequately represented in public policy and regulatory matters, including PMPRB.

I would be pleased to answer any questions.

Thank you.

● (1310)

The Chair: Thank you, Mr. Adams.

We'll go now to Boehringer Ingelheim Canada Limited, with either Mr. Alibhai or Ms. Beauchemin.

Please go ahead for 10 minutes.

[*Translation*]

Ms. Annie Beauchemin (Executive Director, Patient Access, Pricing, HealthCare Affairs Solutions, Boehringer Ingelheim Canada Ltd.): Good afternoon.

[*English*]

My name is Annie Beauchemin, and I'm with Boehringer Ingelheim. I am joined by my colleague, Mehmood Alibhai.

Thank you, Mr. Chair and honourable members of the Standing Committee on Health, for the opportunity and for inviting us to provide testimony today. We appreciate it, especially given the circumstances we find ourselves in.

As we all know, the COVID-19 pandemic has truly transformed our society this year. We want to start by thanking you for all your ongoing work in the face of adversity, particularly your efforts to continue the important work that Canadians elected you to undertake in Parliament.

Since Boehringer Ingelheim began operating in Canada almost 40 years ago, we have proudly played an integral role in the health of Canadians. Headquartered in Burlington, Ontario, we employ approximately 600 people across Canada, and we are committed to finding medical breakthroughs and investing in research, development and medicine therapies that fulfill unmet medical needs.

We're a different kind of company in that we are one of the world's leading pharmaceutical companies, but what makes us unique is the fact that we're still family owned. We were founded over 130 years ago by Albert Boehringer, and we strive each day to live up to the high ethical standards he set.

Albert Boehringer set the tone for the company culture that we continue today, which prides itself in supporting employees and our local communities, guided by our values of trust, respect, empathy and passion for the work we do. Our vision is value through innovation. Simply put, this means that we aim to find new ways to improve health and provide value by being innovative. We are committed to the development of innovative, cost-effective medications that, again, fulfill unmet medical needs,

Through our participation in medical and pharmaceutical research for both humans and animals and health system change projects—we have many of those—we have contributed to the significant improvements in health care and have developed innovative and cost-saving medicines.

Our health care system improvement projects are pharmaceutically agnostic—they are unbranded—and the Boehringer family mandates that we have these initiatives that focus on optimizing patient outcomes and improving health—

● (1315)

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Excuse me, Mr. Chair.

Excuse me, Ms. Beauchemin.

There hasn't been interpretation for some time.

Also, Mr. Chair, I hope it won't happen again, but you may have noticed that I was disconnected for quite some time during Mr. Adams' testimony. So it's not a good day for us in terms of logistics and hardware.

If you could find out why I don't have an interpretation anymore, that would be very helpful.

Thank you.

Ms. Annie Beauchemin: Would you like me to continue?

[*English*]

The Chair: Thank you, Mr. Thériault.

Ms. Beauchemin, would you back up just a paragraph or two? I'll stop your time, and we'll see if the translation is coming through.

Go ahead, please.

Ms. Annie Beauchemin: Our vision is value through innovation. Simply put, this means we want to find new and better ways of improving health, and we provide value by being innovative. We are committed to the development of innovative, cost-saving medications that fulfill unmet medical needs.

Through our participation in medical and pharmaceutical research for both humans and animals and health system projects—we have a number of those ongoing—we've contributed to significant improvement in health care and have developed innovative and cost-effective medicines.

Our health care system improvement projects are unbranded and pharmaceutically agnostic. The Boehringer family mandates that we have these projects that focus on optimizing patient outcomes and improving health system efficiency, contributing to the sustainability of the health care system.

In Canada, Boehringer Ingelheim conducts and sponsors clinical trials to establish the safety and efficacy of the drugs we develop. Our key therapeutic areas in Canada are cardiometabolic diseases, specialty care including oncologies such as lung cancer and progressing fibrosing lung diseases, and respiratory diseases such as asthma and chronic obstructive pulmonary disease.

In a given year, Boehringer Ingelheim is involved in up to 70 clinical trials. As you can imagine, 2020 has not been a restful year for us either. Since we understood what the world was facing with COVID-19, we've been hard at work to understand the virus and create innovative ways to stem its catastrophic effects on our society and our most vulnerable.

In addition, we've been actively testing existing and new compounds that can help to prevent or alleviate some of the devastating organ damage experienced by individuals who contract COVID-19. We are now in phase two of a therapeutic option that could help up to 85% of our sickest patients afflicted with COVID-19 and who are admitted to ICUs with acute respiratory distress syndrome. Should the therapy be approved, it will reduce the need for ventilators among the most severely affected patients.

As a company founded in 1885, more than a century ago, we've always taken the long view of our work's impact. We plan in generations and focus on long-term performance. Being independent and family owned allows us to pursue that vision that we believe, in turn, has allowed us to have the greatest impact in life sciences.

Independence also allows us to pursue initiatives and endeavours where we believe we can do the most good. It means we can focus on solving some of the most complex health problems our country faces and give us an opportunity to be involved in evolving the patient experience and creating lasting change.

We've been involved in these system-changing initiatives for almost a decade in Canada. Unfortunately, none of the resources we've invested in these areas and in these projects are recognized by the Patented Medicines Prices Review Board.

For example, in September 2020 we were pleased to announce the creation of Bridging HOPE, helping others through palliative care education, an industry-first collaboration with Pallium Canada to improve the quality and accessibility of palliative care in Canada. Together we're equipping health care providers with the skills and tools to provide better palliative care and support patients with life-limiting illnesses and their families, addressing an urgent need that will only increase as our population ages.

I'll go over to you, Mehmood.

● (1320)

Mr. Mehmood Alibhai (Director, National Policy and Patient Access, Boehringer Ingelheim Canada Ltd.): Thank you, Annie.

Thank you, Mr. Chair, and honorary members as well.

As a demonstration of our commitment to work with Canadians to solve problems that result in optimized outcomes, for the past three years we have been working with an indigenous-led health policy group to develop an indigenous health policy framework. I should say that one of you has participated in this endeavour. A number of you have been briefed about the work we're doing with the indigenous population.

This indigenous-led, indigenous-informed framework will guide, again, the principled approach that Boehringer will engage in with indigenous communities in partnerships in health system solutions, which are, as Annie mentioned, pharmaceutically agnostic. That is the mandate of the family. That again demonstrates our commitment.

Our mission compels us to invest deeply in research and innovation to bring some of the most advanced therapeutics and medicines to Canadians. The latest regulations would jeopardize our ability to continue funding these innovative projects and research.

Boehringer Ingelheim supports a sustainable health care system in Canada and invests heavily in R and D. We expect to bring new medications to market, and Canadians benefit from early access to life-changing medications through clinical trials, and thereafter, as a prioritized country seeking regulatory review and the launch of new drugs.

However, the model that has enabled us to serve our patients for over a century is threatened by the final guidelines issued by PMPRB. Simply put, we believe the guidelines will ultimately discourage or significantly delay the introduction of new, life-saving medicines and investments in research and development, and delay performing clinical trials in Canada and the prioritization of Canada as a market to launch new medicines.

This point cannot be ignored. The intent of the PMPRB will not matter if it ultimately creates fewer innovative medicines and treatments, fewer clinical trials, fewer innovative health care system change partnerships and less access for Canadians. Intention needs to be met with well-considered, well-developed policy, and that is not where the PMPRB has currently landed with its guidelines.

One of the central principles of the life sciences industry is a predictable process by which patentees can access the market for a drug, invest in research and innovation, and bring it forward for approval to be given to the patients who need it the most. The guidelines bring the PMPRB outside of its original intent as a patent abuse regulator and represent a substantial incursion into an exclusive provincial jurisdiction, namely price control. This process will undermine activities exercised by the provinces that today include input from patients and experts. PMPRB will create significant uncertainty for any company considering investing time and resources in bringing forward innovative medicines.

In keeping with the time, we urge the committee and the federal government to reconsider these guidelines and the regulations that underpin them. The current guidelines are creating uncertainty and will create unintended consequences on business viability and, therefore, access to life-saving drugs for patients.

Once again, Mr. Chair, honorary members, thank you for the opportunity to present and provide the briefing from Boehringer Ingelheim's perspective. We look forward to discussing this important topic, which will shape the future of health care in Canada.

Thank you.

The Chair: Thank you, Mr. Alibhai.

We go now to the Canadian Life and Health Insurance Association. We have Mr. Frank, president and chief executive officer.

Please go ahead for 10 minutes.

● (1325)

Mr. Stephen Frank (President and Chief Executive Officer, Canadian Life and Health Insurance Association): Thank you, Mr. Chair and members of the committee, for giving us the opportunity to speak with you today.

[*Translation*]

Thank you for inviting me to talk to you today as part of your study on Patented Medicine Prices Review Board's guidelines.

The Canadian Life and Health Insurance Association is a voluntary association with member companies which account for 99% of Canada's life and health insurance business. These insurers provide 29 million Canadians with products that contribute to their financial security, including supplementary health insurance.

[*English*]

Our members strongly support the amendments that have been proposed to the Patented Medicine Prices Review Board and that are coming into effect on January 1. Our member companies, which include non-profit regional health insurers, provide prescription drug and other health benefit plans to over 142,000 businesses, large and small, across Canada. Over 26 million Canadians depend on these workplace insurance plans for such benefits as prescription medication, dental care, eye care, physiotherapy and mental health supports.

With so many Canadians struggling and worrying about their family's health and security, now more than ever Canadians want to know what they can count on. Canadians with workplace plans want to know they can count on those plans to be there when they need them. We know that 87% of Canadians value their existing coverage. Moreover, we know that while all Canadians support smart reforms to improve the current system, they do not want it to disrupt their existing coverage.

[*Translation*]

For the past nine months, as the COVID-19 pandemic has unfolded, insurers have been working with employers to ensure that Canadians can continue to rely on their workplace plans. To help them through this difficult time, employers have received direct assistance of several hundred million dollars, including discounts and premium reporting.

Like the health care system in general, private insurance plans were put to the test by the COVID-19 pandemic. I'm pleased to say that workplace plans have passed the test. The health crisis has shown that these plans are resilient.

[*English*]

More than 98% of the 26 million Canadians who had coverage through their health benefit plans in March continue to be covered. Canadian employers and their employees continue to rely on these plans for a wide range of supplementary health benefits, as I mentioned above. However, we cannot take this for granted.

Rising drug costs have been and will continue to be a strain on the sustainability of drug programs, both public and private, going forward. High and rising drug costs are a challenge that must be addressed. Currently, Canadians pay some of the highest prices in the world for patented medicines. These costs put pressure on both employer-sponsored and government plans. That's why the amendments to the Patented Medicine Prices Review Board are so important.

[*Translation*]

Over time, these changes will bring Canadian prices more in line with those in other prosperous countries around the world. This will lead to savings for Canadian provinces and employers, savings that will not only make programs more viable, but will also give them the ability to cover new drugs on the market, which are often very expensive.

It's not just about helping public and private insurance plans. The reforms will translate directly into savings for those who pay out of pocket.

[*English*]

Ultimately, we believe these amendments strike the right balance between reducing the high cost of prescription drugs in Canada, while also ensuring Canadians have access to affordable and necessary medications. As I mentioned, our life and health insurers are proud of the steps we've taken to keep workplace plans in place and provide benefits for 26 million Canadians. Ensuring we pay a fair price relative to other developed countries is important if we're to sustain coverage for Canadians into the future and make fiscal room to cover the newer, expensive medications that are in development.

After consultations that have spanned several years, the PMPRB put forward their final guidelines earlier this fall. Canada's life and health insurers are strongly supportive and urge members of this committee to support their implementation as planned on January 1. These are concrete and immediate measures that will lower patented drug costs for all Canadians and contribute to the future sustainability of prescription drug plans.

Thank you for your time. I look forward to your questions and the opportunity to provide additional detail to help your study if you have any questions for me later.

Thank you, Mr. Chair.

● (1330)

The Chair: Thank you, Mr. Frank.

We will go now to the Independent Voices for Safe and Effective Drugs.

Ms. Fuller, you have 10 minutes, please.

Ms. Colleen Fuller (Representative, Independent Voices for Safe and Effective Drugs): Thank you, and many thanks to the standing committee for inviting our organization to appear before you today.

I'm joining you from western Canada, the beautiful unceded territories of the Musqueam, Tsleil-Waututh and Squamish nations.

Our group focuses on overall pharmaceutical policy, but many of us also have expertise in specific areas, including drugs to treat cancer, Alzheimer's and other conditions. My expertise is in the area of drugs to treat diabetes, with a focus on insulin.

The first time I appeared before the standing committee was in 2003. I was part of a national campaign, organized by a group called the Canadian Society for Diabetic Rights, to fight for ongoing access to animal-sourced insulin products. I appeared during the two days of hearings that the committee conducted to study the issue.

Insulin is sometimes called the "poster child" for pharmaceutical supply issues. Between 1995 and 2006, 26 different types of insulin were withdrawn from the market by Eli Lilly and Novo Nordisk, a move that left almost 45,000 people scrambling to find appropriate alternatives. That move had nothing to do with the safety and efficacy of the insulin products, all of which had been standard treatment since the 1950s and earlier.

The withdrawals were part of a marketing strategy to force people to switch to much higher-cost brands. At the time, and because of the work of this committee, Health Canada acknowledged that there was a significant minority of people whose lives and safety depended on ongoing access to animal insulin, and at the urging of the committee the ministry worked, and in fact, continues to work to this day, to ensure access.

What that experience taught me is that there are two key barriers that patients confront when trying to access medicines. One is supply, and the other is affordability.

It's the job of the price review board to ensure that the introductory price of new drugs is fair. Our organization supports the PMPRB as an important regulatory tool, and we've spent the previous year and more arguing for stronger guidelines. We were pleased earlier this year to see that the guidelines developed by the board took a positive step in that direction. While there is always room for improvement, we hope the committee will support the price review board and, in fact, recommend that its role be strengthened even more.

The decisions of the price review board have a ripple effect across the country and they contribute either to fairness or to inequality in access. As the story of Lantus insulin shows, which was part of the brief we submitted, a decision that results in unreasonable prices for drugs shifts a significant burden to consumers, as well as to public and private insurers.

In the case of insulin, the overwhelming evidence showed that recombinant human insulins, which were introduced beginning in 1983, provided no additional benefit or significant reduction in harm compared to animal insulins, yet prices skyrocketed, including after the founding of the Patented Medicine Prices Review Board in 1987.

As Eli Lilly informed this committee in 2003, the introductory price of its beef-pork insulin was $4.87 for a 10-millilitre vial in 1980. Then, in 1983, the company introduced its recombinant DNA insulin, known as Humulin, at an introductory price of $12.50 for a 10-millilitre vial. That was a threefold increase in the price, yet according to the Cochrane Collaboration, which reviewed all the evidence, Humulin offered no therapeutic advantage over its animal-sourced counterparts.

Then, in 1995, the first analog was introduced at a price of $30, another insulin product that was shown not to offer any therapeutic advantage over recombinant human insulin, and by extension, animal insulin.

Since 1987, the price review board has approved the introductory prices of new insulins, and I would argue, has allowed the price of insulin to increase despite the evidence before it that patients not only don't experience a significant increased benefit in terms of safety and efficacy, but also pay a price that is entirely unjustified. This is precisely why the tools available to the price review board have to be strengthened.

The ones affected the most by a weak price-review mechanism are those who are usually the least able to carry that burden, meaning people who are uninsured or under-insured, poor and in poor health. Of course, during this period when the COVID pandemic has been sweeping across the world, those numbers have increased.

● (1335)

A recent survey of people with disabilities and chronic conditions found that the average number of prescriptions for this group is five and the cost burden is between $200 and $3,000 per month. These are some of the people who need access to safe, effective and affordable medicines, and it is in their interest that the board should act when making decisions about what is fair and reasonable.

Governments often say that after marketing authorization has been granted, they have no control over supply. I don't buy that, and I'm not alone. We believe governments have tools and that if they don't have those tools, they can develop them. This is especially urgent now, in part because global pharmaceutical companies are threatening to stop supplying Canadians with new medicines if the guidelines go into effect. That is totally unethical.

In response, we urge the standing committee to recommend that the House of Commons implement legislation to strengthen its compulsory licensing capacity and to establish a public manufacturer of drugs and vaccines. If Canada utilized its ability to issue compulsory licences, it would mean that Canadians would no longer be vulnerable in situations in which patent holders are unable or unwilling to supply medicines. The Government of Canada could also work with other interested countries that want the intellectual property rules in the WTO TRIPS agreement to be relaxed. For example, other countries such as the Netherlands may be interested in developing policies that meet population needs while upholding obligations undertaken in the WTO.

Compulsory licensing—or even the possibility of compulsory licensing—would shift some of the power over price from the patent holder to government, while at the same time protecting the patent holder's right to make a profit. This would strengthen negotiations with manufacturers over bulk purchasing of essential medicines and strengthen the role of the prices review board.

Finally, Canada has a long history of publicly producing and supplying drugs and vaccines at cost to Canadians, including public and private drug plans, as well as consumers. Connaught Labs, where insulin was discovered and which became a major vaccine producer internationally, played a key role in the establishment of provincial drug plans, providing medicines and vaccines at cost. We continue to pay a very high price for the decision in 1984 to privatize Connaught, but if we can decide to privatize a Crown corporation, we can also decide to create one. We urge the committee to include this in its recommendations to the House of Commons.

The Patented Medicine Prices Review Board is an essential player in efforts to maintain some control over prices in Canada, especially since patents on medicines are granted for longer and longer periods. The new regulations and guidelines are a positive step in providing Canadians with more effective tools, but they aren't enough. The prices review board needs the backing of Parliament and the Government of Canada to ensure it plays a role in supporting access to medicines.

Canadians need to trust that the federal government is using all the tools at its disposable to support access to safe, effective and affordable medicines, and if those tools aren’t there, that Ottawa will develop and implement them.

Thanks again for allowing me to present our views and recommendations, and I hope that we've made a contribution to your discussions. I am happy to answer any questions you might have.

Thank you.

The Chair: Thank you to all the witnesses for your statements.

We will start our first round of questions at this point.

Monsieur d'Entremont, I believe you are up for six minutes, please.

Mr. Chris d'Entremont (West Nova, CPC): Thank you very much, Mr. Chair.

Welcome to everybody who is here today. If I forget towards the end, I want to wish everybody a merry Christmas and, of course, happy holidays as we move into them.

I want to get to an issue. We keep talking about Canada's having the highest drug prices in the world or close to the higher level of drug costs in the world. Since we have a drug company with us here today, Madame Beauchemin or Monsieur Alibhai, how does the pricing of drugs really work in a world context?

We talk about list prices, and we talk about rebated prices. How do we really rate compared with other countries in the world?

Ms. Annie Beauchemin: Yes, I'll take that question. Thank you for asking.

The public prices of drugs in Canada are in line with countries that have similar GDPs and health care structures.

Further to this, it's important to understand that there are significant rebates that are provided to provincial and federal drug plans currently. These are negotiated discounts that represent the drug plan's willingness to pay for the increased health benefits provided to patients upon assessment of the medication's value.

The cost of drugs in Canada is a small proportion of the total health expenditures. They have been quite stable over the last decade in Canada, with all factors considered.

● (1340)

Mr. Chris d'Entremont: Since you're at the mike right now, when you were talking about 70 clinical trials being held, are those just the ones in Canada or are those clinical trials globally?

Ms. Annie Beauchemin: Those are in Canada.

Mr. Chris d'Entremont: How many of those are nearing completion or are maybe on the list of those we're going to have to relook at because of the changes to PMPRB?

Ms. Annie Beauchemin: You're asking about the impact we expect PMPRB to have on us.

The first thing to understand is that we see a great deal of lack of clarity and uncertainty with the PMPRB process so far. We've conducted an assessment of the impact on our existing and upcoming products. We've actually had to restructure and reduce our workforce.

We can't share all the details for competitive reasons, but we've also had to reassess our current products and future launches. We expect to make very difficult decisions on whether we launch or not. Because of PMPRB, currently Canada is not viewed by global organizations as a very attractive market to invest in. We could see this get much worse if PMPRB moves forward with the new guidelines as they stand now.

Mr. Chris d'Entremont: My next question will go to Mr. Adams.

You talk a lot about different programs that might not come forward. Can you give us an example within your group of partners of how many studies, research projects or drugs might not be available within your groups?

I think I just lost him. I'm looking to the clerk. I think we lost Mr. Adams.

The Clerk of the Committee (Mr. Jean-François Pagé): He's not connected. We'll try to reach him.

Mr. Chris d'Entremont: Okay.

I know I don't have a whole lot of time. I'll move on to Mr. Frank before we get back to Mr. Adams.

Your organization is looking at these reforms as being very positive. It will save money for your members. How much of that money would go back into the hands of plan members or the like? Will it bring down premiums, or will it just keep the companies alive? I was trying to understand what you were saying in your presentation.

Mr. Stephen Frank: Thank you for the question. I'll make a couple of points.

Drug costs are borne by the employer, so any savings on the price of the medications will flow directly through to the employer and ultimately to the employee. It's sort of a pass-through cost, from our perspective. The savings there would accrue directly to Canadians.

If I may just comment quickly on one of the other elements I heard earlier, I think it is correct to say that there are pricing negotiations occurring within the public system with manufacturers, but those do not apply on the private side. One of the advantages of an approach that would apply to everyone, and one of the things we find attractive about this, is that PMPRB pricing does apply to all Canadians equally. This is an important piece for us.

Mr. Chris d'Entremont: Thank you.

I see that Mr. Adams is back, and I'm hoping he heard the question.

With your partners within your coalition, can you give us a couple of examples of research projects or drugs that might not be available because of these changes? The majority of the presentations we have received—or at least the briefs we have received—have been very negative towards the changes. I think your group is a good representation of that.

Mr. John Adams: Among our members, we have two patient organizations in the cystic fibrosis space, but I'm going to speak about my direct personal knowledge.

I have a son with a rare condition, which is PKU, or phenylketonuria. He is on the first pharmaceutical and doing extremely well with that one. There is a second pharmaceutical for PKU because the first one doesn't work for everybody. The second one was approved in the United States in 2019 and in Europe in 2020. There's no sign of an application in Canada.

The same drug developer is taking that rare disease seriously. They have launched a clinical trial in Europe and in America—but not in Canada—for the first gene therapy for PKU. There's tangible evidence of at least a delay, if not a complete lack of access, to, frankly, breakthrough therapies for the rare disorder. It affects about 2,500 Canadians, but it's one that I'm intimately familiar with. There's no sign that this drug company is going to make an application for a clinical trial for the gene therapy, for the second drug or for the gene therapy, if and when it appears to be safe and effective.

I would be delighted to do a follow-up with the committee with other tangible examples. It's not the only one, but it's the one that's very near and dear to my own heart.

● (1345)

The Chair: Thank you, Mr. d'Entremont.

We go now to Mr. Kelloway for six minutes, please.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thank you, Mr. Chair.

To you, my colleagues, the witnesses, the analysts, the clerk and all staff, merry Christmas. Hopefully you have a great holiday. Thank you for all the work you do, by the way.

I'm going to start with Ms. Fuller.

Ms. Fuller, I've often heard the claim that lower drug prices will lead to a loss in R and D and manufacturing in Canada. In fact, the countries that receive some of the highest rates of industry investment also have relatively low drug prices. For example, Belgium receives 13 times the investment levels of Canada, despite average prices being 20% or a little lower. In comparison, pharmaceutical investment levels in Canada have been falling for the past 15 years or so, with Canada now having some of the lowest R and D investment and manufacturing activities in the developed world.

Could you comment on that and could you comment on whether there's any evidence to suggest a correlation between affordable drug prices and reduced R and D investments?

Ms. Colleen Fuller: I think your preface to the question sort of answers the question. Companies invest in countries for, I'm sure, lots of different reasons, including the profit that they can make in that country.

The pharmaceutical industry undertook certain obligations in the North American Free Trade Agreement, as I'm sure you know, regarding their investment in Canada, and they have never reached the level of commitment that they made in the agreement. I don't know all the reasons why they do or don't invest in a country.

I think there are reasons that have to do with their profit levels. I know that in some countries in Europe, companies such as Sanofi, for example, have pushed back against regulations in price controls and have threatened to pull their production out of those countries. They haven't done it, so in spite of the fact that countries will implement stronger regulations and guidelines, they continue to invest. I think it has to do with lots of different considerations, and I'm not saying that I know what they all are.

What I do know is that Canada has the capacity within our own country.... We have the scientists. We have the capacity within our academic sector and scientific sector to do the type of research that's needed to support the development of drugs. I'm not saying that we have to do it without the pharmaceutical industry, but I think that we have the capacity to do that. We frame the question as if we will not be able to do it if the pharmaceutical industry doesn't invest. I question whether that's the case.

Mr. Mike Kelloway: Thank you, Ms. Fuller.

I'm going to stay with you, if that's okay. In written submissions to the committee, some stakeholders have expressed concern that the implementation of the amendments to the patented medicines regulations and the PMPRB guidelines will result in fewer innovative medicines being launched here in Canada. Nineteen pharmaceutical companies have further suggested that the PMPRB guidelines are complex and confusing, which is leading to uncertainty in their decision-making.

As a stakeholder, what steps has the PMPRB taken to ensure that its guidelines can be clearly understood by stakeholders and, for that matter, by the general public?

● (1350)

Ms. Colleen Fuller: I agree that the guidelines are difficult to understand when you just read through them. I think that the period of consultation that was undertaken by the price review board really enabled people who were involved in those consultations or who were observing them to understand what the impact of the guidelines could possibly be and what the rationale was behind the guidelines. I think that the price review board did its due diligence to help people understand what the guidelines are intended to do.

The pharmaceutical industry, including the companies that you just referred to, have entire legal departments at their disposal to help them understand what obligations they would be required to undertake if they complied with the guidelines.

Mr. Mike Kelloway: Thank you so much.

I'm going to make it three for Ms. Fuller.

Ms. Fuller, how will the updated guidelines make the process of industry stakeholder engagement a more transparent, equitable and accessible process?

Ms. Colleen Fuller: I'm sorry. I didn't quite understand your question. I'm sorry to take so much time.

Mr. Mike Kelloway: That's okay. I'll repeat it.

How will the updated—and I don't think I said this in my question so that might be the confusion—PMPRB guidelines make the process for industry stakeholder engagement a more transparent, equitable and accessible process?

Ms. Colleen Fuller: I think that some of the guidelines on transparency will certainly, from my point of view [*Technical difficulty—Editor*] enable me to understand a lot better what the rationale is on the part of the industry and in the assessment on the part of the board to either approve a proposed introductory price or not. I think that area of transparency is very important to bring some understanding to that.

One of the things I'd like to see on the part of the price review board, however, is a much more vigorous engagement with the Canadian public about the work that they do, what their intentions are and what their mandate is in order for Canadians to better understand it.

The Chair: Thank you, Mr. Kelloway.

Mr. Mike Kelloway: Thank you, Ms. Fuller.

[*Translation*]

The Chair: We'll now go to Mr. Thériault.

Mr. Thériault, you have six minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

I'd like to welcome all the witnesses and all my colleagues who have worked relentlessly over the past weeks and months. I wish everyone a merry Christmas, a prosperous New Year and a vaccination in 2021. That would be a great gift.

Mr. Adams, first of all, your organization represents many other patient organizations. I would like to point out that you support the principle of drug price reform, "in particular by lowering their prices so that they are in line with those of similar countries", and therefore more affordable for patients.

Your first recommendation has two parts. In the first recommendation, titled "Phased implementation to immediately lower prices", you state:

> We urge the standing committee to request that the application of the new basket of comparator countries should proceed as planned to bring down prices … for all patients …

You also state:

> We urge the standing committee to recommend that the federal government, through cabinet, direct a stay of implementation on parts of the regulations, deferring the application of economic factors in the determination of price to a second stage, pending further study and consultation.

Why do you say that?

● (1355)

[*English*]

Mr. John Adams: Quite simply, on the first point, the people who are most suffering from drug prices are the patients who are paying out of pocket. That represents about 21% of the total spend on prescription drugs in Canada. They don't have an ability to negotiate a better deal.

The second group of people—and they're represented here most ably by Mr. Frank—are the private insurance carriers. When they choose to, they have an ability to negotiate price on behalf of their plan sponsors.

The third group is the government drug programs which, after 60 years, have done the right thing and are bargaining collectively with drug providers through an informal organization, the pan-Canadian pharmaceutical alliance, which all the governments of Canada are participating in. The government drug plans are looking after themselves and they're doing a good job of it.

The problem is the new factors. The simple truth of it is that there is no other jurisdiction in the world that is using those economic factors for the purpose of price controls on drugs.

Let me make the distinction between price controls by regulation versus price negotiations, where individual patients don't have that clout. That's why we are in favour of the proposal and the regulation to change the comparison among countries to countries that are of a similar capacity to pay—gross domestic product.

The economic factors.... Frankly, if the committee and its analysts could take the time to go back to the six case studies of six different kinds of drugs that the PMPRB staff put forward back in 2008—which have not been updated with the final version of the regulations or the guidelines—you will see the problems there. I would invite a deeper dive by the committee and its analysts. I would be happy to help and point to the right documents.

It would be wonderful if the PMPRB had enough confidence in the rest of us that they would actually open their kimono and show us the details of their spreadsheets, their assumptions and their analysis, so that we could be happy to verify or be happy to dispute. There has been a lack of disclosure by the PMPRB staff of what the assumptions are and what the actual details of their analyses are on those case studies.

With all due respect, colour me skeptical when there is a lack of disclosure. Those are the reasons we are concerned about the significant risk that the government and PMPRB are taking by proceeding with all of the changes at the same time.

For my last point, let me use an analogy of a patient and a doctor. No doctor worth his salt would knowingly start a patient on four new drugs at the same time, because if something works, you don't know what is working. More importantly, if something does not work, you don't know what is causing the problem. The problem with these regulations and guidelines is that they're trying to do four different things at the same time. If something goes wrong, what is actually the central cause of the problem?

We ask for them to pause and reflect. Proceed with the change of basket of comparison countries and let's take a deeper dive into the more likely impacts of each of the three additional new economic factors. This is an experiment in public policy that has not taken place anywhere else in the world.

[*Translation*]

Mr. Luc Thériault: Thank you, Mr. Adams.

The Chair: Thank you, Mr. Thériault.

Mr. Luc Thériault: I think I have a minute left.

One of the central principles—

The Chair: No, you don't have any time left.

Mr. Luc Thériault: None at all?

The Chair: No, I'm sorry.

● (1400)

Mr. Luc Thériault: Does anyone want to give me their time?

[*English*]

The Chair: We go now to Mr. Davies, please, for six minutes.

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

Madam Beauchemin, if I understood your testimony correctly, you acknowledge that the pharmaceutical industry provides rebates to provinces. We heard testimony from the PMPRB officials a few weeks ago that part of the changes will require transparency, so that they have a better understanding of what the real prices are in the marketplace to help them set effective pricing for Canadians.

Do you oppose that requirement to have pharmaceutical companies transparently reveal the rebates that they're giving?

Ms. Annie Beauchemin: Let me take you through the process—

Mr. Don Davies: No, I don't want you to take me through the process. I just want to know if you oppose the requirement for transparency or not.

Ms. Annie Beauchemin: This will get to what you're referring to.

I think it's really important to understand that the original intent of the PMPRB was to prevent abuse of excessive prices, and what's happening here goes well beyond this. Our concern is that the guidelines create a great deal of uncertainty, which will prevent life-saving medications from coming to Canada. It is in the jurisdiction of the provinces to negotiate prices. The way the process works now, the pCPA, which is an alliance of provinces, negotiates with companies like ours based on the value that's assigned to a drug, based on an assessment of experts, and then—

Mr. Don Davies: I'm sorry, Ms. Beauchemin. I have limited time. I'm sorry. I'm not going to let you take time to explain things. I want an answer to the question. I understand there are rebates given by pharmaceutical companies.

Ms. Annie Beauchemin: Yes, and they are significant.

Mr. Don Davies: They don't seem to want to reveal those to the PMPRB, which results in a skewed idea from the PMPRB about what the real prices are. Do you or do you not support transparency in the rebates?

Ms. Annie Beauchemin: Those rebates are confidential based on negotiations with the province.

Mr. Don Davies: Thank you. I understand.

Mr. Alibhai, you made a claim that you thought the PMPRB changes would reduce clinical trials in Canada. What evidence or data do you have to support that, and would you provide that to the committee?

I'm sorry, Mr. Chair. Could you please stop the clock? I don't know where Mr. Alibhai is.

Mr. Mehmood Alibhai: I'm sorry. I was muted.

The Chair: I have stopped the clock. I'll restart it in a couple of seconds. Thank you.

Go ahead, Mr. Alibhai.

Mr. Mehmood Alibhai: Thank you for the question, honourable member.

All you have to do is take a look at what's transpired since 2018 when the PMPRB guidelines were initially put out, from the perspective of clinical trials and from the perspective of new drug launches in Canada. Of 34 drug launches globally, 21 of those drugs have not been launched in Canada. These drugs represent rare disease oncology products. Beyond that, honourable member, if you take a look at the clinicaltrials.gov website, where all clinical trials have to register—it's a federal website—the number of clinical trials in Canada has dropped significantly since these guidelines were put out. All you need to do is take a look at what's transpired since 2018, and the data is there.

Mr. Don Davies: Obviously the PMPRB changes are not in force, so you're saying that the mere possibility of PMPRB changes has caused pharmaceutical companies to decide on their own not to launch clinical trials in Canada. Is that what you're saying?

Mr. Mehmood Alibhai: The pharmaceutical industry plans long term—three to five years—in the clinical trials that we establish in any jurisdiction, in the kind of health system partnerships we establish in Canada, and in patient support programs to take care of patients who may fall between the gaps. The guidelines have resulted in significant unpredictability and significant uncertainty. It—

Mr. Don Davies: Can I jump in and suggest, Mr. Alibhai, that it's going to result in reduced profits for the pharmaceutical company? Would you agree with that?

Mr. Mehmood Alibhai: I would say that, if you take a look at the submissions that the patient organizations have made—

● (1405)

Mr. Don Davies: No, I'm asking about the pharmaceutical companies. Is it their concern, sir, that they're going to have reduced pharmaceutical profits if the PMPRB changes come into effect? Is that a fact or not?

Mr. Mehmood Alibhai: Thank you for asking—

Ms. Annie Beauchemin: Our concern is that we will not be able to bring life-saving drugs to Canadian patients.

Mr. Don Davies: Profits have nothing to do with the issue. Is that what you're saying?

Mr. Mehmood Alibhai: No. If I could share with you, Mr. Davies—

Mr. Don Davies: Okay. I think there was a letter that was recently sent by the pharmaceutical industry to the Canadian government that offered to pay a billion dollars to the federal government if they did not proceed with the PMPRB changes. I think they estimated that they would lose $10 billion over the next 10 years.

I'm going to turn my next question to Mr. Frank.

Mr. Frank, you correctly pointed out that the PMPRB changes would result in reduced costs to employers in this country. Do you have any idea of the estimated cost savings to employers in this country from the PMPRB changes?

Mr. Stephen Frank: We have to base our estimates off what the PMPRB's estimates are. The savings to employers would be somewhere around 10% of what's spent currently, which is a significant amount of money. It would be in the billions of dollars, over time, that we would expect to be passed through to employers, and that would, like I said in my notes, allow the capacity and the room for them to contemplate providing funding for these new medications. The envelope is getting full, and the idea that there's even the capacity to pay for some of these new medications, if we don't make some room on what we're already covering, I don't think is correct. We need to address the prices in order for us to be able to even contemplate some of these new therapies.

Mr. Don Davies: Thank you.

The Chair: That ends our first round.

We'll start our second round with Mr. d'Entremont once again.

Mr. d'Entremont, please go ahead for five minutes.

Mr. Chris d'Entremont: Thank you very much, Mr. Chair.

I had a bunch of questions. I need to go back to this. Maybe this is for Boehringer, and maybe others.

We talk about the importance of drugs in our health care system, the availability of therapeutics. Why does it seem that drug companies have become the big bad wolf in all of this discussion? Why do governments seem to have to push back on pricing all the time? Is there a disconnect? What have we missed over the last number of years?

It's probably best for Madam Beauchemin or Mr. Alibhai.

Mr. Mehmood Alibhai: I will leave it up to Annie. Did you want to address that?

Ms. Annie Beauchemin: I think the issue here is.... We've spoken about organizational mandates and our values and we are a company deeply focused on patient needs. We're here to represent the fact that the issue with the regulations is that the original intent of the PMPRB was to prevent abuse of patented drugs with respect to excessive pricing.

What's happening now is that these guidelines go well beyond this. You've heard multiple times from multiple people here today that they are highly complex. They have created a great deal of uncertainty and they will make it difficult for companies to make a sustainable contribution to commercialized medications in Canada.

That's the heart of the matter for us, and that's our concern.

Mr. Chris d'Entremont: Thank you very much.

Maybe I'll go back to Mr. Adams for a second. You brought it up in your opening statement when you talked about whether organizations are taking money from pharmaceutical companies, and that's a bad thing. One of your last recommendations was to create some kind of funding for patient groups so that they can speak on behalf of their organizations. Can you talk to that one just a little bit more?

Mr. John Adams: I'd be delighted. Thank you very much.

I'm a volunteer. There are a lot of patient organizations where the office is a desk in somebody's bedroom. That applies to our little PKU group. It's a very big deal to try to engage with PMPRB—I'll use them as one example but it's not the only one—in order to understand their processes and understand the appropriate opportunities, or lack of them, for the patient voice, the unique perspective of patients as the users of prescription drugs, to engage in the process. I think there's a lot of opportunity for improvement of that in the PMPRB and its processes.

There are other aspects of the health care system. The initial regulatory review by Health Canada for safety and efficacy and quality of manufacturing is very time-consuming. Then there's the other phase, the health technology assessment process. There is a window of opportunity now for patients, individuals and groups to make submissions into that. That's a huge burden of effort for many volunteers in many of the smaller patient organizations. It would be very helpful and I think it would improve the quality of the process and protect the integrity of each of those processes—the price review process, the safety efficacy review process and the health technology assessment process—if the patient voice were strengthened.

● (1410)

Mr. Chris d'Entremont: Thank you very much.

I know I didn't really get in any questions to Ms. Fuller, but maybe I'll ask her a quick one because I know I'm running out of time. I have about a minute left there.

How could the industry work a little more collaboratively together? I just look at how R and D is done across the country. Is there a better way to be doing it, or are the suggestions from PMPRB the only or just one step in that process?

Ms. Colleen Fuller: When you the say industry working together do you mean with each other, or with the board?

Mr. Chris d'Entremont: I would say the industry together because what we see is that pharmaceutical companies seem to be put to one side. They have their way of doing things. We have universities that seem to be doing their own thing. We have companies and governments that want to have a piece of that. I'm just wondering if there's a better way for some of these to go. I'm going to run out of time there.

Ms. Colleen Fuller: Am I able to answer the question?

The Chair: Please be quick if you can and then we'll move on.

Ms. Colleen Fuller: I think that there's remarkable cohesiveness across much of the industry. I think that they act in concert. They are members of a large organization that lobbies on their behalf and that is threatening to pull out of Canada or not to supply drugs in Canada if the guidelines go through. I think that they do.

One of the things I would like to mention is that, on the issue of investment in R and D, a lot of the significant drop, as one of the witnesses said, since 2018 is a drop that didn't just suddenly happen in 2018. It's been going on for a while is my understanding. Maybe I'm wrong about that, but it is my understanding. The industry has never lived up to its obligations under the free trade agreement to invest in research and development to what is, I think, about 10% of profits. All of this about the guidelines is one thing, but they've never stepped up to the plate in the way that they were committed to doing in the past.

The Chair: Thank you, Ms. Fuller. I'm going to have to cut you off there.

We'll go now to Dr. Powlowski.

Doctor, please go ahead for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I would like to follow up on Mr. Davies' question.

Mr. Alibhai said that a whole bunch of new drugs haven't come on to the market in Canada or asked for approval by Health Canada in the last couple of years. He's said that the number of drugs undergoing clinical trials in Canada has gone down—

[*Translation*]

Mr. Luc Thériault: Mr. Chair, there's a problem with the interpretation. The volume for Mr. Powlowski, who I greet, seems to be too low. The interpreters can't work.

[*English*]

The Chair: Thank you.

Dr. Powlowski, just say a few words for the translators to make sure that we have you properly on sound.

Mr. Marcus Powlowski: Merry Christmas to all if I don't get around to that.

The Chair: We're good to go. I'll start your clock again now.

Mr. Marcus Powlowski: I wanted to follow up on Mr. Davies' question.

Mr. Alibhai, said that in the last couple of years there's been a significant drop in the number of new drugs either asking for approval from Health Canada or coming on the market. He's also said that, in the last couple of years, there's been a significant decrease in the number of drugs that are in clinical trials in Canada, and he either said or implied this was a result of the uncertainty arising from the proposed changes to the Patented Medicine Prices Review Board. He can correct me if I'm wrong on that.

I'm not a big opponent of pharmaceutical companies. I realize that, in order to encourage research, pharmaceutical companies have to be able to recoup their cost of the development of new drugs, but I'm sorry. With the decreased number of drugs getting on the market and the fact that there are drugs being approved elsewhere that aren't even being brought before Health Canada for approval, and you're not bringing your drugs to Canada for clinical trials, it looks to me like you're holding sick Canadians for ransom because you want to prevent these new changes from going through in the Patented Medicine Prices Review Board. I have to say this is not a pretty picture for the pharmaceutical companies.

● (1415)

Mr. Mehmood Alibhai: Thank you for that question, honourable member.

There's a process in place in Canada that has been in place for 10 years, which the provinces have implemented. It is called, as you are aware, the pan-Canadian pharmaceutical alliance. Boehringer Ingelheim was the first company that went through the successful negotiation on the pCPA process for a stroke prevention drug, the first drug in 50 years that demonstrated improving stroke outcomes. We built the negotiation framework with the provinces. That demonstrates our commitment to ensuring Canadians' access. Subsequent, to that, we've been through 17 successful negotiations.

Paramount, honourable member, is that there is a process in place, which has been in place for over 10 years now, that falls under the provincial jurisdiction of pricing negotiation. It has worked really well and has led to Canadians' receiving access to innovative treatments. The federal government has joined the pan-Canadian negotiation, as they see how effective it is. The substance, then, is that there is a process in place in Canada. What is being proposed by PMPRB oversteps, respectfully, its jurisdictional boundaries as a patent abuse regulator and circumvents the provincial jurisdiction of price negotiation, which has been demonstrated to be very effective.

Mr. Marcus Powlowski: With all due respect, I don't think you're really answering my question, which is that it certainly looks to me as though the fact that the pharmaceuticals aren't asking for Health Canada approval for their medications is a brazen attempt to get sick Canadians to start advocating on behalf of pharmaceutical companies to have changes put in that will basically allow you to maximize your profits in Canada.

That's the way it looks to me. I have no big chip against pharmaceutical companies, but that's the image you're giving Canadians. I'd like you to respond to that. If this image isn't a true one, then why isn't it true?

Mr. Mehmood Alibhai: In any business, honourable member, you require certainty and predictability over a three- to five-year horizon. Introducing a drug in Canada requires investments in clinical trials. It requires more than just getting a Health Canada approval.

What has happened with the PMPRB regulations is that they have impacted upon the predictability and the certainty of the business model, which is to ensure that beyond just introducing a product, we can ensure that the product supports clinical research on an ongoing basis and supports some of the kinds of initiatives, from a health system perspective, that we've spoken about and supports patient needs for the long term.

Mr. Marcus Powlowski: Thank you. I'd like to address the question to Mr. Adams.

I know you advocate for patients. Am I totally wrong in my perception of what the pharmaceuticals are trying to do here?

Mr. John Adams: Let's be clear. There have been some bad actors among some pharmaceutical company executives who have abused market power in some situations. There are notorious examples of this. With respect, however, they are not necessarily representative of all of the companies by any stretch of the imagination.

I'm going to offer an analogy, and it may make some people uncomfortable. There have been allegations of parliamentarians not having appropriate behaviours towards certain of their staff. That isn't to say that every one of you on this committee is a sexual predator.

Yes, there can be bad actors and they deserve to be taken to task, and I think there are ways and means of doing that. On the other hand, I think some of the criticism comes from a point of view [*Technical difficulty—Editor*] do not have regard for—I will say it—a commercial business or profit-seeking motive. There are patients who share that value judgment, and there are patients who come from among senior business executives—

● (1420)

The Chair: Thank you, Mr. Adams.

Thank you, Doctor.

We go now back to Monsieur d'Entremont for five minutes, please.

Mr. Chris d'Entremont: Sorry about that. I was thinking it was the NDP's turn. Not that I want to give my time to him, but I'd be very happy to do that sometime...or even Luc.

I know we've been going round and round this one a little bit, but we keep hearing the same thing, so let's go back to what we're hearing mostly from patient groups. I think this is probably for Mr. Adams again. We keep hearing from those patient groups that they're worried about that lack of access. I know you had a really great example when it came to the drugs that your son might be able to receive.

Do you have any other thoughts for us before we finish up today of other organizations within your coalition that might not have a big enough voice to get before us and whose story might need to be heard? Trikafta seems to be the one we use the most here, but are there other examples like that?

Mr. John Adams: If I may I'm going to use the example of ALS. You watched one of your colleagues in Parliament live through the disease and the finality of that occursion, as I watched my wife go through it.

I want to put in a plug here for some wonderful folks at Health Canada. There was a drug out of Japan that slowed down the progression of the disease. It did not change the course of the disease. It was not available in Canada. We have a tradition of allowing individuals to bring in, by personal import, a 90-day supply of a drug that's not available in Canada. That's a real problem because there are lots of drugs that are not available in Canada, separate and apart from the discussion on PMPRB.

It was a big deal to go to Japan and bring a 90-day supply. Health Canada reinterpreted the rules in a very humanitarian way. They didn't have to go to Japan. They could ship it, and they could ship in a 180-day supply. That drug company from Japan came to Canada and went through the process. The good news is that the drug is now available in Canada, but they could not come to terms with PMPRB under the old rules—not the new rules, the old rules—so they did a really unusual thing. They allowed their patent to lapse. They fled the jurisdiction of PMPRB. The good news is that drug.... It's not the greatest drug in the world, but when you're dealing with ALS you'll take faint hope.

My concern is that, given the additional barriers to reimbursement and patient access, when there is a breakthrough for ALS, like we've had for COVID-19, Canada's going to be even further back on the list of when ALS patients.... ALS patients don't have very much time for process. They need help ASAP.

I use ALS, but there are lots of other diseases that have no useful therapies, or not adequate therapies, today. With respect, I'm not prepared to wait for governments to pay for all the R and D that will bring a breakthrough molecule for ALS or anything else. We need investors in the private sector to be partners in this. Please, we ought not to be in the business of kicking sand in their faces.

● (1425)

Mr. Chris d'Entremont: Thank you.

Mr. Chair, how much time do I have left in this round?

The Chair: You have a minute and 12 seconds.

Mr. Chris d'Entremont: I know Mr. Thériault wanted to ask a few more questions. I know he doesn't have a whole lot of time, so I'm going to pass my time to Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: Thank you. That's very kind.

[*English*]

The Chair: Go ahead.

[*Translation*]

Mr. Luc Thériault: Doug Clark, executive director of the Patented Medicine Prices Review Board, PMPRB, said on November 27: "I don't think it's the purview of PMPRB to ensure that its guidelines, regulations and regime in its totality encourage R and D." Later, when I said, "My understanding is that, in five years, you have not analyzed the economic or overall impacts of the reform on life sciences. Is that right?" he replied, and I quote, "No, we have not analyzed the impact on life sciences. However, we have done an analysis on prices, and we believe there will be no impact…".

Mr. Adams, you say that the proposed reform denies one of the fundamental principles of the life sciences industry, because the process must be predictable, and it is through such a process that patent holders can assess the market for a drug and invest in research and innovation. Does this kind of answer surprise you?

Ms. Annie Beauchemin: Basically, we don't agree.

[*English*]

The Chair: Give a quick answer, please.

[*Translation*]

Ms. Annie Beauchemin: We're convinced it would have a negative impact.

It's currently under negotiation with the provinces. That's the way the process is going. Significant discounts are being given. We firmly believe that these new regulations go beyond provincial jurisdiction. It's important to take that into account.

Mr. Luc Thériault: Mr. Adams, you have in your brief—

[*English*]

The Chair: Thank you, Mr. Thériault. Chris's time is up. You'll have two and a half minutes shortly.

We go now to Ms. Sidhu.

Ms. Sidhu, please go ahead for five minutes.

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

Maybe this is the last sitting of our committee in 2020. I want to thank my colleagues and committee staff for their incredible work. Happy holidays.

I have a brief observation on the insightful discussion from the comments of one of the witnesses today. I strongly believe that Canada's economy and Canada's health care market is one of the most stable and predictable markets in the world. Through you, Mr. Chair, to Mr. Frank, I talk to my residents every day. The issue of drug costs and reliable insurance comes up in many conversations. As we all know, the government is working to move forward in establishing the fundamental elements of Canada's pharmacare. I often hear from my residents about the high impact of insurance premiums on their household budget.

Do you believe lower drug prices will result in overall savings for Canadians on their insurance premiums if the new guidelines are introduced?

Mr. Stephen Frank: There's no question that they will.

Premiums are a function of the expected cost that we will be outlaying on behalf of an insured individual. If those costs decline, anything we can do to bring those down will have a positive impact on premiums in the extent of reducing them. For many employer plans, they bear the cost of the medication directly. We just administer those on their behalf. It's an immediate and direct flow-through.

This is why we're so supportive of these reforms. It's critical that we get the prices more aligned with what we see globally. It's going to free up capacity to even contemplate paying for some of these new medications. It's really important that we get this done. We've been at this for many years now, and I think January 1 is the date we should be holding to.

Ms. Sonia Sidhu: Ms. Fuller, you spoke about your work with diabetes and access to insulin. As you noted, some drug manufacturers have tried to withdraw the less expensive insulin in favour of more expensive alternatives. Fortunately, the Canadian drug agency proposed under the national pharmacare plan would negotiate the best prices possible and keep affordable options on the market. Do you feel that the new regulations proposed by the PMPRB would effectively limit manufacturers from making decisions that prevent patients living with diabetes from accessing the affordable drugs they need?

● (1430)

Ms. Colleen Fuller: I think that it can make contributions to that. One of the things that the prices review board does is it looks at the evidence that there is a therapeutic advantage in newer insulin products, just like it does for any other drug. If the guidelines are implemented and they are able to access better information and more information, which will allow it to assess whether the introductory price is a fair price, I think that will be good.

Will the manufacturers say, "Sorry, we're not going to therefore introduce this drug"?

Sanofi did that with insulin glargine, brand name Lantus. They were in a huge tug-of-war with the prices review board because the board looked at the evidence and said that the evidence showed that this is not—I can't remember the name of the category—a drug that offers an increased therapeutic benefit. Sanofi got into a wrestling match. They did that in Germany, and they did that in the United Kingdom. It wasn't only in Canada that they were having this fight with regulators about what the fair and reasonable price was for that insulin.

The prices review board basically caved in and relied on the assessment of the fairness based on what was going on in comparator countries. Of course, they're all higher-priced comparator countries. I think that with a change in the comparator countries that's a very positive move. I also think that what needs to also happen is that the prices review board needs to rely more on the evidence. The comparator countries are important, but I also think the evidence really should have greater weight in their decisions.

I hope I answered your question.

Ms. Sonia Sidhu: Thank you.

The Chair: Thank you, Ms. Sidhu.

[*Translation*]

We'll now go to Mr. Thériault.

Mr. Thériault, you have two and a half minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

My question is for Mr. Adams.

Your association brings together several organizations that represent millions of patients with a range of illnesses. During the first meeting, Mr. Clark suggested before the committee that many patient organizations don't want to develop an independent perspective because they are indebted to the companies that support them:

> … there's a lot of research out there to show that, when you take money from someone, it—even implicitly, without your knowledge, subconsciously—impacts your views. There's definitely a correlation, and a pretty strong one, between where patient groups stand on these reforms and the extent to which they accept funding from industry.

In your brief, you lamented the fact that the patients were pushed aside. You say it is unfortunate that the concerns and lack of patient participation in this process have not always been reflected.

Don't you find Mr. Clark's statement to be somewhat contemptuous and bordering on defamation?

[*English*]

Mr. John Adams: I appreciate some of the candour of Mr. Clark. I don't go around looking for fights with anybody. Let me do an analogy. Among other things, as well as being a patient and a patient advocate, I'm also a recovering politician. I'm not unfamiliar with the question of politicians looking for funding for campaigns. We all have to govern ourselves with integrity when we seek and accept money for political campaigns. I don't think that's unique to municipal politics or to provincial. It applies to all levels. One has to be careful about that. I think Mr. Clark might want to....

I would look forward to a face-to-face conversation with Mr. Clark so that we could exchange, in a full and frank way, perspectives. I think he was unfair to many patient advocates and many patient organizations. I appreciate his candour on another point. He did acknowledge the PMPRB has not done a study of the impact on research and development of the proposed new rules. I submit to this committee that this warrants or is cause to pause and reflect before going full steam ahead and changing four different things at the same time.

● (1435)

[*Translation*]

Mr. Luc Thériault: Do you think—

The Chair: Thank you, Mr. Thériault.

[*English*]

We go now to Mr. Davies.

Mr. Davies, you have two and half minutes, please.

Mr. Don Davies: Thank you.

Mr. Adams, on the Best Medicines Coalition website, it says, "The Best Medicines Coalition seeks and receives corporate funding in the form of sponsorships and grants and receives in kind support through collaboration and partnership from its member organizations." Can you confirm whether any of that corporate funding comes from the pharmaceutical industry? If so, how much?

Mr. John Adams: Yes. Actually, in my opening statement I confirmed that, sir, but I'm happy to clarify. Our budget for the last four years has been about $220,000, on average. Yes, we seek unconditional funding from pharmaceutical companies.

Mr. Don Davies: How much of that $220,000 or so annually comes from the pharmaceutical industry?

Mr. John Adams: The majority of it. I don't have the number off the top of my head.

Mr. Don Davies: Could you provide that to the committee?

Mr. John Adams: I'd be happy to. Thank you.

Mr. Don Davies: Thank you.

Ms. Fuller, I'd like to ask you about the issue of the relative weight given to the evidence of improved benefit of medication and other factors, like prices in comparator countries. I would be interested in hearing your comments on how you think that should be weighed by the PMPRB in assessing adequate pricing.

Ms. Colleen Fuller: I think that the issue of evidence is very important. CADTH, for example, the Therapeutics Initiative and other similar agencies in Canada look at evidence and assess whether or not the asking price is worth a recommendation to provincial drug plans to list or not list.

If the prices review board had been looking and relying on the evidence for Lantus insulin, which is the example I used in our brief, I don't think they would have approved a $5.50 per unit introductory price for that insulin if the evidence had weighed in the way it should have.

I've been involved in a lot of these issues around insulin. I've had diabetes for 52 years, so I've seen every single price of insulin for the last half-century in Canada. When I was first diagnosed with diabetes in the late 1960s, insulin cost my family about $1.17 per vial. The price of that insulin went up over the years and when it was finally withdrawn in the mid-1990s it was $11 per vial.

The price of newer branded insulins has gone up just incredibly. They're no better than the insulin that I began using in the late 1960s. I'm not saying that we should be paying $1.17 per vial, but the cost of insulin on the market today is completely unjustified. The prices review board needs to be able to use better tools to assess whether or not those prices are justified.

Now, the highest-priced insulin in Canada is about $150 for a 7.5 millilitre amount. These insulins are not lightening the burden on people with diabetes who use insulin. They're certainly not lightening the financial burden of diabetes either. I think that if the decisions at the board were made on the basis of evidence, we would not be seeing these prices for insulin in Canada. At least, I hope we wouldn't be.

The Chair: Thank you, Mr. Davies.

That brings round two of our questions to a close.

We don't have time for a full third round. We have 20 minutes left. I am going to try cutting the five-minute slots back to four minutes and the two and a half-minute slots back to two minutes. That will get us in right under the wire. I'll be very brutal about the timing.

We will go ahead now with Mr. d'Entremont, please.

● (1440)

You have four minutes, sir.

Mr. Chris d'Entremont: I know we have a quick question from Mr. Maguire.

Mr. Larry Maguire (Brandon—Souris, CPC): Thanks. Would that be okay, Mr. Chair?

The Chair: Yes, go ahead.

Mr. Larry Maguire: I noted that in his opening comments, Mr. Adams made a reference to unwisely taking on unnecessary risks.

Can you just elaborate on who is unwisely taking the unnecessary risks? What are your thoughts on that? Can you expand on it?

Mr. John Adams: Thank you very much.

First of all, there are the regulations and there are the guidelines. The regulations were decided by the cabinet of the Government of Canada. The problem of the unwise combination of risks—doing four changes all at the same time—is baked into the regulations. With respect, the principal point of accountability is the cabinet of the Government of Canada.

The guidelines are the work of the PMPRB in fine-tuning and how they would implement that. They're taking their marching orders from the cabinet. The short answer is the cabinet.

Mr. Larry Maguire: Thank you.

To our witnesses from Boehringer, I know you do work with ventilators, COPD, lung cancers and that sort of thing. To tie it a little bit closer to COVID, maybe you can be responsive in this area. Our long-term care facility seniors are taking the biggest hit in Canada. Eighty per cent of the deaths are from that area. A lot of COPD and lung conditions are fatal with COVID.

You plan in generations, with your Bridging HOPE program and that sort of thing. Could you elaborate on that as to how responsive people have been during this pandemic in regard to trying to solve our situation—the biggest part of the disaster of COVID—under the present rules and perhaps under the changed rules?

Ms. Annie Beauchemin: I'll start, and Mehmood can complement.

We work with the health care system in many different ways. We work with patients and with many stakeholders in health care, and of course everyone has been committed to improving the situation, including us. We mentioned in our opening statement that we, like other companies, are working very hard towards continuing to provide better treatment options.

It's worthwhile to note that many of our partnerships as well help the health care system. That's not factored into what the PMPRB would look at. These partnerships go beyond even R and D investments. Our company is unique in many ways. We work with the system to improve system change, and all of us are hard at work on this. We're concerned that the PMPRB guidelines will in the future limit our ability to do so.

Mr. Larry Maguire: Mr. Alibhai, you mentioned that you're working in the area of a digital health policy framework. Would things be similar in that area as well?

Mr. Mehmood Alibhai: One thing we find as we are working with indigenous communities as well is that they are even more challenged with regard to optimal access during the time of COVID.

Just this morning, for instance, I had a discussion with Greybox, which is a Quebec-based virtual technology digital platform, and an indigenous group concerning how we—Boehringer Ingelheim is partnering with Greybox—can bring Greybox into the picture with this indigenous group, which manages pan-Canadian optimization of diabetes care. We just finished a discussion this morning.

● (1445)

The Chair: Thank you. I'm going to have to cut you off there. I'm sorry.

We'll go now to Mr. Van Bynen, please, for four minutes.

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): Thank you, Mr. Chair.

For those of us who are not too familiar with PMPRB, these conversations are always enlightening. I thank our witnesses for joining the committee today and sharing their expertise.

Even with the third-highest drug prices in the world, the drug industry is falling short of its own 1987 commitment to invest 10% of Canadian revenues back into R and D to be performed in Canada. Current industry investments in Canada are 4% and falling. Annual industry investments in Canada would need to increase by $800 million a year to meet their own commitment and by more than $3 billion to be comparable with what other countries already receive by way of R and D. The evidence suggests that pricing is not the main determinant of industry investments.

My question is to Ms. Fuller. She offered two alternatives. One was compulsory licensing and public manufacturing. To what extend would this help reduce the high cost of drugs?

Ms. Colleen Fuller: As I mentioned, when Connaught was manufacturing drugs in Canada, they provided those drugs at cost to public and private insurers, and to consumers. Obviously they weren't paying dividends to shareholders, they weren't raking money off the top and so on and so forth, so they were able to do that. The pharmaceutical industry is not able to do that. They have an obligation to provide a return on investment to their shareholders and so on. I think that a public manufacturer would go a long way towards contributing to a better cost picture in Canada for drugs.

Compulsory licensing is a tool that Canada used to use and it was also something that we abandoned during the period when we were negotiating free trade deals and so on. These things have undermined our ability to not only have greater control over the prices that we pay for medicine and vaccines, but also our ability to supply drugs to Canadians if the industry is not able or willing to supply them. The industry right now is basically saying that they're not going to supply new drugs in Canada if the guidelines go through. We're not the only country that they've issued that warning to.

I think one of the ways to respond to that, to counter that, is to ensure that if they don't, if they choose not to supply drugs in Canada, we have the capacity to supply them ourselves.

We're looking at this now. There's been a big debate in Canada around the COVID vaccine, as another example. We're not making the COVID vaccine in Canada. We're relying on global manufacturers to supply that. It's not that they're saying that they refuse to supply us. It's that they're saying they'll get around to it after they have supplied these other markets that they have obligations to, or whatever. I think we need to figure out a strategy to deal with that.

The Chair: Thank you, Mr. Van Bynen.

We're now going back to the Conservatives. Is it Monsieur d'Entremont, or is it Mr. Maguire?

Mr. Maguire, please go ahead.

Mr. Larry Maguire: Mr. Chair, I had asked Mr. Alibhai to elaborate on the issues that he was dealing with around the outbreaks that we've had in COVID in some of the indigenous areas. I wonder if he would have more to say on these companies being prohibited from expanding in order to be able to work to solve some of these problems in our own country.

● (1450)

Mr. Mehmood Alibhai: As we shared with you, we are here today because we find the PMPRB consultative process to be ineffective. The feedback provided by not just us but patient organizations has been ignored, as is reflected in the number of significant increases in the number of negative submissions on the guidelines when you move from the initial consultative process to the August timeline.

Patient groups are concerned. The way BI, Boehringer Ingelheim, approaches it is that we are solution solvers. That's what drives us based on the opening...and we continue to work with indigenous communities and with other partners to address their concerns and challenges. In effect, we are reconsidering a number of initiatives, a number of investments, because of the uncertainty and unpredictability that these guidelines have posed.

As I mentioned, we are the first company that negotiated a successful pan-Canadian negotiation. We built the system with the payers. We are committed to optimal, sustainable access for Canadians. We find that the consultative process with PMPRB was not effective.

Mr. Larry Maguire: Thank you.

Here is a quick question to Mr. Frank from the Canadian Life and Health Insurance Association. You mentioned that you hold the insurance for 99% of all the health care insurance programs in Canada and said that 29 million Canadians were insured. Does that mean that—what are we at, 35 or 36 million Canadians now?—as a corollary there are six or seven million people not insured under your programs, or can you give me a more accurate number?

Mr. Stephen Frank: That's right. The difference would be those who are maybe on seniors programs in the various provinces or on some of the other provincial support programs.

Mr. Larry Maguire: You went on to say, I think, that 87% value that coverage.

Can you elaborate a little on how some of the pricing review changes would impact premiums, insurance companies and individuals? I think you said that most of it is paid through their companies, but can you elaborate?

Mr. Stephen Frank: That's correct. The price of the medication is a pass-through from the insurer straight to the employer and straight to premium. Any reduction in cost, any reduction in price would pass through to the employer who is the plan sponsor, or those who have individual coverage would see their premiums reduced.

Mr. Larry Maguire: Most Canadians, though, you're saying here, are very satisfied with the insurance coverage they have.

Mr. Stephen Frank: There's no question. They're either very satisfied or satisfied. It's up in the 85% range.

Mr. Larry Maguire: Thank you.

The Chair: Thank you, Mr. Maguire.

I believe you have finished, have you?

Mr. Larry Maguire: Yes, I have.

The Chair: Thank you.

We go now to Monsieur Thériault.

[*Translation*]

It's your turn, Mr. Thériault.

Mr. Luc Thériault: Mr. Adams, at the end of your brief—

[*English*]

The Chair: I'm sorry; that was my mistake. Next is Mr. Fisher.

I'm getting ahead of myself on the list. I apologize to everyone.

[*Translation*]

Mr. Luc Thériault: It's going to cost you an extra minute, Mr. Chair.

[*English*]

The Chair: Mr. Fisher, please go ahead for four minutes.

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Thank you very much, Mr. Chair.

My apologies to Mr. Thériault, I didn't mean to stop him in midstream there.

I want to take a second to thank all the witnesses here today. Thank you for your expertise. It's an interesting panel because we have diverging opinions.

I want to go to Ms. Fuller, if I may.

Ms. Fuller, these aren't really questions. I'm going to throw a couple of things at you and ask you, if you want, to touch on some of these things.

You made a comment with regard to supply and said that government has the tools and that it's unethical to hold back drugs from Canada because of regulations. Separate to that, you said that PMPRB needs the backing of Parliament. Then there was another comment by a witness earlier in the testimony who said that drug prices in Canada are comparable to those in comparable countries. Would you touch on three of those topics at your leisure?

Ms. Colleen Fuller: First of all, I think that although the industry feels its overarching responsibility is to supply a return on investment to shareholders, from my perspective, the overarching responsibility should be to ensure that Canadians have access to safe and effective medicines. That obviously is not at the top of the list. Canada is not the only country that has confronted threats and warnings from the industry about interrupting access by patients to medicines.

As mentioned in our brief, Global Insight pointed out, “the human-interest angle of patients denied access to potentially life-saving therapies has generated an unusual level of support for a pharmaceutical industry often regarded with deep suspicion.”

I think that what is happening in Canada right now and what has happened in other countries is horribly manipulative on the part of the industry. People are afraid, if they don't get access to medicine. I am a victim of two companies that withdrew all of the only type of insulin I can use, which is animal insulin. Of course it's a threatening and frightening thing when that happens, but I also believe that governments have an obligation and a duty to counter those types of warnings and threats from the industry.

That's why we are arguing that tools that either are there or should be there.... The government should develop those tools if they don't exist. One of them is public manufacturing. We absolutely believe that should be the case. Compulsory licensing is another one. Also, quite frankly, so is national pharmacare.

All of those things are interconnected in one way or another, and the prices review board plays a very positive role in the discussion about access and affordability—and justice, quite frankly.

● (1455)

Mr. Darren Fisher: Thank you.

Are drug prices in Canada comparable to drug prices in comparable countries?

Ms. Colleen Fuller: I think that the prices review board has.... The countries that have been selected will enable us to ascertain where we fall within that range of comparable countries. In the past, it seems the prices review board has fallen midway between that group of comparative countries.

I don't think there's a huge difference in price between Canada and a lot of the comparator countries, which is probably not great. If we had lower prices in countries, we would be able to bring our prices down as well.

The Chair: Thank you, Ms. Fuller.

Mr. Darren Fisher: That was quick. Thank you.

[*Translation*]

The Chair: We're now going to Mr. Thériault, for real this time.

I'm sorry about earlier.

You have two minutes.

Mr. Luc Thériault: Mr. Adams, could you comment on the great uncertainty and lack of transparency associated with the authority of the Patented Medicine Prices Review Board staff questionnaire in the application of the regulations and guidelines?

[*English*]

Mr. John Adams: To me, the central problem is that they have to.... This is about the Patent Act. All of the arguments in favour of what PMPRB and the government are doing are around what I will call consumer protection. The Patent Act is actually about regulating the use of intellectual property and avoiding abuses [*Technical Difficulty—Editor*]. That is not the same as consumer protection. My quarrel—and I think the courts are going to deal with this—is that it's a bit of a stretch to push intellectual property into consumer protection.

If the Government of Canada and the Parliament of Canada see fit to say there's a need for consumer protection around drug prices, I think that would require its own legislation separate and distinct from—

[*Translation*]

Mr. Luc Thériault: Excuse me, Mr. Chair, but there are problems with the interpretation.

Excuse me, Mr. Adams, but we have to be able to hear and understand you.

We should start again, Mr. Chair, because there's no interpretation.

[*English*]

The Chair: Yes. Mr. Adams, can you back up a little bit? We'll check with translation to see if it's working.

● (1500)

Mr. John Adams: Okay. For me, the key point and cause of uncertainty is the desire of some to stretch the Patent Act into a consumer protection act. The Patent Act, in my view, is about regulating intellectual property and avoiding abuses of intellectual property. Its central purpose is not consumer protection. If the government and Parliament see fit that there is a need for consumer protection on drug prices, then, with respect, it would be up to the government and Parliament to pass a law on consumer protection on drug prices.

We're trying to fit a square peg into a round hole here. I fear it's going to make things worse and I fear we're heading towards substantial litigation.

[*Translation*]

The Chair: You have two seconds left, Mr. Thériault.

Mr. Luc Thériault: They're yours, Mr. Chair.

The Chair: Thank you, sir.

[*English*]

We go now to Mr. Davies.

Mr. Davies, please go ahead. You have two minutes.

Mr. Don Davies: Thank you.

I feel like I have to put a few points on the record. It's my understanding that the Patented Medicine Prices Review Board was created by the federal government after they extended patent protection to pharmaceutical companies. It was a quid pro quo for the extended time that pharmaceutical companies would be able to have exclusive profit-making for their molecules. By the way, a lot of research of pharmaceutical companies is done by them, but a lot of it is also done by public taxpayer dollars to universities as well. In exchange for that, there was a commitment by the federal government to control prices.

Ms. Fuller, this committee has received evidence indicating that Canada pays the fourth-highest prices among 31 OECD countries, 17% above the median price of those countries. Canada is the second-highest in the OECD in terms of how much it spends on patented medicines as a proportion of total health care costs, and in per-capita spending. Only the United States is higher in both cases. From 2014 to 2018, growth in spending on patented medicines in Canada has doubled that of GDP, and it's over three times the growth of inflation.

Ms. Fuller, do you believe the changes that the PMPRB is set to bring in will help to lower prices in Canada? The same question goes to you, Mr. Frank.

Ms. Colleen Fuller: I think they will strengthen the ability of the prices review board to ensure that the introductory price on drugs is fairer, so my answer is yes.

I also want to point out that the mandate of the prices review board is to basically, as you say, protect consumers from the impact of extended patents. There is a relationship between the patent period and the exposure of Canadians to unfair pricing.

The Chair: Thank you, Mr. Davies.

Mr. Don Davies: Sorry, Mr. Frank.

The Chair: That brings our third round to a close. I'd like to thank all of the witnesses for sharing their time with us today and for their excellent information. It will be a great help to our study.

I'd also like to take the opportunity to note that this is the last day on this committee for our analyst Karin Phillips. She is moving along to work with PHAC, I believe. I've worked with Karin for quite a number of years now, and she has been an enormous asset. I would like to thank her for that. She is leaving us in very good hands. We have Sonya here, who will be taking over, and of course Dominique will be here as well.

Thank you, Karin, for all your great work and your great writing. I hope you can carry the message of the Oxford comma to your next location.

With that, we will suspend and bring in our next panel.

Thank you, all.

● (1504)

_____(Pause)_____

● (1505)

The Chair: The meeting is now resumed.

We are proceeding pursuant to the order of reference of Tuesday, December 1, 2020, on Bill C-210, an act to amend the Canada Revenue Agency Act related to organ and tissue donors.

We will now begin our clause-by-clause consideration.

(On clause 1)

The Chair: We have an amendment on the floor. I believe Mr. Sorbara wishes to move it.

Mr. Sorbara, please go ahead.

Mr. Francesco Sorbara (Vaughan—Woodbridge, Lib.): Thank you, Chair, and good afternoon, everyone.

Clerk, I believe you received the amendment and have distributed it to all committee members.

Chair, I will obviously be moving this amendment on Bill C-210, and then I wish to speak on it.

Thank you, everyone, for making yourselves available and hearing me out for a few minutes.

First, it's great to be here. It's great to be speaking on a bill that I know is very important to deputy Webber and is very important to MPs on all sides of the aisle. I'm very galvanized by that. It is within that spirit that I present this amendment. In my view, at the end of the day, it's about increasing the number of registered organ and tissue donors in Canada.

I have some prepared remarks for everyone. I thank you for the opportunity to join your committee today as we look at this legislation that seeks to promote a cause that, it's fair to say, all parliamentarians support—namely, increasing the number of registered organ and tissue donors in Canada. This is an extremely important issue to assist Canadians in desperate need. It is truly a matter of life and death. We need the best legislation possible.

I know we all support the intent of the legislation. I do personally, and I applaud the member for Calgary Confederation for his work and his desire to get this bill passed in the House and the Senate. I too am committed to advancing the bill's objective. That's why I'm advocating certain amendments to make Bill C-210 more workable for the Canada Revenue Agency so that it can be implemented as soon as possible. Hopefully, if Parliament can pass it quickly enough, it would be in for the 2021 tax-filing year. We need to ensure that the legislation proposes the most efficient and effective way for the Canada Revenue Agency to collect this information, and for the process to be efficient and useful for the provinces and territories, who are ultimately responsible and within their jurisdiction for organ and tissue donation.

As Parliamentary Secretary to the Minister of National Revenue, I've made it a priority to examine the legislation in great detail and to discuss it with experts at the CRA who would be asked to implement it. I truly believe this committee should hear directly from those professional experts at the CRA regarding this legislation, especially their experiences with the precursor legislation to Bill C-210 from the last Parliament, Bill C-316, and the CRA's interactions with the provinces and territories on that legislation that occurred.

Nevertheless, I am proposing a strongly recommended amendment to make the legislation more straightforward for the CRA to implement with the provinces and territories, and also to make it so that it can be implemented in the quickest fashion possible. This amendment does not change the objective of the bill, but rather the manner in which the objective will be achieved, to remove potentially significant roadblocks and time-consuming delays.

This simple amendment would do as such. Rather than having the CRA directly collect organ and donor consent on behalf of the provinces and territories, the CRA would collect and share the personal information of individuals wishing to become organ and tissue donors with their respective provinces and territories, which would then obtain direct consent. The amendment, accordingly, would remove references set out in proposed subsections 63.1(1) and (2) of the bill, which would make reference to returns of income filed under paragraph 150(1)(d) of the Income Tax Act.

Rest assured that under this approach, a form would be included within the T1 return, both a paper format and in certified tax software, asking if the individual wishes to be sent information by their province or territory on becoming an organ and tissue donor. It should also be noted that the notice of assessment would still advise the individual that, in accordance with their request, their information has been forwarded to their province or territory as a potential organ and tissue donor. Once the information would be sent to the relevant province or territory, the province or territory would then be able to follow up with the individual on the actual consent to organ and tissue donation.

● (1510)

This is an important and appropriate role for provinces and territories to undertake, as it is within their jurisdiction as opposed to that of the Canada Revenue Agency. Legal requirements for donor eligibility and informed consent are very complex and vary greatly by jurisdiction in Canada, meaning different provinces and territories have different roles. By having provinces and territories play their proper roles in obtaining consent, we are not only respecting their jurisdiction, but equally important, we are removing an obstacle by eliminating the need for protracted negotiations and complicated agreements with each of the provinces and territories on legal requirements for collecting the proper consent.

With the amendment I am proposing today, our hope is that we would put the federal government in a position to reach swifter agreements with provinces and territories on a more straightforward, simple and efficient approach, which, I understand from CRA officials, might need only months instead of potentially years to achieve.

I repeat, we all want the objectives of Bill C-210 to become a reality, and sooner rather than later. However, for the CRA to meet the earliest window of the 2021 tax-filing year—next year's income earned, when you file your taxes in January to March or the period in 2021—the provinces and territories have to come on board. We need to create the quickest path to make that happen.

I would like to add that the approach taken here, for the MPs who have been elected from the beautiful province of Ontario, would be a similar approach to where information is collected for what's called the Ontario trillium benefit, where a separate page is provided in the tax package, whether it is online or in paper format, and where the information is then passed to the Province of Ontario.

I am confident that our amendment today will do that and make the member for Calgary Confederation's objective a reality, potentially—and most likely—saving the lives of thousands of Canadians.

Chair, thank you for the time today.

To the committee, I wish to again applaud deputy Webber for his efforts over the years in making the bill come to fruition and bringing it this way.

We are with you in the spirit of the bill, Mr. Webber, and I applaud your work on it.

I thank my colleagues for listening to me this afternoon.

The Chair: Thank you, Mr. Sorbara.

Members, I will remind you that to engage in the debate, you should use the “raise hand” function on the participants panel.

Mr. Webber, please go ahead.

● (1515)

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

I want to start off by saying hi to everyone. It's good to be back in a HESA committee meeting. I served for five years with you guys and I miss it, but I'm now on the public accounts committee, so that's quite interesting as well.

Mr. Chair, as all of you are aware because I sent you a document indicating my thoughts on the amendments here, in short I cannot support the proposed changes. It changes the scope and it changes the spirit of the bill, which is to get the initiative front and centre on the income tax form.

I want to talk a bit about the bill and the fact that it would not infringe on the provincial responsibilities of managing donor lists. It would just support their existing work.

My proposal is so simple and it could be implemented so quickly. The federal government, via the CRA, already successfully shares, every day, with the provinces and territories via these encrypted networks with strong privacy and reliability safeguards. The existing infrastructure is already in place so there would be virtually no cost to the CRA. The CRA, as you guys know, already shares dozens of data fields on information on every taxpayer with the provinces and territories. This would simply be one more data exchange.

The actual proposal by Mr. Sorbara, in my mind and in many people's minds, would change the scope of the entire bill. It would take it off where you can see it, which is right on the front page of the T1 form. By moving the question off the main income tax return, it becomes a footnote of irrelevance, and the effectiveness is dramatically reduced to the point of being basically pointless. These amendments would allow CRA to put the question somewhere less obvious and it could even be as obtuse as asking people to file a separate form, which nobody would do.

This issue came up in the last Parliament, in the HESA committee, and all the parties were clear that they wanted the question to be on the front page. The CRA was also clear about their ability to do this, as requested and expected by the members of Parliament.

I want to ensure today that the CRA hears loudly and clearly that the expectation of Parliament is to have this addition made on the front page of the T1 tax returns in all provinces and territories. This is déjà vu. We covered the same issue in the last Parliament. I testified at this health committee on the bill, which at the time was Bill C-316. I said that I wanted to ensure that the CRA hears loudly and clearly that the expectation of Parliament is to have this addition made on the front page of the T1 tax returns in all the provinces and territories. I also wanted it made clear that we expect people to have the option to tick a box on that front page, which would basically be a call to action.

I have to indicate also that the CRA was at the committee meeting and it was made clear to them. In fact, Sheila Barnard was at that meeting. She is with the CRA. She is responsible for the legislative changes affecting the T1 returns. She testified and stated that they had understood the intention of the bill to be on the annual tax return.

● (1520)

Mr. Frank Vermaeten, the assistant commissioner with the Canada Revenue Agency, was also there, and he was more direct in confirming his understanding on this issue. He stated:

> The front page is certainly a crowded page, especially when you move into the French version of it. That being said, we believe we can put it in that first page. That would be our intention.

Even our colleague Sonia Sidhu discussed it at HESA. She commented, "You said it's possible that, on the T1 layout, we can have a tick box on the front page so it can't be missed."

That is the point here. If we allow this question or process to be buried, it will be ineffective. I completely agree with her.

Mr. Chair, you also said:

> In our discussion, we have talked about the importance of this data capture appearing on the first page of the T1, but it doesn't specify that anywhere in the bill. Is there a way to ensure that this happens?

The CRA, Mr. Frank Vermaeten, said:

> I don't think there's a clear legislative way to ensure that this happens. As I indicated, it would be our intent to put it on the front page.

The CRA, then, indicated at the time that it can be done and that they were going to do it. All of a sudden, here we are again: déjà vu.

We have to simply ask ourselves the question: Does the amendment that MP Sorbara put forth strengthen the effectiveness of the bill and better improve the outcomes for those awaiting a life-saving transplant? I believe the answer is painfully obvious and I would strongly welcome your agreement, committee members, in this regard.

We have all worked so hard. I have worked so hard. Parliament has passed this unanimously, up to this point. We have worked hard to make sure that this initiative has been unanimously supported, just as it was in the last Parliament.

There are many people awaiting a life-saving transplant. They would be bitterly disappointed if we wasted this important opportunity and buried the question on some form in the back pages that nobody is going to fill out. Let's show all Canadians that we are united and determined in our desire to truly improve Canada's organ and tissue donation procurement system here in Canada. Please do not support the proposed amendments.

Thank you, Mr. Chair.

The Chair: Thank you, Mr. Webber. It is indeed good to have you back.

We go now to Mr. Davies.

Mr. Davies, go ahead.

Mr. Don Davies: Thank you. I don't have a lot to say, but I do have a question for clarification.

Just in general I want to thank Mr. Webber again for being so determined and persistent in this bill. I can say that I've worked with many parliamentarians, and—I said this in the House and I want to put it on the record here—there has been no more collegial or finer parliamentarian to work with in any venue than Mr. Webber. His contributions to this health committee were incredibly important.

Thank you.

I also want to second every single thing Mr. Webber said. I was privileged enough to serve on the health committee through the entire last Parliament, and I can vouch that every single fact and every single point that Mr. Webber just made is exactly true. I won't belabour the points. It's just that this is not just Mr. Webber's opinion; this is actually a very accurate recitation of what the evidence was.

My question, really, is to Mr. Sorbara. I want to make sure I understand what the purpose of his amendments is. It didn't strike me, when I was listening to Mr. Sorbara's remarks, that his purpose is aligning with what Mr. Webber says the changes are.

Mr. Sorbara, I'll ask you a direct question and feel free to elaborate if you feel it necessary.

Is it the intent of your motion, basically, to allow CRA to put the indication as to whether someone wants to have their information forwarded to a province for a potential organ donation anywhere on the form, including on a separate form or otherwise? Is that the main thrust of your amendment?

In other words, is Mr. Webber characterizing your amendment accurately?

The Chair: Mr. Sorbara, you may respond to the question, if you wish.

Mr. Francesco Sorbara: Thank you, Mr. Chair. I'll try to be as succinct as possible.

The intention of the amendment would be to have a separate sheet or page inserted into the tax package—it would be within the contents of the tax package—whereby if, for example, in negotiations with provinces a province wanted to have more information or less information with regard to the collection of information on tissue and organ donations, that wish could be accommodated. If it were solely contained on the first page of the T1 form, it would be very constrictive, given what's already on the front page of the T1 form.

As we know, the Province of Nova Scotia has already opted out of this process with their own system. Please correct me if I am wrong, my fellow parliamentarians.

We have also committed $35 million or $36 million over five years, I think it is, to improve the collection of data related to tissue and organ transplant.

As I said in my remarks, MP Davies, the page that would be inserted would be very similar to what is happening here in Ontario, whereby we have a separate page for what's called the Ontario trillium benefit. That information is collected and then shared with the Province of Ontario.

● (1525)

The Chair: Thank you, Mr. Sorbara.

Mr. Davies, did you wish to continue?

Mr. Don Davies: Maybe I'll offer a little bit of follow-up.

The purpose of Mr. Webber's bill, and Mr. Webber can correct me if I am wrong, is...because of jurisdictional issues. I remember when the NDP proposed—I think MPs from all parties at that one time proposed—the national organ donation registry. The reason it couldn't be done, according to, I think, the Liberals, was because of jurisdiction. They felt that was the jurisdiction of the provinces, which I think has informed Mr. Webber's bill.

This means that what we're doing on the tax form is having each taxpayer check off a box that will authorize CRA to furnish the information—the name and the contact information, I suppose—to a province that is in control of organ donation and that would then contact the person and take it from there.

If that's the case—and maybe I will ask Mr. Webber to confirm it—it's my feeling that we should stay with Mr. Webber's position, because we want the most prominent placement possible. Again without belabouring the point, CRA said that, although it was a crowded first page, it could be done. They understood that, and they had the resources and the ability to do it.

Do I understand this correctly, Mr. Webber and Mr. Sorbara? Really, all the tax form is doing is indicating to the province that the person may want to be available for follow-up.

This is why I'm not quite clear, Mr. Sorbara, what else would be on this single form, when this is the process we're actually doing.

Mr. Len Webber: Mr. Chair, that is the case. The fact that the national registry that was attempted by a colleague on the Conservative side years ago was shot down was the fact that the Liberals thought it was a provincial jurisdiction, which is fine. That's why my bill came to fruition.

Yes, Mr. Davies, all that is required by the CRA is to collect the name and contact information from the tax filer. That's it. You don't need a form put on the back pages of the tax-filing documentation system. It needs to be front and centre. Otherwise, it will not be filled out. Mr. Davies, that's the information there.

Thank you.

The Chair: Thank you.

Mr. Sorbara, did you wish to respond quickly?

Mr. Francesco Sorbara: Yes, I have a quick follow-up.

Obviously, becoming a tissue and organ donor is a very personal issue for all Canadians, and we want to make sure they have the proper information before making that decision. I would encourage everyone to become a tissue and organ donor, absolutely.

With regard to the placement within the tax package, to use the characterization that it's going to be buried in the back and that no Canadian is going to see it or that it has to be placed right on the front of the T1 form.... In my role as the PS to the national revenue minister, I often wonder why Canadians are filing their taxes. Obviously they're doing it to voluntarily declare how much income they've made to pay taxes owing or to get taxes received, but also to get their benefits and credits back, which they obviously have worked very hard for and deserve. That's within the CRA's mandate. We are now asking CRA to expand the scope of their original mandate to also include this information collection from Canadians.

Having it solely put on the T1 form would be.... If a province or Canadians asked for further information on why they were being asked to answer this, it would be very prudent to have it on a separate page so that provinces could get the information they need and Canadians could give the information needed and be confident. We also remember that 70% of tax forms are not prepared by the tax filer. We need to ensure that Canadians have the information they need and that the provinces will be able to rest assured that jurisdictional issues are being respected.

● (1530)

The Chair: Thank you, Mr. Sorbara.

Mr. Francesco Sorbara: I just want to say thank you to Mr. Webber.

I understand this issue and I'm with you. Obviously, there's a view here that I've brought forward. Len, I've reached out. We've chatted and had conversations, and I want to thank you for explaining your position. I fully respect it. The goal is to increase the number of people who have signed up to become organ and tissue donors.

The Chair: Thank you, Mr. Sorbara.

Mr. Davies, I don't know if you're done, but I'd like to move on to Mr. Van Bynen. Thank you.

Mr. Van Bynen, please go ahead.

Mr. Tony Van Bynen: Thank you, Mr. Chair.

Given the history, I've been struggling to support the amendment. If, as a result of not amending the bill, there's a delay in implementation, it's a trade-off with the effectiveness of where it is positioned on the tax document. I am happy to say that I am an organ donor as a result of the process that was in place in the province of Ontario.

I will support the bill either way, but I do believe that the proposed amendments will improve the process and expedite the implementation. For that reason, I'll support the amendment.

Thank you, Mr. Chair.

The Chair: Thank you, Mr. Van Bynen.

We'll move to Mr. Fisher, please.

Mr. Darren Fisher: Thank you, Mr. Chair.

I'm not speaking on the amendment, but please keep my name for when we are past the amendment stage.

Thank you.

The Chair: Okay, I'll try to remember that. It gets too hard to keep track of.

Ms. Rempel Garner, please go ahead.

Hon. Michelle Rempel Garner (Calgary Nose Hill, CPC): Thank you, Chair.

I appreciate that CRA is probably giving direction to the parliamentary secretary on this amendment, but I think Mr. Van Bynen brings up a really salient point here. I think the amendment is being characterized as this either-or dichotomy: Either we do this with a separate form or we're never going to get this implemented in an expedient period of time. I can't accept that. In this situation, the will and intent of Parliament is supreme. If Parliament gives direction to make this happen, with the intent of it being front and centre rather than buried in some separate form, then that's direction to the bureaucracy to make it happen.

I would rather that it happen properly than have it happen with limited impact. I think that's really the trade-off we're looking at here.

My understanding from Mr. Webber of the spirit of the bill is to incent as many Canadians as possible to think about making this decision and actually do it. I don't think that having assistance in a tax form is going to somehow remove consent. When you submit your tax return, even if you have assistance preparing it, you're still obligated as an individual to review that information and sign off on it that it's truthful and that you've disclosed everything. You are involved in informed consent in the submission of a tax form to begin with, so I think that's a bit of a false argument.

I think what's happening here is that perhaps the bureaucracy has given advice to the government that might make it easier for them to implement this, but in doing so it takes away the spirit and intent of the legislation. I don't think we can support the amendment while simultaneously supporting the spirit of the legislation, which is why I think we shouldn't support it.

With regard to the issue of provincial jurisdiction, in no way does the amendment remove the obligation to work with the provinces to make this acceptable within their jurisdiction. Again, I think that's been a bit of a false presentation; this would still have to happen. At this point, the time period to get that done is really a matter of the minister giving direction and overseeing the bureaucrats to make this happen between the provinces and the federal government. It's more of a matter of political will and efficiency within the bureaucracy than necessarily....

What I'm trying to say is that a statement that this is going to take years to happen is really a timeline being given by the bureaucracy, rather than political will or direction. I would like to think that, on an issue that's this urgent and that could save this many lives, we would see more political will.

The last thing is that I think the parliamentary secretary said that Nova Scotia had opted out. That's not correct. I believe they're moving to presumed consent, which is different from what was characterized.

I implore my colleagues, especially those from the Liberal Party, particularly Mr. Van Bynen. I think it's more important that we support the spirit of the legislation rather than the pedantry of a proposed implementation approach. This amendment would, I think, in effect neuter the spirit of the bill. I urge my colleagues that we can respect provincial jurisdiction, we can give direction to the minister and to the bureaucracy to make this happen within the spirit that it's being proposed, and we can actually do something that's going to save lives.

I strongly want to reiterate what my colleague Mr. Webber said about having this buried as a supplementary form in the back. The whole purpose of this bill is to have it up front so that people think about this and make a decision that could save lives. Having a form at the back might make the lives of a few bureaucrats a little easier, but I would rather that we, as Parliament, give direction to the government and to the bureaucracy to make this happen in a way that will actually save Canadian lives, rather than just put together a form.

● (1535)

Thank you.

The Chair: Thank you, Ms. Rempel Garner.

Mr. Barlow, you're up next.

Mr. John Barlow (Foothills, CPC): Thank you, Mr. Chair. I won't take much time.

Ms. Rempel Garner articulated very well much of what I was going to say.

I was not part of the health committee during the original debate, but I've certainly spoken to Mr. Webber about this legislation many times. This amendment—no offence, Mr. Sorbara—is a very big change from what all parties agreed to in the previous Parliament and have agreed to all along. Looking through the blues at some of the previous debates at the health committee on this, for the CRA to say previously that this wouldn't be a problem, that they have the wherewithal, the funding and the guidance from Parliament to do this with that tick box on the front page, and then to come back with a completely different position is alarming.

As to Mr. Sorbara's amendment, I know he said there would be a separate form as part of the T1 paperwork, but we have no assurance that's what it would be. Would it just be line 247 on your income tax return? Would it be an actual form that would be easily read and visible? The essence of Mr. Webber's legislation is to have this on the front page of the tax return. Every Canadian will see it. It will be prominent and well displayed. The CRA agreed to do that. No offence to the bureaucrats, but parliamentarians are the ones who are supposed to be providing that guidance and that direction to the bureaucracy. It's not the other way around.

The CRA could have brought these concerns to a previous Parliament or any time up until now. The assurance that we had from the CRA previously was that this was doable and would be done. Now to come back with an amendment.... Mr. Sorbara is being the messenger here so I don't want to put too much on his plate, but there's no assurance for us as parliamentarians where this message on becoming an organ and tissue donor would be in the application. He's saying it would be a form, but we don't know that because now they have gone from “Yes, we will have this as a tick box on the front page” to “We don't really want to do that. We could kind of commit to do this but...”. There are no assurances in the amendment Mr. Sorbara has offered.

I know, Mr. Chair, you've spoken in strong support of Mr. Webber's initiative during my short time on this committee. It is so rare when all of us as parliamentarians of different political stripes come together and put forward something that we all support, we all agreed to and we all worked hard to get to this point, and something we know is going to benefit Canadians. I just don't think it's right for bureaucrats within the CRA to say, “You know what? It would be easier for us or less work if we did *x* instead of what Parliament and the House of Commons has unanimously supported us to do”. I think that sends a poor message to Canadians whom Mr. Webber and many of you on this committee have worked with on this legislation. They are looking to us to follow through on what we committed to do in a previous Parliament and what we have committed to do up until now.

In conclusion, I know how hard Mr. Webber has worked on this. To get that support from all parliamentarians is something I think we should respect and not change on the whim of the CRA, which again isn't giving us any assurance on what it will look like. In the spirit of the legislation, I cannot support these amendments and I would certainly encourage my colleagues on the committee not to support the amendments as well and to maintain what we had all agreed to over the past several years.

To get so close to the finish line...and I know Mr. Webber was so close in the previous Parliament and that was a tough pill to swallow. To get here again, so close to the finish line, and then get this wrench thrown into the system is really unfortunate. I hope we can all respect what we agreed to before, not support the amendment and support the spirit of this legislation for the benefit of all our constituents.

Thank you very much, Mr. Chair.

● (1540)

The Chair: Thank you, Mr. Barlow.

Next up, we have Mr. Webber.

Mr. Len Webber: Yes, it's me again, Mr. Chair. Thank you.

I just want to make a couple of comments and ask a couple of questions to Mr. Sorbara.

First, regarding his comments about his concern about expanding the scope of the CRA, to me these amendments would further expand the scope of the CRA by having them ask additional questions rather than just the basics. The tombstone data such as your name and your contact information are all that is required by the provinces. It's just the contact information of tax filers who are interested in registering in their provincial organ donor registries. That's it. You don't need a whole form for that. You need a tick box for the tax filer to just indicate that, and the CRA will then transfer your name and your contact information. That's all they require. Of course, that's when the provinces will go forward with their forms in order to complete the process of registering the individual who would like to be registered.

I want to talk about consultation. I know, Mr. Sorbara, you have consulted with the CRA. I've consulted with the CRA as well, but not only them. I've contacted the Trillium Gift of Life Network, Canadian Blood Services, the Kidney Foundation and the Canadian Transplant Association. These organizations want it front and centre. They made it clear, and that's who we should be listening to: Canadians.

My question for Mr. Sorbara is this. Do you believe these amendments would strengthen the effectiveness of the bill and better improve the outcomes for those awaiting a life-saving transplant? I'd like to get your answer on that. Thank you.

The Chair: Thank you, Mr. Webber. I'm not quite sure I like the idea of tombstone data on my income tax, but we'll move on.

Go ahead, Mr. Sorbara.

Mr. Francesco Sorbara: Thank you to all the MPs who have provided substantive feedback on their views. I'm going to take this on a couple of levels, and I'll answer Mr. Webber's question. It's a very important question because to say that we're in favour of the intent of the bill, for me, means that we're in favour of the effectiveness of the bill and the final result we'd get from the bill, which is increasing the number of individuals who will have signed up to become registered tissue and organ donors. That has to be the goal of the bill, and this is a very important issue for many Canadians and for the organizations you highlighted.

There's always a balance in crafting legislation and getting legislation done, and there are many stakeholders and many points of view. As I know Mr. Barlow commented, what does it mean to listen to bureaucrats and other representatives? We need to take advice from our government officials and listen. Obviously, the final decision is with the government in terms of the direction, but it is pertinent and very imperative for them to provide that feedback to parliamentarians. It doesn't mean that we don't see issues or flags or say yes or no, but it is important to receive that feedback, in this circumstance, from the CRA officials.

In my gut, in my honest estimation, in this process that I've been involved with in examining Bill C-210, I would like to see, as Mr. Van Bynen commented, at the end of the day, the bill moving forward, absolutely. What I would like to see is a separate page within the tax package that clearly states...and that we could utilize with the provinces in a very quick and efficient manner. It would say what we could agree on with the provinces and what descriptive information may be needed to be put in there.

Again, I take it back. This is not simply, if I can use the analogy, our asking people if they wish to pass on their information to be registered by Elections Canada. Elections Canada is a federal agency. They pass on the information to them. They then make sure that individuals are on the electors list, and that is on the front page. On this example here, there are jurisdictional issues. Regarding the opt-out by Nova Scotia, I know Ms. Rempel Garner has commented on that. I'm going to take another look at that because I'm obviously always open to constructive feedback and learning if I've erred in interpretation.

Again, in terms of efficiency, effectiveness and getting this in the tax package, the quickest way to do that is to have it on a separate page, not on the T1 form, but within the tax package. It's still there. It would still be for everybody to see. We know that when the tax filers are preparing their information, it is important to ask. We need to ensure that Canadians have the information they need to make those decisions that are very personal in nature, including becoming a registered tissue and organ donor.

To Mr. Webber, that's a very long way of saying yes. I believe this still maintains the effectiveness of Bill C-210.

Thank you.

● (1545)

The Chair: Thank you, Mr. Sorbara.

We have Mr. Webber again.

Please go ahead.

Mr. Len Webber: Thank you again, Mr. Chair.

I have a very quick comment on Mr. Sorbara's comments. He says that the quickest way to get this done is to put it on a separate form. I would beg to differ. First of all, why would it take longer to put it on the front of the form than to put it on a form? Are you suggesting that putting it on a separate form would then put it into the 2020-21 tax season, yet if it was put on the front, it would take longer?

I would say, first of all, why would you think that? Second, I would disagree. I don't know why it would take longer to put it on the front than it would to put it on a separate form.

The Chair: Speak through the chair, please, if you wouldn't mind.

Mr. Len Webber: Okay.

Anyway, that was my point there regarding the quickest way. I would say absolutely not. It would take the same amount of time.

I'm done now. Let's go to the vote.

Thank you, Mr. Chair.

The Chair: Thank you, Mr. Webber.

Seeing no further speakers, I shall then call the question. Shall the amendment carry?

(Amendment negatived: nays 6; yeas 2 [*See Minutes of Proceedings*])

The Chair: We will move on to the vote on clause 1.

Mr. Fisher, I believe you wanted to speak to this. Go ahead.

● (1550)

Mr. Darren Fisher: I did want to speak to this, but Mr. Davies said exactly what I wanted to say. We have so many tremendous people in the House of Commons.

Len, you are truly one of them, and I'm happy to support your bill.

The Chair: Thank you, Mr. Fisher.

Seeing no further speakers, I shall call the question.

(Clause 1 agreed to: yeas 11; nays 0)

The Chair: Thank you.

Shall the title carry?

(Title agreed to: yeas 11; nays 0)

The Chair: Shall the bill carry?

(Bill C-210 agreed to: yeas 11; nays 0)

The Chair: That brings us to our last question. Shall the chair report the bill to the House?

Some hon. members: Agreed.

The Chair: Thank you, all.

Congratulations, Mr. Webber.

I would certainly like to thank everyone for their earnest and sincere advocacy on all the issues before us today.

I see that Mr. Webber has his hand up.

Mr. Webber, if you wish to speak, go ahead.

● (1555)

Mr. Len Webber: Thank you, Mr. Chair.

I just want to thank you all. I know I was a little bit passionate here today and a little bit, perhaps, emotional with respect to how I was speaking. I just want to say that I get that from visiting these transplant—

[*Translation*]

Mr. Luc Desilets (Rivière-des-Mille-Îles, BQ): I'd like to offer my congratulations to Mr. Webber.

[*English*]

Mr. Len Webber: I'm sorry. I didn't quite get that.

Anyway, I just want to say thank you—even to you, Mr. Sorbara. I know that you support this bill.

I just thank you, all, for supporting it when it does come to the vote. Yes, I'm very happy with the outcome today, so I just want to thank you. I know a lot of people who are waiting for organ donation thank you as well.

Thank you, all, very much, and have a merry Christmas, everyone. Thank you.

The Chair: Thank you, Mr. Webber.

Mr. Sorbara, please.

Mr. Francesco Sorbara: Very quickly, Chair, to Mr. Webber, I just want to say congratulations on the work you've done in pushing this forward.

It has been a pleasure to get to know you in this last week. I think these are the first interactions we've had, and it's been an absolute pleasure to chat with you and to get to know you.

My best to you and your family over the holidays.

The Chair: Thank you, Mr. Sorbara. We go now to Ms. Sidhu.

Ms. Sidhu, go ahead.

Ms. Sonia Sidhu: Thank you, Mr. Chair.

Mr. Chair, I want to put on the record on behalf of those who have served on the committee with you that we will miss you, Mr. Webber. Congratulations. You were the nicest person on the committee. Thank you for all the work you did on the previous committees and for this one too. Thank you.

The Chair: Thank you, Ms. Sidhu.

Ms. Rempel Garner is next, please.

Hon. Michelle Rempel Garner: From the slightly less nice person who replaced Len on the committee, from me to everyone else on the committee this year, I just wanted to say, on behalf of the Conservative caucus, thank you, Chair, and thank you to the clerk and the interpreters.

We have a lot of work to do in the coming few weeks and in the new year, but this year I think has placed an inordinate amount of strain on everybody, in every walk of life. No matter where you are or what you do, this year has created challenges.

I sincerely hope that we can work together in the new year to come up with solutions for Canadians. While we do sit in positions of privilege, I want to wish all of you time with your families, as much as possible with the COVID restrictions, and some rest and relaxation before we hit the grind again in the new year.

Merry Christmas and happy holidays to everybody on the committee on behalf of the Conservative caucus.

The Chair: Thank you, Ms. Rempel Garner.

Mr. Davies, go ahead.

Mr. Don Davies: Thank you.

On behalf of the large New Democrat caucus represented on this committee, I would also like to express my appreciation to all of you. I knew that if we waited long enough violent agreement would break out.

I know that it takes time for a committee to gel, and I want to say that we have different opinions on things, but I never doubt the absolute goodwill, integrity and desire to make things better that comes from each and every one of you. It's a real privilege to serve on this committee.

Like Michelle, I want to wish all of you the best of the season. I hope you have a safe time with your families. I look forward to seeing all of you in the new year.

The Chair: Thank you, Mr. Davies.

Mr. Van Bynen, go ahead please.

Mr. Tony Van Bynen: Thank you, Mr. Chair.

It has been a very interesting and good learning experience for me. I certainly appreciate having the benefit of many seasoned politicians on the committee. That's been to my benefit.

I very much respect and appreciate the deep commitment that brings all of us to the Hill and the genuine intent to make this country a better country for our citizens. I truly appreciate the way that we're all working together, and I am honestly looking forward to making some great progress next year.

The Chair: Thank you, Mr. Van Bynen.

We'll go now to Mr. Kelloway, please.

Mr. Mike Kelloway: Thanks, Chair.

I may be the last one up, but I want to share in the sentiments here. I want to say thank you to each of the members, because as a newbie you learn from your team, but you also watch and learn as others in the committee work and you see how they ask questions and how passionate they are.

To old members and new members of the committee, have a merry Christmas, have a great rest, hopefully, and we'll come back in January ready to rock and roll.

● (1600)

The Chair: Thank you, Mr. Kelloway.

Mr. Davies, your hand is up again.

Mr. Don Davies: I'm sorry. I was remiss in not expressing my thanks to Karin as well.

Not only was it a pleasure, but we were so fortunate to have Karin's excellent research and stewardship for this committee over the last five years. I want to thank her and also wish her all the best in her next venture.

The Chair: Thank you, Mr. Davies.

Mr. Maguire.

Mr. Larry Maguire: I want to add my congratulations to everyone for the hard work they've done throughout this whole committee and the whole year and take this opportunity to wish everyone a merry Christmas as well.

I've spent a lot of years in Manitoba, working across the floor with my colleagues in the Manitoba government and on my own side of the House, so this is nothing new to me. I really appreciate the opportunity today to congratulate everyone on moving Len's bill to the point it's at. It's a bill for all of us.

I want to wish everyone a merry Christmas.

Thank you.

The Chair: Thank you, Mr. Maguire.

I'm going to take the last word here. I also would like to thank everyone for all their work throughout this past year. It's been interesting and very useful. I wish you all a merry Christmas and happy holidays.

I would like to leave you with the words of Dr. Bonnie Henry: “Be kind. Be calm. Be safe.” Thank you all.

With that, we are adjourned.