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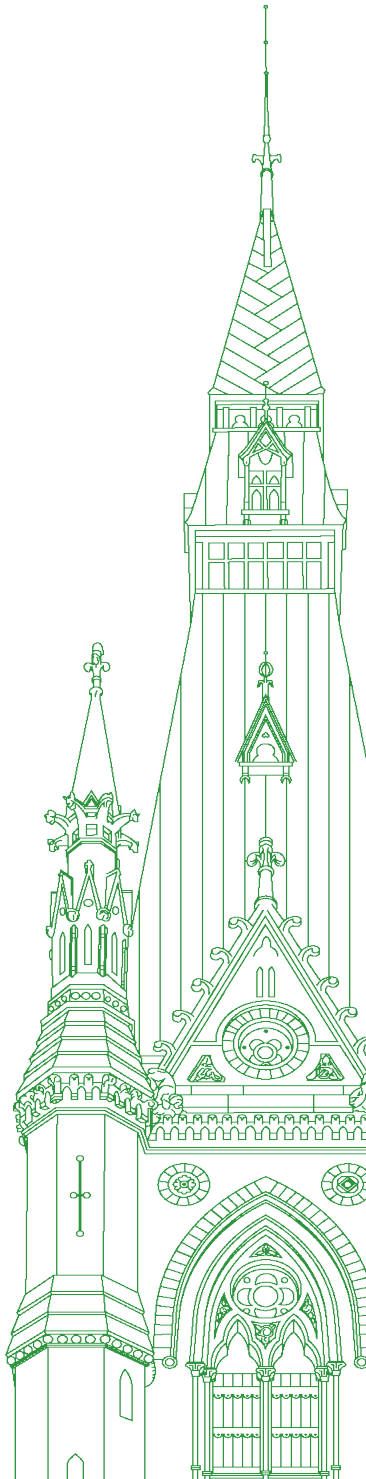

Chair: Mr. Ron McKinnon

Standing Committee on Health

Friday, June 11, 2021

● (1305)

[*English*]

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

Welcome, everyone, to meeting number 43 of the House of Commons Standing Committee on Health.

The committee is meeting today to study the emergency situation facing Canadians in light of the COVID-19 pandemic.

I'd like to welcome the witnesses.

Appearing as an individual is Dr. Jillian Kohler, professor, Leslie Dan Faculty of Pharmacy, University of Toronto. Also appearing as an individual is Mr. Yanick Labrie, health economist.

Mr. Labrie will be joining us for both panels. He will be talking, actually, about the PMPRB, I understand.

We have, from Dan's Legacy Foundation, Ms. Barbara Coates, executive director; and Mr. Tom Littlewood, psychologist and program director.

I'd like now to invite the witnesses to make their brief statements.

Before we do that, I will note that I have cards—magic cards. I will display the yellow one when there's roughly a minute left in your time, and when your time is up, I'll display the red card. When you see the red card, you don't have to stop instantly, but do try to wrap up.

That being said, we will start now with Dr. Kohler.

Dr. Kohler, please go ahead. You have five minutes.

Professor Jillian Kohler (Professor, Leslie Dan Faculty of Pharmacy, University of Toronto, As an Individual): Thank you so much.

Honourable members, thank you for the opportunity to speak today.

I am going to focus on how a lack of transparency and accountability in the supply of COVID vaccines has impacted Canadians. The COVID-19 pandemic has amplified the vital importance of the role of governments to ensure access of their populations to safe and effective vaccines.

The deployment of COVID-19 vaccines illuminates the importance of transparency. The large sums of public funding involved in the research and development process, every country's urgent need for the vaccines, and the need to enhance public confidence in them are reasons we need transparency. What is more, public funding has contributed to the development of the COVID-19 vaccines, earning the global public a right to have much more transparency around their procurement.

COVID-19 vaccines are a global public good. Everyone everywhere can benefit from them.

When information regarding the deployment and supply of these vaccines is not publicly available, there is an information vacuum. That creates fertile ground for public distrust in vaccines and may contribute to vaccine hesitancy, as well as allowing for misinformation to flourish.

Opacity in clinical trial reporting of adverse effects can contribute to vaccine hesitancy as well. According to a recent Gallup world poll, such hesitancy translates into about 32% of people worldwide who are unwilling to get a vaccine. This will put a critical dent in our efforts to end this pandemic.

Uncertainty and misinformation can only be tackled by the sharing of evidence often and clearly. The more this is done, the more likely we are to generate public trust and bolster our vaccine deployment efforts.

In "For Whose Benefit?", a recent study my research team contributed to with colleagues from Transparency International UK, we found that Canada has done relatively well in making its clinical studies report available. Still, Canada has also participated in the alarming trend of governments censoring key details of their orders from drug companies, or not releasing them at all. This creates, and rightly so, a perception of asymmetric power between pharmaceutical officials and public officials.

Procurement in the best of times is a government function that is at the highest risk of corruption. During emergencies, these risks are amplified due to the need for speed and flexibility in the process. We need to move fast. That is why transparent and accountable public emergency procurement processes are vital during a pandemic.

Accountability helps to ensure that relevant institutions answer to those who will be affected by decisions or actions taken by them. It can also reduce the risk of abuses, assure compliance with standards and procedures, and improve performance and organizational learning. Institutions need to explain and justify their results to internal and external monitors or stakeholders and, when performance falls short, we need to let that be known.

We have witnessed a deficit of transparency and accountability on the part of the Canadian government, particularly in terms of its negotiations and purchasing agreements with pharmaceutical companies. Greater transparency will allow the public to know what prices were paid. This will allow for more informed decisions and can, over time, lead to greater purchasing power to negotiate prices with suppliers. Transparent pricing data can illuminate patterns and any outliers, such as overpayments, kickbacks, etc.

Procurement systems without accountability and transparency mechanisms create real risk in terms of credibility and trust in the process.

We know that this pandemic will only end when we are all safe. This means we, as Canadians, need to be concerned not only about our own vaccine supply but also about those of other countries, not only for health reasons but for humanitarian ones, as well.

We're dealing with the pharmaceutical industry, which is often secret in order to protect its commercial interests. This has never been acceptable. As the saying goes, in times of crisis, there is opportunity. The global pandemic is an opportunity for the Government of Canada to insist on transparency from the pharmaceutical industry and, in doing so, heighten its accountability to the Canadian people. It needs to be forthcoming with how much it's paying, what it's negotiating and why, in order to boost public trust and confidence in our supply of COVID-19 vaccines.

Early on, prior to Health Canada’s authorization of any COVID vaccine, the federal government overbought doses for the Canadian population. In our study we found that we have, as Canadians, 11 agreements in place, which translates to about 16.23 doses per person. By comparison, the United States has eight total agreements and about 10.2 doses per person.

In Canada, despite this abundance, we failed to meet clear timelines in terms of when the deliveries from manufacturers would happen. As a result, supplies were erratic and uncertain in the first quarter of 2021, and this meant frustration and fear amongst Canadians.

Even though our government made agreements with manufacturers that far exceed our population needs, we also dipped into COVAX, which is the multilateral initiative for helping to ensure equity of access to COVID vaccines globally. Canada's standing as a global health leader is now in question, as it turned to COVAX when the majority of low-income countries globally are still struggling to have enough vaccine supply to vaccinate even their health workers.

In closing, what I will say is that it's essential to integrate better transparency and accountability measures in our agreement with the pharmaceutical industry if we hope to gain public trust. Canada has the opportunity right now to champion pricing transparency, become a global leader for clinical trial transparency, and also release full information about its vaccine negotiations with suppliers.

Thank you for your time.

● (1310)

The Chair: Thank you, Doctor.

[*Translation*]

Mr. Labrie, go ahead for five minutes.

Mr. Yanick Labrie (Health Economist, As an Individual): Thank you, Mr. Chair.

Good afternoon, everyone.

First of all, I would like to thank the members of the Standing Committee on Health for the opportunity to testify today as an individual on the regulatory changes contemplated by the Patent Medicine Prices Review Board, the PMPRB.

My name is Yanick Labrie, and I am a health economist. I have taught economics at various colleges and universities in Quebec. In the past 15 years, I have conducted more than 30 studies on pharmaceutical policy issues for various research centres. My presentation today is based in large part on research that I have conducted and published in recent years.

In March 2020, the PMPRB's executive director stated that the tightening of price controls under consideration would not have a negative impact on R&D investment or drug launches in Canada. It was a surprising statement, to say the least, and one that contradicted both economic theory and the empirical literature on the subject.

First of all, we know from economic theory and experience that pharmaceutical companies rank potential investment projects in descending order of each one's expected rate of return. Obviously, in the context of tightening price controls, with increasing uncertainty surrounding R&D projects and declining anticipated profits, one should clearly expect a drop in pharmaceutical R&D investment in Canada if the PMPRB decided to implement its regulatory reform. The entire life sciences ecosystem across the country, particularly in Quebec and Ontario, would be affected.

Furthermore, there can be no doubt that pharmaceutical companies will tend to prioritize launching their drugs in countries where anticipated profits will potentially be highest. Since stricter price controls decrease companies' anticipated profits, there will be less incentive to prioritize new drug launches in the Canadian market, which is relatively small in the global context.

These are not merely theoretical predictions. Last year, I conducted an exhaustive review of the scientific literature on the links between price regulation, pharmaceutical R&D investment and access to medicines. That peer-reviewed study was published in the June 2020 issue of *Canadian Health Policy*. Only 4 of the 49 academic studies surveyed established a significant link between price controls and delays in new medication launches, and only one found no evidence that price controls reduce pharmaceutical R&D spending. All the other 44 studies showed that price control policies discourage R&D investment and reduce or delay drug launches in countries that impose them. Small markets for pharmaceutical companies, such as Canada, are particularly at risk of seeing delays in the marketing of new medicines.

You also have to understand that delayed drug launches generate societal costs because they prevent many patients from enjoying the drugs' health benefits sooner. These delays increase the risks of complications and premature death and have negative effects on patients' quality of life. They also increase the economic burden that patients are very often forced to bear while waiting for a more effective drug.

From 2009 to 2018, it took an average of 690 days, nearly 2 years, for provincial governments to agree to cover new medicines approved for marketing in Canada. Unfortunately, the tightening of price regulation contemplated by the PMPRB could vastly undermine pharmaceutical innovation and force patients to go without drugs they need or to wait even longer for access thereto.

The regulatory changes proposed by the PMPRB are based on the idea that the rising influx of costly drugs in recent years would compromise the capacity of insurance plans to bear the increased costs associated with them. However, the data that the Canadian Institute for Health Information has published on changes in total spending on prescription drugs in the past 10 years show that this is not all the case.

In fact, despite the rising influx of more expensive drugs into Canada, we have seen slower growth in total pharmaceutical spending in the past few years, including distribution and pharmacy services. Adjusted for inflation, real per capita spending on medicines has experienced zero growth in Canada since 2010.

● (1315)

Spending in all other main health expenditure categories has risen faster than spending on prescription drugs in the past 10 years. In 2019, prescription medicine spending represented 13% of total health expenditure in Canada, a figure that had declined since 2010. Spending on prescription drugs across the country also fell as a percentage of GDP from 1.7% in 2010 to 1.5% in 2019.

This pharmaceutical expenditure actually tends to be overestimated as it does not reflect confidential discounts secured by federal, provincial and private drug insurance plans.

In conclusion, I do not recommend that the members of the Standing Committee on Health support the regulatory changes contemplated by the PMPRB. Contrary to what one frequently hears, spending on drugs and pharmaceutical services is not out of control in Canada. Spending on prescription medicines has represented a steadily declining segment of Canada's economy and health budget since 2010.

The tightening of price regulation that the PMPRB is considering could well have negative consequences for the Canadian public. It will not only delay the launch of new drugs in Canada and reduce their number but will also discourage R&D investment, which is essential to guaranteeing the development and availability of new medicines for Canadians in future.

Thank you for your attention.

The Chair: Thank you, Mr. Labrie.

[*English*]

We go now to Dan's Legacy, starting off with Ms. Coates.

Ms. Coates, please go ahead.

Ms. Barbara Coates (Executive Director, Dan's Legacy Foundation): Thank you, Mr. McKinnon.

Hello, everyone. I'm Barbara Coates. I'm the executive director of the Dan's Legacy Foundation. I'm joining you today with my colleague, Tom Littlewood. We thank you for this invitation to speak to the committee.

I'm Zooming in with you from Delta, British Columbia, which is on the traditional and unceded territory of the Tsawwassen and Musqueam first nations. Mr. Littlewood is joining us from Coquitlam, which is in Mr. McKinnon's riding and is, of course, the traditional and unceded territory of the Kwikwetlem First Nation.

My colleague, Mr. Littlewood, is a psychologist with over 45 years' experience in working with youth at risk in the community, and we're here today to offer both our testimony on how the coronavirus pandemic has affected the opioid crisis here in Metro Vancouver and our recommendations for harm prevention solutions.

I'd like to turn it over to Mr. Littlewood now.

Thank you.

Mr. Tom Littlewood (Psychologist and Program Director, Dan's Legacy Foundation): Thanks, Barb.

Regarding COVID-19 and its effect on mental health, overdoses, self-harm and psychosis incidents have increased 50% with our youth clients. We serve about 300 clients a year currently, and that is about to double. Hospitalizations, because of this, cost $1,500 to $2,500 a day and up.

Anxiety and depression are widespread. These mental health issues paralyze young people, causing many to retreat and hide in their single-room occupancy, SRO suites, or basement suites.

The opioid crisis has worsened during the COVID-19 pandemic. We predict that the situation will only get worse, as there are thousands of young people in line to become the next wave of addiction to hit our streets.

Every year about 1,000 youth age out of care in British Columbia, and a further 1,000 hit the streets, running away from dysfunctional homes. Over 60% of these youths aging out of foster care will descend into entrenched addiction to numb their psychological pain.

However, there is a critical period between the ages of 15 and 25, when these young people usually ask for help. If trauma-informed therapy is provided to them for free and without a waiting list, up to 75% of these youth will respond and achieve success in school, work, recovery, housing and job-skills training. They can be diverted from the path towards homelessness, entrenched addiction, overdose and suicide and on towards lives they will enjoy living.

The initial effects of past trauma, which include physical abuse, mental abuse, sexual abuse, poverty and intergenerational trauma experienced by our indigenous clients, are normally expressed, to begin with, as anxiety, depression, eating and sleeping disorders, and self-medicating behaviour.

Our therapeutic intervention of four months of trauma-informed counselling costs approximately $2,500. Once the youth descends into entrenched addiction, it costs the community millions of dollars when police services, first responders, hospitals, corrections system, etc., are factored in. This does not even begin to take into account what the addict has to steal, or the sex acts they have to perform in order to get the money to buy the drugs they need.

Harm prevention, specifically trauma-informed therapy, can divert a youth's path away from addiction and homelessness, which not only saves valuable lives but saves millions of dollars in costs to the community.

Trauma-informed recovery is a new idea, and it's still controversial. Rather than the 12-step abstinence recovery programs, which are not best practices with youth, especially regarding opioid addiction, trauma-informed recovery involves a doctor, a therapist and a client agreeing to a contract whereby the physician prescribes an opioid replacement for the client while the client is undergoing trauma counselling.

When working with a therapist, typically over a period of four months, the client first learns self-regulation techniques. This is followed by the counselling trauma work, to help youth gain insight into their past trauma.

Once the trauma work is complete, the client has no need to self-medicate for the psychological pain, and this is when the physician steps in to provide something like an opioid replacement of Suboxone to help them come down without the drug sickness.

This approach is new and controversial, but it is becoming the best-practice model for young people with opioid addiction. Using prescribed stimulants as a replacement for street drugs like crack or meth is also being explored.

The side effect of the opioid crisis and the overdose crisis is the growing number of permanent brain damage situations caused when someone is brought back using Narcan or Naloxone. Some youth brag about how many times they have recovered using Naloxone; however, as therapists we can see the gradual deterioration of cognitive function after multiple applications of Naloxone over multiple overdoses.

A practical harm prevention idea that you can take from this is a CERB forgiveness program for young people who engage in recovery, education, work or training for a year. The money is gone; it's not going to be recovered. These kids don't have this, but it will create an insurmountable obstacle for these young people and cause thousands to give up and go underground to the street, speeding up the path to addiction and homelessness. I have had a youth end their life by suicide when faced with $1,000 in transit fines, which come due when they are about to get their first driver's licence. Imagine the chaos we're going to find when thousands are asked to repay the thousands of dollars they received from CERB fraudulently.

● (1320)

In summary, our goal is to get ahead of the curve of both COVID-19 and the opioid crisis by employing harm-prevention strategies of trauma-informed therapy, training and recovery.

Thank you.

The Chair: Thank you all.

We will now start our questions with Ms. Rempel Garner.

Please go ahead, Ms. Rempel Garner, for six minutes.

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

My questions will be for Dr. Kohler.

Dr. Kohler, our committee has had a great degree of difficulty obtaining details around the contracts that were signed by the federal government with vaccine manufacturers. One small example would be that I don't think Canada has received a single dose of vaccine from AstraZeneca, in spite of our bilateral contracts.

Based on your research, is there any reason why we as parliamentarians shouldn't be getting access to that?

Prof. Jillian Kohler: The short answer is that there should be absolutely no reason why you can't get access to that. What I was advocating for—and I had to shorten my presentation—was that the public as well as our representatives in Parliament should know.

What was interesting was that in our research we were looking globally, but we found it was very hard to get access to these contracts. Again, don't cite me—I can give you the proper numbers—but I think we looked at about 182. We could get good information for only—

● (1325)

The Chair: Dr. Kohler, could you lift your mike, please?

Prof. Jillian Kohler: I apologize. I'm using my own microphone. Does that work better?

Even with the contracts we found, there were a lot of redactions. Even if they are publicly available, oftentimes the information is limited. I'm speaking generally now.

My point is that I think this is a political decision. This is about the government not standing up to its suppliers and saying, "We need to have transparent contracts in place."

The other point I want to raise here is that Canada, as we all know, has done prepurchases with suppliers that far exceed those of pretty much any other nation in the world.

Hon. Michelle Rempel Garner: Can I just get in on that?

Do you think that happened because they came late to the table? Once upon a time I used to work in something like that space, and that's really the only reason I can surmise.

Prof. Jillian Kohler: Again, I defer to you on that.

I would say, though, that it in fact gives Canada a lot of power to negotiate. When we purchase so many doses, we can say, "We're going to be a big purchaser, and this is what we want: We want transparency."

Hon. Michelle Rempel Garner: I'm sorry to cut you off, but I have a very short period of time.

I've read some of your work, and I know you do a lot of work on anti-corruption and accountability. Do you have any comments on what potentially went wrong between CanSino and the federal government on that vaccine contract?

Prof. Jillian Kohler: It's a big question. I would argue that we're talking here about bigger issues. We're talking about foreign affairs. We're talking about geopolitics here, so I don't think we can look at that as simply a contract between the Canadian government and one supplier. I think we're looking at the global political context, in that light.

Hon. Michelle Rempel Garner: The other thing the committee is looking at right now, in the context of both PMPRB reform and access to vaccines, is the concept of the government's role and what the government has done in terms of supporting research and pharmaceutical research, particularly in the private sector in Canada, and then what the trade-off should be.

In bullet-point format, in 30 seconds or less, what are the types of subsidies that government would give to pharma right now, including intellectual property protection frameworks?

Prof. Jillian Kohler: I'm going to speak to what I know, which is intellectual property. I'm not an economist; I'm a political scientist.

I'm going to actually say we don't need to be giving IP protection. In fact, I think if anything, we need to be rethinking the IP model. That is one of the major issues we have in terms of access to COVID-19 vaccines. We've seen that, historically, the United States is actually saying we should be waiving intellectual property rights.

I would say we need to be negotiating differently with the industry. These are different times and bigger crises, and the same old doesn't work. That doesn't quite directly answer your question, but I'm hoping—

Hon. Michelle Rempel Garner: No, no; it's good. I think we have to talk about intellectual property rights in a broader context here.

In that context, I know that therapeutics for infectious diseases and vaccine development are normally on the low end of the priority list for pharma development. What are the incentives, and what are the reasons for that? Is it our IP protection model or what?

Prof. Jillian Kohler: It's about where the market is, quite frankly. The industry will be the first to say that it will invest where there are markets and where profits are greatest.

I know I'm sounding extreme here, but I've been working in this area for 25 years as a policy person and as an academic, so I've worked on many sides of this issue. The reality is that we can't rely on the industry to fill all our needs. There needs to be a rethinking in terms of the role of government—

Hon. Michelle Rempel Garner: I have just a last question. I'm sorry. I'd love for you to table any recommendations that you have with our committee.

It's on a different subject, but it's related. The COVID Alert exposure app has only been downloaded a few million times. One expert called this ludicrously low, but a lot of government resources have been attached to it.

You talk about value for money. Do you think additional resources for this app at this time are a good idea? This is another thing that is before our committee in terms of supplementary estimates.

Prof. Jillian Kohler: Absolutely not. In the development world, we look at value for money and the biggest bang for the buck. If there's not a bang for the buck and it's not working, then shift resources elsewhere. Maybe it's more about public health education and information strategies, etc.

In terms of recommendations, we should be waiving intellectual property rights, one hundred per cent. That is my strongest and probably most passionate recommendation.

● (1330)

Hon. Michelle Rempel Garner: Thank you.

The Chair: Thank you, Ms. Rempel Garner.

We go now to Dr. Powlowski.

Dr. Powlowski, go ahead, please, for six minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): My question is for Dr. Kohler as well. Let me begin by saying that I absolutely agree with waiving the intellectual property rights on vaccines so developing countries can get greater access to them.

I wanted to comment or question you about your article in The Globe and Mail in February, entitled “Developing countries won't forget Canada's 'me-first' approach to vaccines” , in which you talk about a “my-nation-first” approach to vaccines.

An article just came out in the Globe, I think, suggesting that we're committing 100 million doses to developing countries. I think you realize we are one of the biggest contributors to COVAX.

I think the question is going to be when we start sending those doses of vaccine. Let me ask you this. I'm a member of Parliament for Thunder Bay—Rainy River. I have an obligation to my constituents. I have spent seven years working in developing countries for $1,000 a month, when I obviously could have made way more money here. My kids got malaria; I got malaria and our kids got dengue, but I absolutely believe that global equality in health care ought to be one of our society's greatest goals.

Having said that, if we're advocating starting to give vaccine doses now, when Canadians haven't been fully vaccinated.... For example, my parents, who are in their 80s, have only gotten one dose. If we get the delta variant, apparently one dose decreases incidences of symptomatic disease by only 33%. It's not that good.

What can you say to us as MPs? How should we balance those two important considerations and the fact that people in my riding would probably say that they agree with giving these vaccines, but let's protect our own population first?

Prof. Jillian Kohler: Thank you. That's a very good comment.

I'm going to go back. The world has changed since I wrote my op-ed.

I don't think it should be an us or them proposition. I want to stand very clearly on that. Of course, I don't want to be accused of saying that I'm trying to take vaccines away from Canadians. Of course I'm not. I don't think it's us versus them. That's my main argument. We're all in it together. That's a cliché; we're not really all in it together if you look at the inequities, but let's use that as our framework.

While we're working towards getting all Canadians vaccinated, we need to think about what we can contribute, whether it's funding, perhaps providing other medical supplies or, when we're able to, providing the doses, as you said. It just came out in The Globe and Mail. I did see that this morning, as well, which obviously makes me very happy.

I think we need to look at this differently. It's not about us versus them. It's about how we all work on this.

As the head of the WHO has repeatedly said, we're dealing with a global pandemic, so the reality is that even if you don't buy into the need to address other countries' needs, this will never be resolved unless everyone gets access to a vaccine. This is putting the need for more equity in terms of vaccines, medicines and other supplies into the spotlight.

I would say we need to make sure we don't frame it as taking away from us for them. That's not the right approach. I think it's more about how we can help as best we can and when we can.

Mr. Marcus Powlowski: My second question is also for you. You talked about our vaccine supply being erratic and uncertain. I am a Liberal, so obviously I'm going to try to defend our own position, although I don't always do that.

I would suggest, however, that we've been told by vaccine makers that orders were made on a quarterly basis by pretty well every country, and that this is the way it's done. Although we couldn't predict exactly whether we were going to get supplies in February or March, we knew that by the end of March, we were to get so much. Most of the vaccine producers have been pretty good.

The other reason for some uncertainty has been manufacturing difficulties, like when Pfizer had to decrease production in order to revamp its production facilities to increase production, which it really did.

Doesn't this account for at least part of that uncertainty, and things that are kind of beyond our control?

● (1335)

Prof. Jillian Kohler: Those are fair points and absolutely true. Vaccines are very complex to manufacture. There are always going to be delays, but this goes back to my main message regarding the lack of transparency.

What Canadians needed to know.... Again, I'm not assuming that every Canadian was going to be interested, or wanted to know, about the nuances or the details of the supply system. However, it just wasn't clearly articulated. There was fear, and there were concerns. If people had been informed that this was not going to be necessarily a smooth process—that we would have to deal with unknowns and, perhaps, with manufacturing glitches, which was what we experienced—that would have been better.

The messaging was that we're all going to get it at certain dates, which was done in order to appease people's concerns, but at the same time the full story was not provided. There wasn't enough about what the government did, or the how and why. Again, keeping Canadians better informed would have led to a lot less anxiety. Speaking just about people I know and my own personal experiences, it was really stressful to understand when and how people would get supplies.

Happily, things are better now, but as Canadians we went through a lot of uncertainty. If we had just been prepared for that, it might have been a little easier. I'm not saying fully easier, but slightly easier.

Mr. Marcus Powlowski: Thank you.

The Chair: Thank you, Dr. Powlowski.

[*Translation*]

We now go to Mr. Thériault for six minutes.

Mr. Luc Thériault (Montcalm, BQ): Thank you very much, Mr. Chair.

I'd like to thank all the witnesses for their testimony today.

We parliamentarians are here to find solutions and make recommendations. Your remarks are interesting and can help us in that effort.

My question is for Mr. Labrie.

Health Canada boasts on its website of the regulatory relief it has introduced to make Canada an attractive place for research and clinical trials on COVID-19 vaccines and drugs. It seems to me that contradicts the reform and regulatory tightening the PMPRB is proposing. Many stakeholders have come and told us the contrary: that this tightening will have an impact on new drug launches and clinical trials. I wanted to know if the same regulatory relief would be available for other diseases, and it appears it won't. In addition, the coming into force of the reform, which is scheduled for July 1, will not be postponed.

Consequently, I see a contradiction here in your saying that this reform will have an impact on the life sciences ecosystem, R&D and new drug launches. The PMPRB seems to be flying blind. On the one hand, it tells us these consequences won't occur and that that's just an illusion. On the other hand, witnesses have told us in committee that, in five years, the PMPRB has conducted no studies to determine what the negative effects on the life sciences ecosystem might be.

What do you think of that omission from a methodological standpoint?

Mr. Yanick Labrie: Thank you for your question, Mr. Thériault.

First, you're entirely right to note the contradiction. It's obvious.

In fact, the PMPRB admits, through its actions and regulatory relief for vaccines, that its reform will indeed cause launch delays and problems. If it were consistent, it would continue this trend and do the same thing, which is to tighten price controls for vaccines as well. You're entirely right in saying that the fact it's currently loosening them is contradictory. That confirms what I'm saying.

You noted that the PMPRB hadn't even conducted an impact study to determine what consequences the regulatory reform might have on the life-sciences ecosystem. You're entirely right. I was able to lay my hands on only one simple—I'd even say simplistic—analysis. It's a correlation analysis involving a few variables and a number of countries, but no confounding factors. However, it's extremely important in science to have this type of study. Economists and other researchers in the social sciences will tell you it's very important, when you conduct this kind of study, to try to assess not only the correlation but also causal links. A study is virtually worthless without them.

Consequently, I'm not surprised there's been no impact study. The study I got my hands on isn't a very rigorous one for a public body such as the PMPRB.

● (1340)

Mr. Luc Thériault: Earlier you said there were 44 studies that demonstrated the opposite of the claims made by the PMPRB, which, in your own words, relies on a simplistic methodology.

I've often heard people cite, as a counterexample, Belgium, a country where there's a lot of R&D and drug prices are low.

Could you explain that counterexample to me? Do you think it's valid?

Mr. Yanick Labrie: Actually, the PMPRB people cited that example in public debate. It's an example of what you shouldn't do when you want to advance an argument in science. It's anecdotal. They took a suitable country that exhibits in several respects what they wanted to demonstrate, but it's a small, two-country correlation. I'm sure you'll agree the sample is very small. They also disregarded many factors. They may have omitted many factors that are responsible for the fact that there's no more investment in Belgium, for example.

They could have presented a counterexample such as Switzerland, where prices are higher and there's an extremely high level of spending, private pharmaceutical R&D investment and extremely enviable access, for the Swiss, to new medicines.

So this kind of example is of little value in practice because it's anecdotal.

Mr. Luc Thériault: You told us that the growth in spending on prescription drugs was under control in Canada. That's not really what the PMPRB is saying with [*Technical difficulty*]. Are you questioning its analysis and figures?

Mr. Yanick Labrie: Absolutely. It really surprised me. When I look at the PMPRB's annual reports, I'm always surprised that it fails to adjust for inflation, for example, in presenting chronological data on changes in drug spending. It's an amateur mistake. In fact, you can't make that kind of mistake when you present data to the general public. You also can't fail to take into account demographic changes and population growth. That's another frequently committed error. You obviously have to conduct rigorous analyses. That's extremely important.

When you carefully consider data from the Canadian Institute for Health Information, which is a parapublic, independent and unbiased body, you see, after adjusting for inflation and population growth, that there hasn't been a sharp increase in spending on prescription medicines. In fact, this is the health expenditure category that has risen the most slowly. It's [*Technical difficulty*]. In addition, the main reason for this growth in drug expenditure isn't higher prices but rather an increase in consumption. There's a larger quantity of prescription drugs…

The Chair: Pardon me, but time is already up. Thank you.

Mr. Yanick Labrie: Thank you.

The Chair: Thank you, Mr. Thériault.

[*English*]

We'll go now to Mr. Davies.

Mr. Davies, please go ahead for six minutes.

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

Dr. Kohler, federal procurement minister Anita Anand has told this committee that Canada's vaccine contracts are subject to confidentiality clauses in their entirety. She even claimed that the confidentiality clauses themselves are confidential.

I just want to make sure I understand your evidence. Is it your evidence that this secretive approach to Canada's vaccine contracts does not serve the public interest?

Prof. Jillian Kohler: That is absolutely what I'm saying. As I said, I'm referring to research I did. Canada was a small part of a pool of countries that we looked at, including countries within the European Union, as well as Brazil, the United States, etc. The bottom line is that we should know what are in the clauses—

● (1345)

The Chair: Dr. Kohler, could you hold your mike up?

Prof. Jillian Kohler: Again, I apologize for my lack of technology skills here.

My point is that, yes, we in the public domain should have access to information contained in these reports. As I mentioned earlier, when we did our studies—I'm not just referring to Canada here, just to be clear—we found, interestingly enough, that even public agreements were redacted; they had lots of black lines on them, so that the information was limited. We need to know more.

I'll stop there.

Mr. Don Davies: Thanks.

In a May 25 article in the Toronto Star, you were quoted as saying, “The government is not being forthcoming with how much it's paying, what it's negotiating and why.” You also said, “There is no barrier in terms of making this public. It's just a political decision to do so.”

Why do you think that's a political decision? Do you see any reason why the government couldn't take a different approach to disclosing this information to Canadians?

Prof. Jillian Kohler: I still stand by my quote, happily, and I would say that the government indeed can take a stand. Oftentimes, the argument is made—and I know this happens usually behind closed doors—where the industry will say they're going to give you a better deal, but they don't want others to find out about it, because if they give you a better deal, they're going to have to negotiate the same deal with country X, Y or Z for less, so it's in your best interests to keep this quiet and to keep this confidential.

I don't buy that. I don't think that's a valid reason. Just so you know, but in case you're not aware, I'm sure many of you know that the World Health Assembly in 2019 came out with a resolution demanding pricing “transparency”. It was the beginning of global efforts to demand much more transparency in terms of research and development and in terms of contract negotiations with the industry.

I do believe, still, that it's a political decision. I think that if the government were standing a little more strongly with its suppliers, it could make some of this information public.

Mr. Don Davies: Let me drill into that. In that same article, you said, “The pharmaceutical industry tends to be a secretive industry and that's because of market dynamics, concerns about their branding, et cetera. But that's an outdated model that doesn't work for building trust.”

Can you explain why that model doesn't work for building trust and perhaps how you would recommend that it be reformed?

Prof. Jillian Kohler: We now live in a world that has shifted. The industry is still operating like it did 25 years ago, when it concealed things. Again, though, in terms of information, we have a revolution that's been happening for a long time now. This is nothing new. The public wants to know. The public is much more invested in terms of finding out what drugs cost and how and why we determine, for example, research and development costs, which has always been very murky and can lead to some policies that are favourable to the industry without our really knowing why. I would say we need to turn the industry on its head.

The other point is that the industry is generally working with public institutions in order to do a lot of its work, so we have a vested interest as citizens who contribute to public institutions to find out what these institutions are actually doing. The old model of vertical integration, I would argue, is outdated. It might have allowed for secrecy. I'd say we need to think about who is actually contributing to the research and development and contributing to the outcomes we want. In order to do so, we need to think much more fully about getting full access to information.

Mr. Don Davies: Dr. Kohler, do you happen to know approximately what percentage of taxpayer dollars went into funding the COVID-19 vaccines? Is there a stronger case to be made for public transparency when the research that goes into producing the product is actually publicly funded?

Prof. Jillian Kohler: There absolutely is, and I don't know the exact numbers but we could refer to Operation Warp Speed, which, again, had huge amounts of money invested from the U.S. side. One could argue that this is just for U.S. citizens, but again, I was making the case that I think it's for the global public. I think that if we were to dig deeply—I haven't done the numbers, and I'm sure we could get to them—we would probably find mostly significant funding, even in areas that, again, we weren't aware of.

Given the existence of public engagement, involvement and resources, I would say, yes, we should be getting access to information.

Mr. Don Davies: I'm going to squeeze in one more question.

There's clearly a disparity in prices. Obviously, the pharmaceutical companies, I will just posit, as the monopoly sellers of the product, have an interest in keeping it secret. I don't know if the customer does.

The analysis you published in Transparency International said that upper middle-income economies, such as South Africa, paid an average 25% more per dose than high-income economies like the European Union. This committee saw in a document, which fortunately was unredacted at first, that there was quite a disparity in what various jurisdictions paid for AstraZeneca. In fact, Canada actually paid among the highest prices, significantly higher than what the EU, South Africa and other countries paid, which kind of belies the argument that we would have been paying a lower price in order to keep it secret.

How do you explain this pricing disparity? Is keeping this whole thing secret just something that benefits the pharmaceutical industry as opposed to customers in the end?

● (1350)

Prof. Jillian Kohler: Yes, it does. I'll keep it short here, because I know we're pressed for time.

I'll go back to my days working with the World Bank. I was in a program with a representative from a large pharmaceutical company. I asked him, “How do you determine prices?” He put his hands in the air and said, “Wherever the wind blows.”

There is a lot of variability in terms of how prices are negotiated, who does it, when, how and why. Again, I'm not saying that greater transparency is going to be the solution, but it's probably the beginning of getting to a better solution, in terms of more equity of access and more transparency in pricing.

Mr. Don Davies: Thank you, Dr. Kohler.

The Chair: Thank you, Mr. Davies.

That wraps up round one. We have a few minutes left. I'm going to propose to the committee that we do a snapper round. We have time for maybe one minute per party. With that in mind, I'll go to Mr. Maguire.

Mr. Maguire, please go ahead for one minute.

Mr. Larry Maguire (Brandon—Souris, CPC): Thank you, Mr. Chair. I think we probably have a couple of minutes.

I just want to say in regard to my NDP colleague's comment just now, he is absolutely correct. We paid double what the Americans paid and three and four times what some of the European countries paid, even for some of the Pfizer vaccines we got early, and even throughout the period of time here.

To your comment, what kind of a premium did we have to pay on those and why? How will the rest of the world be looking at paying for these? I think it's roughly 80% that are not even vaccinated yet and do not have vaccines yet. What's Canada's role in that?

Prof. Jillian Kohler: To answer the question where I feel I can, again, this goes back to bigger questions like, why are we offering intellectual property? Why are we allowing for pricing to be so secretive?

The best thing we can do is expand access through the waiving of intellectual property rights, by allowing for technology transfer where it's needed, more manufacturing and more access for the global population. I will repeat again that when the global population has equity of access to COVID vaccines, we all win. It's not an “us versus them”. We all win if we are all getting equity in terms of access.

Mr. Larry Maguire: That's actually—

The Chair: Thank you, Mr. Maguire.

We'll go now to Ms. Sidhu.

Ms. Sidhu, please go ahead for one minute.

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

Before my time starts, I have a point of clarification. We need to clarify that there's never been a contract between CanSino and the Government of Canada. I believe it was suggested earlier that there was one. This is not correct.

My question is for the witnesses from Dan's Legacy.

As many young people are going back to school, or will be going back in the fall, we know that all levels of government are looking at how to support our return to normal. Where do you think the federal government can be most effective in supporting youth as we reopen, particularly youth in similar circumstances to those your organization supports?

Mr. Tom Littlewood: As I mentioned, thousands of young people have gotten CERB fraudulently. There were websites that showed them how to do it and what to say. These kids are not self-regulated, so they responded to this in droves. If we keep that repayment program that's in place now, we're going to see...I think it was 48 million that went to high school students. That doesn't count the kids that are not in school or anything. We really need to look at that as a potential way to solve a problem, rather than creating a barrier.

This is going to affect thousands of young people, and we're not going to get the money back anyway. We could encourage them to engage in things that will help them, like going back to school, working, recovery, etc.

The Chair: Thank you, Ms. Sidhu.

[*Translation*]

Mr. Thériault, go ahead for one minute.

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

I'd like to speak to Mr. Labrie.

We have to find solutions. I know you'll be making another statement shortly, but first I want to discuss a proposal that Research Canada is also attached to.

Rather than postpone the reform, as was previously done on two occasions, the proposal is instead to implement it in stages. First of all, there appears to be a consensus that the reference basket of countries with substantial economies should be redefined. Then all it would take would be for all the players to sit down at the same table and discuss solutions related to pharmaco-economic factors.

Would that be a desirable solution? Would it be a promising point that we could agree on to begin the discussion and come up with win-win solutions?

● (1355)

Mr. Yanick Labrie: Yes, absolutely.

I mentioned in my remarks that this reform wouldn't likely generate long-term benefits for Canadians. On the contrary, there's considerable risk for access to new drugs. Access could be delayed or R&D investment undermined. You know the rest. I won't repeat it all because I've already said it.

One thing is certain, and that's that the various industry stakeholders could sit down around the same table and show that drugs aren't just pills. They're backed by an ecosystem, a body of knowledge and research, both basic and applied. It's very important that all those people, including patient groups, have a voice in that discussion.

You definitely have to be transparent and honest with Canadians. It's not true that this reform doesn't offer benefits; it entails not negligible costs. That's what you have to present to people in order to reach informed decisions.

The Chair: Thank you, Mr. Thériault.

[*English*]

We will go now to Mr. Davies.

Go ahead for one minute, please.

Mr. Don Davies: Thank you.

Mr. Littlewood, you touched on the impact on indigenous youth in particular. I think I can fairly safely assume that there's probably no group in Canada that has suffered more trauma than indigenous youth, on a variety of factors.

I've read a lot of Dr. Gabor Maté and his theory that one of the foundations of addiction substance use is rooted [*Technical difficulty—Editor*]. I'm just wondering if you have an opinion on criminalization of drugs, whether or not that serves to reduce or exacerbate the trauma. Would you support a move to decriminalize drugs and move to a health-based approach to dealing with substance use and addiction?

Mr. Tom Littlewood: I would, absolutely. Even though there have been some changes whereby small amounts are legal or are not criminalized, the police still intercept it and take it away from clients. A lot of my clients who are indigenous basically wait for the next beating. It is not a good situation for them, and the more stigma there is around drugs, the less we're going to see progress and reform.

Reform has to happen. Even if it's made legal, it's still a lethal dose, so whether it's legal or not, it's not going to be a good thing. There needs to be a safe drug supply as well. They're not going to stop using them because we want them to stop. They need to get through a therapeutic process. Yes, I think it would be good, not only to legalize drugs but also to make sure there is a safe supply.

Mr. Don Davies: Thank you.

The Chair: Thank you, Mr. Davies.

Thank you to all the witnesses for sharing your time with us today and helping us with our study. Thank you to the committee for all your great questions.

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

Thank you all.

● (1355)

_____(Pause)_____

● (1400)

The Chair: We are now resumed. Welcome back, everyone, to meeting number 43 of the House of Commons Standing Committee on Health. The committee is meeting today to study the emergency situation facing Canadians in light of the COVID-19 pandemic.

I'd like to welcome the witnesses. We have as an individual, Mr. Yanick Labrie, health economist.

As an individual, we have Dr. Joel Lexchin, medical doctor. From Jacobs Engineering we have Mr. Ansar Ahmed, vice-president.

With that, I will invite the witnesses to give statements.

I will point out to witnesses and everyone that when your time is nearly up I will display a yellow card, and when it is actually up I will display a red card. When you see the red card, you don't have to stop instantly but do try to wrap up in good order.

Thank you all.

With that, I will invite Mr. Labrie to make a statement. Go ahead, please, sir, for five minutes.

[*Translation*]

Mr. Yanick Labrie: Thank you, Mr. Chair.

I would like to thank members of the Standing Committee on Health for the opportunity to testify today as an individual on the regulatory changes contemplated by the Patent Medicine Prices Review Board, the PMPRB.

Earlier this afternoon, I showed that spending on prescription drugs was not out of control in Canada, despite frequent statements to the contrary. In fact, spending on prescription medicines represents a steadily declining share of Canada's economy and health budget.

I also noted that there is a risk that the tightening of price controls that the PMPRB is considering may force down the number of new drugs launched in Canada or delay their launch, in addition to discouraging pharmaceutical R&D investment.

Now I intend to address the issue of drug prices and value.

In the past two years, the public debate on the regulatory changes the PMPRB is contemplating has largely focused on the launch price of new medicines.

According to one idea that is making the rounds, Canadians pay more for their drugs than citizens of other countries. For example, the most recent annual report published by the PMPRB contains a comparative analysis showing that the average price of all patented drugs in Canada in 2017 was 19% higher than the average of the OECD countries. However, that excludes manufacturer discounts. The PMPRB's data on medicines for treating rare diseases show that current prices in Canada in 2019 were 3% higher than median prices in all OECD countries.

However, you must take care in comparing prices of Canadian pharmaceutical products with those in effect in countries with much lower standards of living, such as Greece, Chile and Turkey, to name only a few. An international comparison of drug prices is a complex undertaking, since many factors must be considered, including differences in products consumed in each country, respective market shares of generic and innovative drugs, distribution costs and retail sales, exchange rate fluctuations and purchasing power of the various currencies.

In addition, information on real prices is limited in most countries. Where available, it paints a misleading picture that fails to reflect the actual prices of medicines as a result of confidential discounts that pharmaceutical companies offer payers. Those discounts or rebates are generally required by public drug insurance plans in Canada under agreements respecting registration on provincial drug plan forms. For example, the Quebec government has received a total rebate of more than $1 billion from innovative drug manufacturers over the past four years.

The situation regarding drug prices also cannot be analyzed in isolation without considering the value attached thereto.

In recent decades, major advances have been made in the treatment of many health problems through the use of innovative medicines. Those new-generation drugs have revolutionized the world and medicine by responding more effectively to patient needs than previous drugs.

In the case of rare diseases, the PMPRB itself has established that 35% of new drugs launched in Canada in 2019 resulted in modest or major improvements and that 27% represented major discoveries relative to existing therapies. The rising influx of these innovative molecules both intensifies competition and affords patients new and better therapeutic options.

For example, researchers at McGill University recently considered the long-term impact of biological treatments for Quebec patients suffering from ulcerative colitis. They showed that the risks of having to undergo a colorectal procedure considerably declined after biological drugs arrived on the market. In the year when those drugs were first used, the mortality rate among Quebec patients requiring colectomies declined by more than half from the previous year. The reduction in the number of surgical procedures and hospital stays thus helped reduce the burden of medical expenses associated with ulcerative colitis in Quebec by 25%.

Similar benefits are observed in cancer cases, which impose a substantial financial burden on patients and society as a whole. Many innovative drugs developed in recent years have completely revolutionized the treatment of cancers and improved patients' quality of life and life expectancy. Drug therapies now more accurately target the genes and proteins responsible for cancerous cell growth, thus vastly improving patients' chances of survival, while reducing the secondary effect generally associated with chemotherapy. By helping to reduce the number of hospital stays and thus work absenteeism and to minimize productivity losses, these innovative drugs thus generate major cost savings to society.

In conclusion, the situation regarding drug costs should not be analyzed in isolation from consideration of related benefits.

● (1405)

Once again, I would like to inform the members of the Standing Committee on Health of the negative impact on the people of Canada that could result from the stricter price controls being envisaged by the PMPRB. This kind of reform would not only reduce the number of new medicines launched in Canada, or slow their launch down, but also discourage research and development investment, which is nevertheless indispensable for the development and availability of new medicines for Canadians in the future.

Thank you for your attention.

[*English*]

The Chair: Thank you, Mr. Labrie.

We go now to Dr. Joel Lexchin.

Go ahead, Doctor, for five minutes, please.

Dr. Joel Lexchin (Medical Doctor, As an Individual): Thank you for the opportunity to appear before the committee.

I work as an emergency physician in downtown Toronto. Between 2001 and 2016, I taught health policy at York University. Over the past 40 years, I've been involved in researching and writing about pharmaceutical policy issues.

I want to address the question about proposed reforms to the Canadian regulatory system, although I will also touch on some points that Mr. Labrie made.

When the pandemic started, Health Canada brought in an interim order to allow for a more rapid introduction of products to treat and prevent COVID-19. More recently, it's produced a discussion document about what it terms “agile regulations”, which are supposed to decrease regulatory burden and get new drugs onto the market in Canada faster.

The first point to make is contrary to Mr. Labrie's. Independent research has shown that only about 10% of new drugs that are introduced into Canada—or, in fact, in other markets—offer any substantial therapeutic gain over what already exists. This applies to drugs that are approved in general. It applies to drugs that are approved through Health Canada's priority review process. It applies to drugs that are approved with limited data through the notice of compliance with conditions process.

Even if you look at what are called first-in-class drugs—drugs that are unlike anything else on the market—the proportion of those that are innovative is only about one in six. When you look at drugs for orphan diseases, about one in five of these are substantial therapeutic improvements. This is not based on my assessment. This is based on independent assessments by organizations that have nothing to do with the pharmaceutical industry.

When we think about changing the regulatory system, we also need to think about the safety of drugs that are on the market. The push for agile regulation makes mention of safety, but it seems to put safety second to reducing regulatory burden, which is a mistake. It ignores what we know about the safety of drugs that come on the market based on how long they are reviewed by organizations like Health Canada.

If a drug goes through a standard review process, eventually about one in five of those drugs will acquire a serious safety warning. If it goes through a priority review process, which is shorter—instead of the standard 300 days, it's 180 days—one-third of those drugs will acquire a serious safety warning, up from one in five. If you look at drugs that go through a notice of compliance with conditions process, about one in four of those drugs will acquire a serious safety warning.

There are consequences to changing the regulatory system in terms of safety. Currently, in any five-year period, if you look at the drugs that are withdrawn from the Canadian market, about one out of every 20 will eventually be pulled from the market for safety reasons. If we go ahead with changes in the regulatory system, that percentage may increase.

In conclusion, it's reasonable to change how we get drugs on the market in response to a pandemic. As a doctor in the emergency department, I recognize that. If you're talking about making long-term permanent changes, then you have to look at whether that results in better, more effective drugs reaching the market and in the increased or decreased safety of the products that come onto the market.

● (1410)

Until Health Canada can come up with good data to show that we'll get more therapeutically efficient drugs and more safety, we should not be going ahead.

Thank you.

The Chair: Thank you, Doctor.

We'll go now to Jacobs Engineering. I need to apologize to Mr. Ahmed. I think I skipped over his name when making introductions. If that's the case, I certainly apologize.

From Jacobs Engineering, we have Mr. Ansar Ahmed, vice-president.

Mr. Ahmed, please go ahead, for five minutes.

Mr. Ansar Ahmed (Vice-President, Jacobs Engineering): Thank you, Chairman McKinnon, and thank you, Vice-Chairs Rempel Garner and Thériault, for the opportunity to speak to the committee today.

I'm pleased to be here today representing Jacobs Engineering. First of all, on behalf of all of us at Jacobs, I'd like to extend our deepest condolences to the families of the nearly 26,000 Canadians who have lost their lives during this pandemic.

As engineers and architects, we approach problems from a very simple perspective of an unbiased lens. We examine the causes, and we identify what needs to be done differently in order to achieve more favourable outcomes in the future.

I'd like to focus my remarks today on the impact of COVID-19 in our long-term care homes.

In January, Jacobs hosted an industry round table to examine how the built environment—the actual interior and physical space—may have contributed to the disproportionate impact of COVID-19 within our long-term care homes. The round table report outlined a series of nine recommendations, and I'd like to speak to two of them today.

Many jurisdictions have design standards for long-term care homes that have not been updated for years, and in some cases decades. In homes designed to those outdated standards, residents were confined, for the most part, to their rooms. They had little, if any, physical or social interaction with others, simply because the facility was not designed, or improved over the years, to meet the challenges of containing the spread of COVID-19.

It was acknowledged in the round table that the built environment is as important an element of health care as any other medical or clinical intervention. There needs to be a legislated framework that mandates regular updates to design standards, so the built environment within our long-term care homes keeps pace with the latest clinical research on caring for those with physical or cognitive impairments.

A second recommendation involved evidence-based decision-making and value-based procurements. Following the January round table, Jacobs and the Ontario Association of Architects, in consultation with the Ontario Ministry of Long-Term Care, have funded a research study by the University of Toronto's Centre for Design + Health Innovation to conduct performance assessments of long-term care homes. This is the type of experiential data that governments need to have access to in order to ensure they are making the right investments in the right areas at the right time.

The findings of such work must become the basis for value-based procurement. In a sector as sensitive as long-term care, seeking out the lowest-cost and technically compliant bids should not be the benchmark we are striving to achieve. Rather, it should be about value creation in design, construction, maintenance and operations to help secure the best outcome for our most vulnerable citizens.

The COVID-19 pandemic has challenged governments at all levels to respond with urgency to its devastating outcomes, including the loss of over 15,000 lives in long-term care homes. In examining the root causes of these losses, it's important to recognize the pre-existence of structural and systemic vulnerabilities that heightened the risk of such outcomes occurring in our long-term care homes.

To make the most of proposed investments in long-term care, it's vital that governments first identify and, through updated standards and guidelines, resolve those structural and systemic vulnerabilities. Without this first critical step, we miss an important opportunity to ensure the best results for the investment of public funds.

If I had three recommendations to make, they would be that governments at all levels need to come together: first, to establish grant-based funding programs to vigorously re-engage Canada in public health research and development; second, to activate and mobilize Canada's manufacturing sector to produce vast supplies of PPE and other mission-critical supplies and equipment; and lastly, to mandate regular updates to design and operating standards governing long-term care homes, to ensure these remain resilient places of care for our most vulnerable citizens.

In closing, I'd like to make one last observation with respect to mental health. This pandemic has raised awareness of the importance of mental health. As we emerge from this pandemic, it's my sincere hope we do not lose the momentum that has been created, and that the attention drawn to mental health does not fade away. All levels of government have a role to play in ensuring that hospitals across the country have access to stable and long-term funding for mental health programs, and that local non-profit organizations, delivering invaluable intervention programs, similarly have access to predictable and long-term government funding and support.

Thank you very much for your time and attention today.

● (1415)

The Chair: Thank you.

We will start our rounds of questions now, with Mr. d'Entremont.

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

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

To our witnesses today, welcome to the health committee.

[*Translation*]

Welcome for the second time, Mr. Labrie.

[*English*]

My first question is for Mr. Ahmed.

When it comes to long-term care, it continues to interest me to see how different provinces look at long-term care standards. There was a tremendous move in Nova Scotia a number of years ago to come up with a standard that makes sense. It's not necessarily included in the building codes, but it was knowing their square footage per patient and making sure there isn't an opportunity for different pathogens to go from one patient to another.

Have you looked across Canada to see who is doing this and what other provinces may not be doing it?

Mr. Ansar Ahmed: One of the findings that came out of our round table, frankly, was the absence of exactly that sort of evidence to support decision-making.

I don't believe a lot of research has been done pan-Canada and from coast to coast in terms of looking at how different jurisdictions manage long-term care, or the standards they use or mandate within their facilities. If anything came out of our round table, it was a desire to push governments to make sure this type of research is done. We are hoping, for example, through our partnership with the University of Toronto, to obtain that sort of information and evidence, which we can then share with governments to ensure they're making the right investments in the future.

Mr. Chris d'Entremont: Thank you.

Ultimately, if we're all doing sort of the same things, then hopefully infection control will be maintained across the system. Whether each has an individual room and an individual bathroom—those kinds of things make a big difference to what infection control actually is within our long-term care facilities.

Mr. Ansar Ahmed: They do, absolutely. That's why our focus during our round table was on looking at the built environment and all aspects of the long-term care facilities, not just, for example, the number of beds assigned per long-term care home. It was looking really at how the entire long-term care home operates and how it functions.

● (1420)

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

I'm going to move on to ask a few questions on the PMPRB.

[*Translation*]

Mr. Labrie, were you involved in the consultations held by the PMPRB over the past few years?

Mr. Yanick Labrie: Thank you for the question.

I was not. My involvement was more through the studies I conducted and published, which are in the public domain.

Mr. Chris d'Entremont: When they appeared before our committee, various patient associations told us that the PMPRB collaboration was neither satisfactory nor sufficient.

Did you have an opportunity to pay close attention to it?

Mr. Yanick Labrie: No, I did not pay close attention to any collaboration between the PMPRB and patient groups. I kept my distance. I'm an independent researcher. To be sure, I paid special attention to the reform being considered and to everything in the public domain. On the other hand, I'm not up to date on any meetings that may have been held between members of that organization and patient groups.

Mr. Chris d'Entremont: In your research, did you see any forms of collaboration, or anything else, that we could draw upon to ensure that all parties are sitting at the same table and can have a useful discussion?

Mr. Yanick Labrie: Based on my own experience, when the regulatory organization, in this instance the PMPRB, maintains a climate of trust with the other stakeholders, things go much more smoothly. A dialogue on both sides is established. When people are transparent and acknowledge that the proposed regulatory reform has advantages, but also some potential costs, that allows for dialogue.

What I have noticed at the moment is that there is a conflictual climate between the various parties, and I find that unfortunate. That would be harmful not only to Canadian patients, but the entire Canadian population, because they are the ones who would pay the price.

Mr. Chris d'Entremont: The pharmaceutical companies told us that they had already had the launch of some medicines sidelined or at least slowed down by a few years.

Is that because of the regulations being considered or the uncertain outcome of the discussion that has been going on for three years already?

Mr. Yanick Labrie: It's a bit of both of these factors, but mainly the uncertainty. As you know, uncertainty is the worst enemy of investors and companies, particularly pharmaceutical companies, which don't know what to do at the moment. They are very much afraid that the reform would reduce expected profits, which would make it more difficult to launch medicines in a timely manner in Canada.

Of course, as I mentioned in my first address, Canada is not the only potential market. We only have a very small share of the global market in pharmaceuticals. The companies will very likely focus on other places where the conditions are more conducive to the launch of new medicines.

Mr. Chris d'Entremont: Thank you.

[*English*]

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

We go now to Mr. Van Bynen.

Mr. Van Bynen, go ahead, please, for six minutes.

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): Thank you, Mr. Chair. I'll be sharing the second two minutes of my time slot with Ms. Sidhu, who also has an interest in long-term care.

Thank you especially to all of our witnesses, and to Mr. Ahmed for accepting our invitation to join us today and for sharing his experience and learnings on long-term care from his round table discussions. My questions will be for him.

Mr. Ahmed, earlier this year, Jacobs brought together health care leaders from across the province, including the Southlake Regional Health Centre's CEO, Arden Krystal, for a productive discussion on long-term care.

I have some questions about the report produced following this round table, but first I would like to ask you to table it with the committee so we can consider it in our study. Would you be prepared to do that for us?

● (1425)

Mr. Ansar Ahmed: I absolutely would. We will circulate that through the committee clerk's office.

Mr. Tony Van Bynen: Thank you.

Can you share with the committee today, though, some of the key findings from this discussion? You alluded to two major discussions, but there were nine recommendations. Could you let us know what was in the report that followed?

Mr. Ansar Ahmed: The report itself focused on Ontario, just because that was where people's experience was in terms of both residing here in Ontario and being active in the long-term care space, but I think the findings were, frankly, applicable to any other province or territory in Canada.

There were nine recommendations that came out of that report, and they've been shared with officials in different jurisdictions. I can tell you right now that one of the first recommendations—and I think one of the drivers for this study, based on the fact that we saw a number of investment plans being tabled and being set into motion—was based on a concern amongst those who attended the round table about over-building.

Obviously we've never come across a global pandemic like this, but in circumstances like that, you tend to throw money at a problem and it can result in over-building. Until you analyze what some of the shortcomings are within these facilities—the structural vulnerabilities I spoke to in my comments—you're really throwing good money after bad. One of our recommendations was essentially to put some brakes on, take the time to do some research, figure out what these structural vulnerabilities are and address those, and then fuel the recovery in these long-term care homes through the planned investments across governments.

The other recommendation centred around making sure they consulted with stakeholders, both residents and those who are active in the long-term space, and then also ensuring there was a robust program for accreditation of these facilities, as well as ongoing monitoring and compliance. Once the standards have been modernized, they have to make sure there is a program executed either at the provincial level or through local health authorities, so that these long-term care homes are frequently visited to ensure they are meeting the planned objectives of the provincial ministries of long-term care and health.

Mr. Tony Van Bynen: You've had a round table and you've produced a report with a lot of insight and good findings. What's next?

Mr. Ansar Ahmed: I think one of the most important steps we've taken is through the University of Toronto and through our partnership with the Ontario Association of Architects, getting that initial research under way.

The University of Toronto is planning a three-month research study that they're undertaking. I believe it's due to start in the coming weeks. It's going to focus on gathering the experiential data I talked about during my remarks.

We're hoping it will then set the groundwork for a larger, broader, more comprehensive study that we hope to move forward. We are in conversation with the Ontario Ministry of Long-Term Care to ensure that we hit that research in the right spot, where it has the most optimal benefit to the public.

Mr. Tony Van Bynen: That's a probably a good segue to Ms. Sidhu.

Ms. Sonia Sidhu: Mr. Van Bynen, thank you for sharing your time. I also have a question for Mr. Ahmed.

We can all agree that one of the great tragedies of the pandemic has been the situation in long-term care homes across the country. My caucus colleagues, including my fellow committee member Ms. O'Connell, rang the alarm during the terrible tragedies in long-term care in Ontario.

We know that delivering these services falls to the provinces and territories, but there is a role for the federal government to play in ensuring consistent quality of standards across the different provinces and territories. Would you agree that a national standard for long-term care would be an important step to ensure the safety and dignity of those living in long-term care?

Mr. Ansar Ahmed: Absolutely there is room for a national standard to be developed and to be adhered to from coast to coast.

I think back now to when the federal government instituted municipal gas tax funding. There was a lot of disparity amongst different municipalities across Canada in terms of how they managed their assets.

I remember that the Public Sector Accounting Board put forward regulations that mandated certain standards for asset management.

In that same [*Technical difficulty—Editor*] for the federal government and for federal agencies to set up those sorts of basic standards to ensure that there is a level playing field across all long-term care homes across Canada.

● (1430)

The Chair: Thank you, Ms. Sidhu and Mr. Van Bynen.

[*Translation*]

Mr. Thériault, over to you for six minutes.

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

Mr. Labrie, tell me if I've understood correctly.

Several witnesses came here to tell us that the PMPRB was flying blind. On the one hand, they told us that drug prices were too high and that this would have consequences. On the other, they did not have all the tools they needed to tell us exactly how much too high people were being charged for their medicines.

And there doesn't appear to be that much of a lack of transparency, since you just told us that it had been possible to determine that the government of Quebec had received a total rebate of $1 billion. So we know the actual price of the medicines.

It's all a bit difficult to understand. There appears to be some doublespeak. We're complaining that it's too expensive, but we can't say by how much.

Mr. Yanick Labrie: Personally, I've lost confidence in the PMPRB's ability to make accurate international price comparisons.

And of course it's also related to the discounts and rebates that manufacturers offer to different clients, which are confidential. These types of discounts exist in Canada, but also in other countries.

As for transparency, I know that this was addressed in the first part of today's meeting. Transparency does exist at the global level, by which I mean that we can have access to some types of aggregated data. I revealed how this worked for Quebec, when I presented the numbers that you've just quoted. Innovative pharmaceutical companies gave a rebate worth more than $1 billion to the government of Quebec over the past four years.

This should be taken into account, at least when providing an overview of pharmaceutical spending trends. At the moment, the situation is being depicted as out of control, when this is not the case. To begin with, the population is aging and needs more medicines. Inflation also needs to be taken into account, which the PMPRB does not do. We also need to factor in the discounts I mentioned, and our ability to pay, which is based on our economy and the wealth generated. When all these factors are combined, it becomes clear that spending on drugs in Canada's economy and health budget has been decreasing over time. So there's no need to panic.

Mr. Luc Thériault: I'd like to hear you talk about another point you raised, a very important one. It's about the value, over the next 10 years, of innovative drugs in oncology and immunology. Therapies are becoming more narrowly focused, and even individualized. Innovative molecules and drugs are going to become important.

Can you tell us more about this value?

It's as if we were looking at medicines strictly from the cost standpoint, when what we should be looking at is the therapeutic value and positive impacts not only on the patient, but also on the economy, system costs, and society as a whole.

Mr. Yanick Labrie: Yes, that's right. It's a part of the debate that remains completely hidden. We focus a lot on prices, but the other side of the story is the benefits in all spheres of the economy. We shouldn't look at prices alone, but rather at what we get in exchange. In the case of drugs, as you mentioned, the progress made over the years has been extremely positive.

Dr. Lexchin alluded to the fact that sometimes there are only minor improvements. However, it's important to understand how innovative processes work in the pharmaceutical world. Generally speaking, technological process comes as a result of many gradual improvements in methodology and existing products. It's the same in all sectors, and even more so in pharmaceuticals. In other words, sometimes we only become aware of the progress that has been made after several years.

The development of the COVID-19 vaccines was based on other drugs that had been developed and on other research efforts conducted in the past, including efforts to find an HIV vaccine. We are now benefiting from this work.

If we fail to cover drugs on grounds that they are too expensive, we risk depriving ourselves over the longer term of drugs that are extremely valuable to Canadians.

In this debate it's important to have a vision that is much more dynamic than static .

● (1435)

Mr. Luc Thériault: It also represents savings for the system. It's important to consider not only the patient's quality of life, but also the costs of drugs. You gave the example of colorectal cancer, which generates significant costs to the system, but we don't appear to take this into account when determining a drug's beneficial effects.

Mr. Yanick Labrie: We often neglect these aspects. And yet, the drugs were able to replace much more expensive surgical procedures. Not only do patients benefit directly in terms of health and quality of life, but hospitalizations and operations that are often much more expensive are avoided. It also means workers can return sooner to the labour market. There are gains in productivity and income for these patients. Society as a whole benefits. It has to be taken into consideration.

Mr. Luc Thériault: Thank you.

The Chair: Thank you, Mr. Thériault.

[*English*]

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

Mr. Don Davies: Thank you.

Dr. Lexchin, can you explain why 90% of new drugs approved in Canada fail to offer significant new therapeutic advantage and, if that's the case, why they would be approved?

Dr. Joel Lexchin: There are a number of things that you have to consider.

First of all, it's that drug companies, by and large, look at established markets. They see that there's a drug on the market and it has good sales, and they want to get a piece of that pie. They develop their own version of that product. They manipulate a few molecules and produce that new drug. Then they market that new drug very heavily to doctors. The last figures I saw showed that drug companies were spending about $450 million per year on their sales representatives and ads in medical journals. That's about $60,000 per doctor, per year, just on those two forms of promotion.

When you look at the regulatory requirements for approving drugs, you see that they don't have to be better than what's on the market. They can, in fact, be inferior to what's on the market. The only thing that's required to get a new drug on the market in Canada and in other countries is that they be better than placebos, and the amount “better” is marginal.

Mr. Don Davies: Thanks.

I'd like to move to the amount of time it takes to get new drugs approved in Canada. A recent article said that the most important factor explaining delays in getting drugs to market and in approval of new medicines in Canada is “the difference in the dates on which manufacturers submitted new drugs to agencies for regulatory approval”.

It turns out that the average gap between regulators for approving new drugs is actually very, very small once they've received applications; in Canada it is about four days different from the U.S. and nine days different from the EU. Can you outline why pharmaceutical companies are delaying access to new drugs in Canada by waiting over a year, on average, to submit their applications to Health Canada?

Dr. Joel Lexchin: Primarily it comes down to economics. Even the large drug companies have limits on resources, and they are going to submit to get a drug on the market in places where they can get the largest return on those drugs, and that's the United States. The United States prices for brand name drugs are two to three times higher than virtually any other country around. Second and third in terms of new drug prices are Switzerland and Germany. After the United States, you go to those two countries, because you can get more money back. Then they go to places like Canada, Australia and New Zealand, where the market size is smaller and prices are more controlled.

● (1440)

Mr. Don Davies: I'm going to turn to a different subject, and that is vaccines. In a March 2020 op-ed in Open Canada, you co-authored a piece that said the following:

> We cannot increase vaccine supply without worldwide expansion of production capacities. One way to facilitate this is through the COVID-19 Technology Access Pool...formally launched in May by the World Health Organization. The overall aim of C-TAP is to promote open innovation, pooling not only research outcomes and intellectual property rights but also manufacturing processes and other kinds of "know-how". C-TAP has the backing of 40 countries, but Canada is not one of them.

Why has the Government of Canada refused to support of the COVID-19 Technology Access Pool, and is that justifiable?

Dr. Joel Lexchin: As to why it's refused, you'd have to ask the people in government who are in charge of that kind of decision-making.

If you look at the history of Canada, the Canadian government has had to make a choice between supporting improved access to medications in low- and middle-income countries versus supporting intellectual property rights, and we go back to 1999. There have been about six or seven times when they've had to make that choice, and every time they've made the choice of supporting intellectual property rights as opposed to better access to medications in the poorer countries.

Mr. Don Davies: You've also written about Canada's failure to be able to produce domestic vaccine manufacturing. You say that we have ignored warnings that go back to SARS in 2003 and H1N1 in 2009. The Naylor report following SARS noted the lack of security of vaccine supply and recommended the development of a national vaccine strategy, but that was basically ignored by successive governments.

Right now, have we taken adequate steps, in your view, to address this lack of domestic vaccine production capacity?

Dr. Joel Lexchin: The government is putting money into a number of facilities. There's the NRC plant that's being built in Montreal, and there's Medicago in Quebec City. They're investing money in Sanofi in northern Toronto, but none of these are Canadian-controlled companies.

What we've seen is that, when companies are controlled internationally, those decisions are not necessarily made with the best interests of Canada in mind, so we've got a COVID vaccine being developed by Sanofi and GlaxoSmithKline. Sanofi has the plant in northern Toronto. GlaxoSmithKline has a plant in Quebec, but if that vaccine is successful and is approved in Canada, it's not going to be made in either of those places; it's going to be made in the United States.

The Chair: Thank you, Mr. Davies.

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

Thank you, Dr. Lexchin.

The Chair: Thank you, all. That wraps up our first round of questions. I think we will have time for a short, snap round, maybe two minutes per party.

On that basis, I will invite Mr. Maguire to go ahead, please.

Mr. Don Davies: Mr. Chair, my clock says we have over 15 minutes. Could we not do three minutes per party?

The Chair: Okay, we can take a shot at that. Three minutes is always four or five, but let's do the best we can.

Mr. Maguire, you have three minutes.

Mr. Larry Maguire: Thanks, Mr. Chair.

Thanks to my NDP colleague for that.

Mr. Labrie, in your initial comments in this section you mentioned that drugs increased 19% in 2016. I wonder if you can just elaborate on that. You also indicated that we should not support the PMPRB drug pricing recommendations. I got your details as to why. Is there anything else you'd like to elaborate on in that area, since we're not manufacturing them here in Canada?

[*Translation*]

Mr. Yanick Labrie: Thank you for your question Mr. Maguire.

The data I reported on price differences came from PMPRB annual reports. The 19% rate represents the difference between average prices in Canada and in the rest of the OECD countries in 2017.

However, as I mentioned, these differences are difficult to establish. Comparisons can be distorted by all kinds of factors, some of which I listed. For example, populations and economies vary in size. Some OECD member countries are poorer and others richer.

If we break down the data by drug group, it can be seen that drugs for rare diseases are…

● (1445)

[*English*]

Mr. Larry Maguire: Pardon me for interrupting, Mr. Labrie.

How does that impact the price we've had to pay for our COVID drugs? I know you're talking in general, but what are your thoughts on that?

[*Translation*]

Mr. Yanick Labrie: Some information is available for drug prices, but I've been unable to determine whether it is accurate. Once again, it was impossible to make international comparisons that struck me as credible.

One thing is clear, and that is that decisions are made in favour of certain markets when the conditions are right. In Quebec, as in other Canadian provinces, conditions are not favourable, partly because of the uncertainty caused by this debate over regulatory changes.

[*English*]

Mr. Larry Maguire: Mr. Ahmed, I will quickly move to you.

In regard to not losing ground on mental health because of COVID, you mentioned the support of the private sector in developing and funding mental health. What do you think the private sector's role should be in that? I know you want to keep all governments working together. Where does that fit in?

Mr. Ansar Ahmed: There's a small organization here in my hometown of Newmarket called Inn From the Cold. I've seen the tremendous work that they're doing first-hand, primarily through the support of volunteers, to try to support those suffering from mental health, homelessness and other issues. I think there is definitely a role for government to play in providing those non-profit organization some line to stable, long-term funding, so that they can continue to provide these invaluable services.

The other thing is that if we don't do that early intervention in terms of those mental health programs, then by and large we're going to end up paying a price through other social services, the justice system or other areas. It behooves us as a society to make sure we do that early intervention.

The Chair: Thank you, Mr. Maguire.

We go now to Dr. Powlowski.

Dr. Powlowski, you have three minutes, please.

Mr. Marcus Powlowski: Thank you.

My question is for Dr. Lexchin on the issue of the proposed changes to the PMPRB. I'm no expert on this subject, but it certainly seems to me that a lot of pharmaceutical companies want to play hardball with the government. They basically say that if we don't drop these proposed changes, they're either not going to bring their product onto the market in Canada, or they're certainly going to delay it. If it costs Canadian lives or Canadian health, so be it. We started it. It's us.

Even though I think these proposed changes are not coming even close to eliminating profits made by pharmaceutical companies, it's about limiting those profits. Maybe evidently, I'm not impressed with this pharmaceutical company approach and the fact that they seem to be holding Canadians hostage to their demands.

How can the Canadian government level the playing field as we discuss how to go forward? I think you've written on this. What do you think about the possibility of our introducing compulsory licensing in order to level the playing field in our negotiations with drug companies?

Dr. Joel Lexchin: Let me emphasize your point about companies trying to blackmail Canada. This goes back to the early 1970s with the Manitoba government, when they were introducing public payment for drugs. They were saying that if there is a generic on the market, they would cover only the cost of the generic. The brand-name drug companies' response was that if Manitoba did that, they wouldn't put any money into Manitoba. That's the pattern they've followed over a long period of time.

As far as compulsory licensing goes, in fact, that was a possibility. When they introduced the legislation early in the pandemic—I believe in April of 2020—they allowed for compulsory licensing for products that would treat COVID. However, that expired at the end of September 2020, and it was never used.

Compulsory licensing as a way of bringing in drugs at lower prices is certainly a possibility, although the American government and the brand-name drug companies would probably go nuclear if we tried to do that.

● (1450)

The Chair: Dr. Powlowski, you have 10 seconds. I think we'll call your time as up.

I'm sure you'll get it back sometime.

Thank you, both.

We will go now to Monsieur Thériault.

[*Translation*]

You have the floor for three minutes.

Mr. Luc Thériault: Mr. Chair, Mr. Davies and I have switched our speaking order. He will therefore speak before I do.

[*English*]

The Chair: Go ahead, Mr. Davies. You have three minutes.

[*Translation*]

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

And thank you, Mr. Thériault.

[*English*]

Dr. Lexchin, I'm just going to lay bare this issue with the PMPRB. On the one side, you have pharmaceutical companies and patient groups who are arguing that the PMPRB reforms will be bad for Canadians and bad for Canada. They will reduce clinical trials. They will hold up the introduction of innovative medicines to our market, etc.

On the other side, you have those who say these are necessary reforms that will lower the cost of drugs in Canada. They will increase transparency in the pricing process. Simply, this is yet another example of pharmaceutical companies essentially blackmailing Canadians and a lot of vulnerable patients by threatening to withhold drugs to Canadians as a means of trying to influence Canadian pharmaceutical policy. In fact, a good example of that is Trikafta. The cystic fibrosis community is desperately in need of this very effective drug, and the company that makes it has not even applied to Health Canada for approval.

What's your sense of this? Where you come down on this issue?

Dr. Joel Lexchin: It's important to realize that some drugs are very important, and we should get those on the market. However, they don't necessarily have to come on to the market at the prices that are being demanded by the drug companies. There's an independent organization in the United States that looks at the cost-effectiveness of medications and decides what is a reasonable price. When they looked at Trikafta for cystic fibrosis, their determination was that instead of the $300,000 price per year, it should be valued at about $80,000 per person per year.

The drug companies primarily are pricing drugs on the basis of desperation. How sick are you? How much are you willing to pay, or is your government willing to pay, for new medications so that you can be treated? That's the way they price. You won't get a company asking $300,000 for a drug that will reduce the symptoms of a common cold from seven days to two days, for instance, because nobody will pay that price. On the other hand, if you have a new cancer drug that you want to bring on the market and it will increase lifespan by three to six months, people are willing to pay hundreds of thousands of dollars for that kind of product. Drug companies know it and are taking advantage.

Mr. Don Davies: Finally, Canada has contributed hundreds of thousands of dollars towards vaccine development. We don't know the exact amount, because there's a lack of transparency. The terms of those grants have not been revealed. We also don't know if there were any requirements about sharing any resulting intellectual property with the public who paid for that. Should we have done that? Should Canada have obtained those rights?

Dr. Joel Lexchin: In one word, yes. We paid for part of the cost of developing that. We should make sure that the intellectual property rights are public, so that those drugs can not only be produced in Canada or other rich countries but also be shared with the rest of the world to increase vaccine production.

The Chair: Thank you, Mr. Davies.

Mr. Don Davies: Thank you.

[*Translation*]

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

Mr. Luc Thériault: Whatever my colleague Mr. Davies may think, it's not necessary to have such a Manichaean vision of things. There are people who are trying to find solutions and areas of agreement. If the reform is adopted, the pharmaceutical companies won't even need to blackmail anyone; they can simply up stakes and quietly move elsewhere. We are living in a global context where competition is rather fierce.

That said, Mr. Chair, I'd like to propose the following motion:

> That, pursuant to the motion adopted by the Committee on October 26, 2020 regarding the Patented Medicine Prices Review Board's (PMPRB) Guidelines Study, the Committee takes the following actions regarding the writing of the draft report:
>
> That a first drafted version of the report be sent to the members of the Committee;
>
> That, within two days following the adoption of this motion, all recognized parties recognized at the Committee send the recommendations it wishes to include into the report;
>
> That an additional hour be added to the June 18 meeting and that it be devoted to the study of the report and its adoption;
>
> That the deadline for tabling supplementary or dissenting opinions with the Clerk be set at 6:00 pm, two sitting days following the adoption of the report;
>
> That the Chair, Clerk and Analysts be authorized to make any necessary grammatical and editorial changes without changing the substance of the report, that the Chair or Vice-Chair be authorized to table the report in the House of Commons no later than June 22, 2021, and that the government provide a response to its results within 30 days
>
> That without altering the previously agreed upon calendar, and recognizing that committee resources are limited, that everything be done to have this report tabled by the date listed above.

● (1455)

[*English*]

The Chair: Monsieur Thériault, which report are we talking about?

[*Translation*]

Mr. Luc Thériault: You will also have received the translation of the motion, which I sent to the clerk.

[*English*]

The Chair: We'll suspend for one minute while I have a look at this.

Thank you.

● (1455)

_____(Pause)_____

● (1455)

The Chair: Welcome back. The meeting is now resumed.

The business before us at this time is on an emergency situation facing Canadians in light of the COVID-19 pandemic. Since this is a motion relating to the Patent Medicines Prices Review Board study, it's not related; it's not directly derived from this business.

I'm going to move it out of order at this time.

We did get a notice of motion, and it's certainly acceptable as a notice of motion.

[*Translation*]

Mr. Luc Thériault: I challenge your decision, Mr. Chair.

[*English*]

The Chair: If you could wait until I have finished speaking—

[*Translation*]

Mr. Luc Thériault: Of course.

[*English*]

The Chair: I would advise the committee that the timelines mentioned in this, given the backlog in translations, etc., are probably not achievable, and I would suggest that we get the analyst to weigh in on this.

Monsieur Thériault, you challenged my ruling. That is not debatable, so we will have a vote on that.

[*Translation*]

Mr. Luc Thériault: I agree, Mr. Chair, but I would simply like to remind you that in the motion that brought us here for today's meeting, it was clearly indicated that we could address any other topic. I therefore think that my motion is admissible, and that's why I'm challenging your decision.

● (1500)

[*English*]

The Chair: Thank you. That's fair enough.

The question is, shall the decision of the chair be sustained? If you vote yes, you agree with the chair that the motion is not in order at this time. If you vote no, you're reporting that the motion is in order at this time.

(Ruling of the chair sustained: yeas 8; nays 3)

The Chair: Thank you, all. The decision of the chair is sustained. I would advise Mr. Thériault that as a notice of motion, this is okay. He can move it at our next meeting.

Thank you, all. The witnesses have departed, but I would like to thank them *in absentia* for their help, their great testimony and their sharing of time with us. I would also like to thank the members of the committee for their participation today and their care and concern.

With that, we are adjourned. Thank you.