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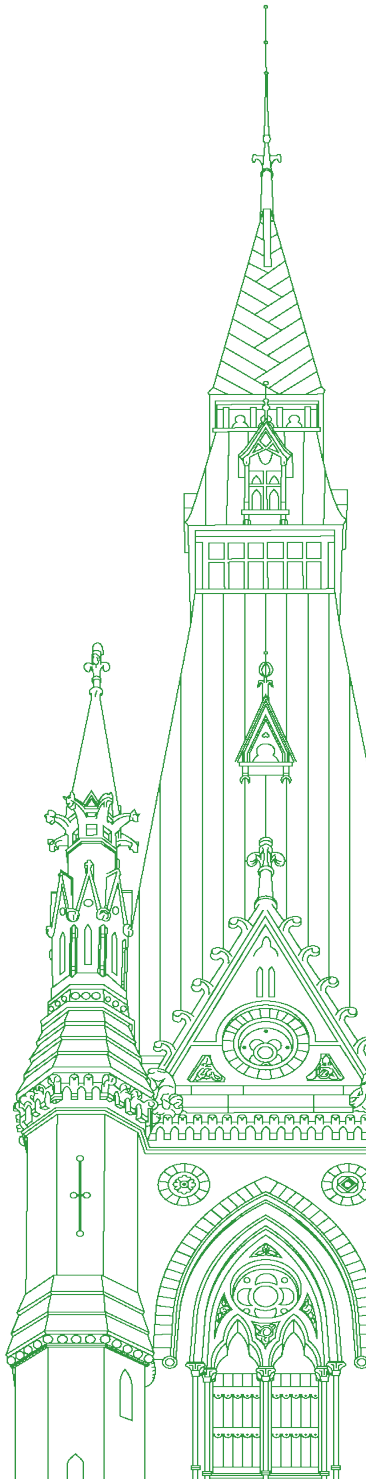

Chair: Mr. Sean Casey

Standing Committee on Health

Tuesday, November 15, 2022

● (1100)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 42 of the House of Commons Standing Committee on Health.

Today we meet for two hours with witnesses on our study of over-the-counter pediatric medication.

I see that we have a couple of members participating online who are well aware of the procedures and the fact that the hybrid format is permitted pursuant to the House order of June 23, 2022.

We're going to get right into welcoming the witnesses. We have a panel in front of us today who are quite familiar with the committee, as we are with them.

We have Dr. Stephen Lucas, deputy minister of Health Canada; Dr. Supriya Sharma, chief medical advisor and senior medical advisor in the health products and food branch; Stefania Trombetti, assistant deputy minister, regulatory operations and enforcement branch; Linsey Hollett, director general, health product compliance; and Dr. Kim Godard, director, health product inspection and licensing division, regulatory operations and enforcement branch.

Thank you all for being with us here today.

I understand that Dr. Lucas is going to lead us off.

You have up to five minutes, Doctor. Welcome to the committee. Thanks for being here. You have the floor.

Dr. Stephen Lucas (Deputy Minister, Department of Health): Thank you, Mr. Chair.

Good morning, and thank you for the opportunity to appear before the Standing Committee on Health today to participate in the discussion on the availability of non-prescription analgesics for infants and children.

As you noted, I am joined by a number of colleagues from Health Canada. They are Dr. Supriya Sharma, Stefania Trombetti, Linsey Hollett and Kim Godard, who will work with me to respond to your questions.

[*Translation*]

First, I want to emphasize that the shortage of pediatric analgesics is a top priority for Health Canada, and all efforts are being taken to resolve this shortage.

[*English*]

We share the concerns of everyone in Canada touched by this shortage. We also understand the impact that it is having on children in need of these medications and the stress it has created for parents and caregivers.

With the time that I have for my opening remarks, I would like to share with the committee a quick snapshot of the work that Health Canada has been undertaking to mitigate the effects of this shortage.

Drug shortages are a complex and multi-faceted issue with a range of stakeholders having roles to play. Mitigating and resolving drug shortages require a collective effort of many players. Health Canada's experience in managing shortages, the regulatory tools at its disposal and well-developed government-to-government networks and stakeholder relationships have provided Canada with a solid foundation to address shortages.

In regard to pediatric analgesics, Health Canada has been actively engaging in bringing together manufacturers, distributors, retailers, provinces and territories, children's hospitals, the Canadian Pharmacists Association, and industry associations and health care practitioners, including the Canadian Paediatric Society, to assess demand, assess the options for expanding supply and implement measures to limit the effects of the shortage. Our engagement has been constant over many months, with daily interactions with key stakeholders over the last number of months.

Companies who supply the Canadian market, be they large or small, have ramped up their supply. Some manufacturers are now producing these products at record levels in Canada; however, demand continues to outpace supply. Health Canada is using other tools at its disposal to increase the supply, including facilitating the importation of foreign products.

When Health Canada first became aware of supply constraints for these products in the spring, we reached out to the suppliers and made it clear that regulatory flexibilities to permit the exceptional importation of foreign product were available and could be used to increase the supply coming into Canada.

With the information available at that time, the mitigation approach adopted by suppliers was to ramp up domestic production. The department continued to engage multiple players in the supply chain over the following months, but by late summer the unprecedented spike in demand made clear that ramping up production would not be sufficient. Again, the department sought proposals from market authorization holders for the importation and sale of foreign-authorized supply.

In a statement released yesterday by Health Canada, we advised Canadians that we have secured foreign supply of children's acetaminophen that will be available for sale at retail and in community pharmacies in the coming weeks. The amount to be imported will increase supply available to consumers and will help address the immediate situation. To further increase supply, Health Canada has also approved the exceptional importation of infant and children's ibuprofen and acetaminophen to supply hospitals in Canada. The importation of ibuprofen has occurred, and distribution has begun.

Each proposal received from a company to import a foreign-authorized product undergoes careful review by Health Canada to confirm that the product was manufactured according to standards of safety, quality and efficacy that are comparable to those for all drug products approved for use in Canada.

● (1105)

[*Translation*]

For foreign supply of children's analgesics, in addition to meeting the required safety standards, information related to cautions and warnings, dosing directions, ingredients, and other important details will be made available in both English and French to ensure parents and caregivers clearly understand what medication they are using and how to give it to their children.

As foreign product generally does not have important safety information available in both official languages, Health Canada works to ensure this is not an impediment to importation.

[*English*]

When this involves products at a retail level, this can be done, for example, by providing and visibly posting a QR code, website information and paper printouts in community pharmacies and retail stores where the safety information can be accessed.

Health Canada is continuing to work alongside suppliers to facilitate more product coming into Canada to fill the supply needs. We know that companies are continuing to produce at record levels to meet the needs of Canadians.

In addition, through the exercise of regulatory flexibility, Health Canada has facilitated greater access to these needed medications by temporarily allowing the sale of compounded acetaminophen or ibuprofen without a prescription. Regulations on the safety and quality of these products continue to apply. This measure will be in place until the shortage is resolved.

I will conclude by reaffirming that addressing this issue is a top priority for Health Canada. All possible efforts are being made to mitigate the shortage of pediatric analgesics. The health and well-being of infants and children has been and remains our highest priority. Health Canada has been actively engaged since observing early signals of a potential shortage. We have and will continue to dedicate significant resources to resolving the shortage. As I've noted, we have mobilized, convened and worked with all the players involved to address it as quickly as possible and on a sustained basis over many months.

We will continue to communicate with Canadians, including through the dedicated pediatric analgesics information on our website.

[*Translation*]

We look forward to today's discussion and will be happy to answer any questions that committee members may have.

[*English*]

Thank you, Mr. Chair.

The Chair: Thank you, Dr. Lucas.

We're now going to begin with rounds of questions, starting with Mrs. Goodridge, please, for six minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair. Thank you to our witnesses for being here on this critically important issue.

I'm going to start out by asking when Health Canada became aware of this shortage and the crisis.

Dr. Stephen Lucas: Mr. Chair, Health Canada first received reports last spring—in April—concerning some issues in some provinces, like Ontario and Newfoundland, for example. We sought further information and engaged the range of stakeholders, including the manufacturers and market authorization holders.

Certainly, from that part onwards, we engaged a group of stakeholders and made clear the opportunity to augment supply through the importation of foreign product.

Mrs. Laila Goodridge: I don't have much time, so I'm going to ask relatively short questions. I'm going to ask that you perhaps respect and answer relatively shortly, if possible.

I'm the member of Parliament for Fort McMurray—Cold Lake. Up in northern Alberta, we don't really have an option to drive across a border to get these medications, which are in vast supply down in the States.

I didn't even know that was an option. I just thought I was a mom going crazy in April when my little guy was teething and I could not find these products. I thought it was just a supply chain issue. I would come to Ontario and I could still find them. I wasn't as stressed out as perhaps I could have been, but it was ridiculously stressful.

The last time I saw these products on the shelves in my community was May. That's terrifying for a community that's five hours from children's hospital.

When did you start to procure products from elsewhere?

● (1110)

Dr. Stephen Lucas: Mr. Chair, I'll start the response then I'll ask my colleague, Stefania Trombetti, to augment it.

As I had indicated, at the earliest signs of issues last spring, we started engaging the industry on supplying the Canadian market asking them to ramp up production, which they've done. We asked them to provide the input, as well as through retail networks from pharmacists, pediatricians and others, about what was going on.

From that time, we have both requested and conveyed the importance of increasing supply through increasing domestic production as well as by importing product from foreign jurisdictions.

Mrs. Laila Goodridge: Some of the news reports have stated that the first international shipments of acetaminophen and ibuprofen are slated to go to our hospitals. How close were our hospitals to running out of supply?

Dr. Stephen Lucas: I'll turn to Stefania.

Ms. Stefania Trombetti (Assistant Deputy Minister, Regulatory Operations and Enforcement Branch, Department of Health): We know that hospitals, Mr. Chair, were running very low on supplies. As we do in shortages all the time, part of the mitigation measures are to manage the supply that already exists. They were managing that supply. They did have supply, but obviously these additional supplies are very welcome to those hospitals.

Mrs. Laila Goodridge: I'm looking at Drug Shortages Canada. I've learned a lot about drugs in the last very short period of time. It's not something I thought I would have to do as a brand new mom, but that's the case.

I'm seeing that there are shortages of other drugs, such as amoxicillin and azithromycin. They are pretty basic antibacterial antibiotics.

What other pediatric medications are in shortage? What is Health Canada doing to prevent us from having a crisis?

Ms. Stefania Trombetti: You're correct. The drugshortagescanada.ca website is a very transparent way to see what drugs are in shortage.

I'll put that into perspective. You're correct that there are other pediatric drugs that are currently in shortage. That does not necessarily mean that there will be a stock outage. At this point, there are about 800 drugs in shortage in Canada. To put that into further perspective, with regard to those that reach the national critical level, at this point we have 22. On a regular basis, we do manage these shortages successfully.

On the other two you mentioned, azithromycin and amoxicillin, when we receive signals, we take them seriously. We look to understand what the situation is with the suppliers, what the supply looks like, what the demand looks like, what the reason for the shortage is and what the anticipated end date of the shortage is. We always look at how we can manage supply that exists and how we can shore up that supply. In some cases, manufacturers are able to ramp up supply or bring in supply that is manufactured in other markets.

I'll speak about one example because you asked about examples.

Caffeine citrate, for example, is another drug that you'll see on that list that is currently at a national critical level. It's used to treat infants and newborns with apnea. In that situation, we have been able to understand early in the shortage what the supply gaps will be and to work with manufacturers to make sure that we have supply coming in that will fill those supply gaps before they are even felt.

● (1115)

Mrs. Laila Goodridge: Why are we seeing this in Canada and not seeing it elsewhere in the world? This is an absolute failure of the government leadership, because for months the idea was that it wasn't Canada's problem. We didn't see public information coming out from the Government of Canada—even telling parents that they're not going crazy and that this is an actual problem—until it was brought up in question period, and all of a sudden now Health Canada is responding.

Why did it take that long for us to get any attention? I brought this up in the committee in September, and it was crickets from Health Canada—crickets.

The Chair: We're well past time. Keep your response short, please.

Ms. Stefania Trombetti: The issue of drug shortages is not unique to Canada. Many other countries in the world experience shortages and, like Canada, have mitigation measures that they put in place as soon as they identify signals of shortages. Health Canada works behind the scenes. Many of these shortages will not be felt or seen at the patient level. That may be why you haven't heard about it—because they are being managed.

The Chair: Thank you.

Next up is Dr. Powlowski for six minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Well, as you may or may not know, I'm a doctor. I still work a little bit in medicine. Before going into politics, I was an emergency room doctor in Thunder Bay for about 18 years.

I have to say that I kind of disagree with you when you say that Canada has a history of managing drug shortages successfully and that we have a foundation for addressing drug shortages. It didn't start with the Liberal government. I was working in an emergency room from 2003 or 2004 in Canada, and in the hospital we were constantly undergoing shortages, often of important drugs like etomidate, which you need for rapid sequence induction in the emergency room. At times we were out of IV Levaquin, which is the primary go-to drug with community-acquired pneumonia. We were out of pediatric bicarbonate, which is just baking soda and water, and Stemetil, which is, and continues to be, the best IV drug to treat migraines. We haven't been able to get that in Canada for years. This was constantly a source of frustration for me in the emergency room, and I don't blame it all on the federal government. The hospital wasn't interested in addressing this issue. They'd just tell us, "Well, we're out of the drug."

My understanding of the regulatory process, especially for drugs that are off-patent, is that it's rather onerous. There are a lot of hurdles you have to clear. You have to get a drug product licence and you also have to have an establishment licence. My understanding is that it's easier to import drugs from countries where we have a shared good manufacturing process, but especially with drugs that are off-patent, my understanding is that the profit margin is fairly small, and if, for instance, an Indian or Chinese company wants to get that product into the market in Canada, it has to go through all these hurdles, which are fairly onerous. Given that often the profit margin for some of these drugs is small—that isn't the case for acetaminophen, for which there's a big market—and the market is much more limited and the regulatory process is complex, they don't want to do it, and that's why these products aren't getting to the market in Canada.

That's certainly how I, as a doctor, perceive the problem. I don't know whether that's Health Canada's perception of the problem. As an emergency room doctor, I was really frigging frustrated with constantly having this process with drugs, so how can we address this problem?

Dr. Stephen Lucas: Mr. Chair, I will start by indicating that Health Canada has taken and continues to take the issue of drug shortages very seriously. We have certainly seen the challenges increase over the past decade. The challenges are of a global nature with supply chains. In some cases, the active pharmaceutical ingredient is coming from just a single supplier. We've been working domestically to strengthen our capability in Health Canada—with Stefania's team and with colleagues here—to have a focused organizational unit and task force working to address it.

There has also been work globally, and Stefania co-chairs an international group of regulators looking at this issue. Certainly, as we saw in the pandemic, the importance of supporting domestic biomanufacturing is a critical priority and one in which the government has invested significantly to attract and support businesses and develop manufacturing operations in Canada.

We routinely work with—and we recently updated, in 2021—regulatory authorities to further facilitate addressing drug shortages. My colleagues can speak to that. As Stefania said, at any point in time we could be having supply challenges with 10% to 15% of drugs, but we work actively with multiple suppliers to avoid, to the greatest extent possible, those having impacts at the clinician and importantly at the patient and care provider/parent level.

As well, we have worked to look at novel ways of addressing it, including, during the pandemic, by establishing a critical drug reserve with provinces and territories.

We are fully engaged in addressing this and in using regulatory flexibilities to help ensure that Canadians get the supply of drugs they need.

● (1120)

Mr. Marcus Powlowski: Thank you.

Having worked in a lot of different developing countries, I can tell you that the issue of drug supply is a critical one all over the world. Certainly all over the world there's concern about getting good, cheap medications but also drugs that are effective. That's certainly a challenge.

What is Canada doing with other countries in order to have some sort of global approach to the problems—some sort of common standards that other countries can look to in ensuring that a medication that's being bought and used on patients in those countries as well is actually effective and safe?

Dr. Stephen Lucas: I will start and then turn to Dr. Sharma and Stefania on this.

Canada works through Global Affairs Canada in supporting increasing access to needed medicines, as was the case and continues to be the case in the pandemic, with access to vaccine treatments and diagnostics through organizations like COVAX. In addition, we have extensive regulatory co-operation on a global scale.

To speak to that, first I'll turn to Dr. Sharma.

Dr. Supriya Sharma (Chief Medical Advisor and Senior Medical Advisor, Health Products and Food Branch, Department of Health): Thank you, Mr. Chair.

The manufacture of pharmaceuticals is absolutely global. It's not unusual to have a pharmaceutical where the active pharmaceutical ingredient comes from one country, the first part of manufacturing happens in another country and then maybe packaging and labelling happens in another country before it would come to the country in which it's sold. That's why it's really important that we have harmonized international standards to make sure that regardless of where those ingredients come from or where the finished drug product comes, they meet the standards for safety, efficacy and quality in Canada.

That's the case no matter where it's manufactured. An incredible amount of work goes on internationally on standards for the places where the manufacturing is happening, through what we call “good manufacturing practices”. That's basically the same everywhere in the world.

As well, there's a lot of work on harmonization of the technical standards of how those medications are looked at. A group called the International Council on Harmonisation involves multiple countries from around the world, along with industry, to put together those technical standards.

Again, because of the global nature, it's really important that we have harmonization and can rely on those medications being safe and effective and of high quality.

The Chair: Thank you, Dr. Sharma.

[*Translation*]

Mr. Garon, you have the floor for six minutes.

Mr. Jean-Denis Garon (Mirabel, BQ): Thank you, Mr. Chair.

I thank all the witnesses for being here today.

I would like you to keep your answers short, because I just want to make sure I understand the situation.

Since last spring, Health Canada has been aware that there is a shortage of a number of drugs. This is a well-known fact. You tell us that there are problems with the supply chain and that this happens frequently in other countries. I would like you to name me another G20 country where today I could not find infant or children's Tylenol on the shelves in pharmacies. I want you to name a country.

Dr. Stephen Lucas: I would point out that drug shortages are a global problem. There are drugs for which there is a shortage in other countries as well as in Canada. On the other hand, there are situations that are unique to Canada.

Other countries with shortages of infant or child painkillers include Germany and the UK. I would ask Ms. Trombetti to complete the list.

● (1125)

[*English*]

Ms. Stefania Trombetti: That's correct.

There are constraints that we know of in countries like Germany, France and Ireland. You are correct that the impact isn't as felt as it is here, but there are constraints for sure in other parts of the world.

The way shortages—

[*Translation*]

Mr. Jean-Denis Garon: I'm going to interrupt you, because I don't have much time, and you answered my question well. It's rare that civil servants answer well. I congratulate you on that, I'm very pleased.

When I look at the data, the Canadian situation looks worse than most of these places. I'd like you to tell me what other G20 country is at the same point today as we are, having to call health department officials before a parliamentary committee to get answers and try to understand these shortages. In Ireland, England and Germany, do parliamentarians have to question their health department officials to find out what is behind the shortages?

Dr. Stephen Lucas: I want to say something first and then my colleague Ms. Trombetti can answer your question in more detail.

First, there are factors that are unique to Canada. For example, demand has grown much more significantly in Canada, compared to other countries. The increase in demand started in August and has been going on since then.

There are also shortages of drugs elsewhere, such as Adderall in the U.S., that don't exist in Canada right now. So there are challenges in every jurisdiction.

As I said, there are factors today that are unique to Canada, particularly the fact that, for some products, demand has doubled, or even quadrupled.

Mr. Jean-Denis Garon: I understand.

What is Health Canada's obligation to communicate? There has been a shortage since the spring, and it took the Conservatives tabling a motion in our committee to try to find out what is going on. Despite that, we haven't had any data.

Since you are talking about supply and demand, I will use the example of the announcements that have been made this week on amoxicillin. What I'm hearing from the manufacturers and the people who trade in it is that it has created a panic among parents. In the last few days, the quantities of this drug that have had to be ordered are unprecedented.

What I understand from this, at least as an economist who has contacted the industry, is that the communications from Health Canada are so bad that people learn the bad news at the last minute and panic. You are part of the problem right now. You're contributing to the panic among parents and the abnormal increase in demand, which makes the shortage worse.

I have been paying attention to what the Minister of Health has said since the spring. He has said, among other things, that health funding is futile. Whatever else he has said, he has never alerted Canadians and families. He never reassured them and never explained the processes.

Do you have a job to do communicating with Canadians, or do we really need to drag you in front of a committee, like today, to make you talk?

Dr. Stephen Lucas: By the spring we were communicating on a weekly basis with industry and various stakeholders, such as pediatricians and children's hospitals. Since the latter part of the summer and early autumn, we have been doing it on a daily basis. So the level of involvement is very high. We communicate, but, importantly, they play their own role every day, too.

I will ask Dr. Sharma to—

Mr. Jean-Denis Garon: Excuse me, but I only have 15 seconds left.

At this time, parents are in a panic, so you understand that you must not have done a good job of communicating, right?

Dr. Stephen Lucas: I'll let Dr. Sharma respond to that.

● (1130)

[*English*]

Dr. Supriya Sharma: Mr. Chair, absolutely the point is well taken that communications need to be very carefully done when it comes to drug shortages. You don't want to precipitate any panic buying. What we've seen specifically with Tylenol and ibuprofen is that there was some tightness in supply back in the spring. There was an increase in supply as manufacturers stepped up to ramp up production. There were intermittent stock outages in different places, but really it was in August when there was more attention to the issue. That's when we saw this huge, drastic increase in purchasing. That's when it tripled and quadrupled, in August.

Again, it was variable across the country, but that's when we really had from the manufacturers the notification that they were unlikely to meet supply, and we then went to working with looking at alternatives to supply. That's when a lot of the communication started as well. We worked with the Canadian Paediatric Society to put out advice to patients. We worked with other stakeholders as well. Again, we had seen in August that some attention to this and some of the communications around it encouraged people to go out and potentially stock up and buy more than they needed. That's really when we started to see some of that shift in not being able to meet the demand nationally.

The Chair: Thank you, Dr. Sharma.

Go ahead, Mr. Davies, please, for six minutes.

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

On November 11 Health Canada announced that special imports of pediatric ibuprofen from the U.S. are awaiting distribution in Canada, and pediatric acetaminophen imports from Australia are imminent. The department didn't disclose how much was expected or how the stock will be divided, but it promised fair distribution of supply across Canada.

Can you please confirm how many doses of ibuprofen have been imported from the U.S. to date, and how many acetaminophen doses will be imported from Australia?

Dr. Stephen Lucas: I will turn to Stefania and Linsey Hollett to respond.

Ms. Linsey Hollett (Director General, Health Product Compliance , Department of Health): That is accurate in that we were prioritizing supply to hospitals and we were able to secure supply from two jurisdictions. Unfortunately, I'm not able to share the exact quantities, but what I can say around fair and equitable distribution is that you've heard a lot this morning on the importance that we placed on collaboration and a multistakeholder approach to the shortage. That is coming to benefit us greatly when we are determining fair and equitable distribution. We will look at things like historical patterns, certainly, and also, by having these open communication chains with pediatric hospitals, with provinces and territories, with health care professionals, we will have a very good line of sight on where need is greatest.

Mr. Don Davies: If I can interrupt, why can't you tell me how many doses have been imported? Is it that you know and you won't tell us, or you don't know?

Ms. Linsey Hollett: Thank you again for the question.

We work quite closely with market authorization holders. I'm sure you can appreciate that when we have confidential business information in our possession, we needed to treat it as such. Quantities have been established, but because of confidential business information, I'm not able to share them.

Mr. Don Davies: It's confidential how many doses Canadians can expect to receive of a medicine for their children that there's a shortage of? You won't tell them how many doses you have available?

Ms. Linsey Hollett: It's the information of those companies that are importing.

Mr. Don Davies: Do you have those doses? Have they been received in Canada?

Ms. Linsey Hollett: As I was saying, we are talking here about two different importations. One importation has arrived in Canada.

Mr. Don Davies: Is that from the U.S.?

Ms. Linsey Hollett: That's right.

Mr. Don Davies: Australia's you haven't received. When do you expect to receive Australia's?

Ms. Linsey Hollett: We expect to receive the Australian product this month. I don't have an exact date, but it's in the next couple of weeks. I can also say that to expedite the transport here to Canada, we are using air freight to get it here as quickly as possible.

Mr. Don Davies: I would hope so—not a boat.

Given that India and China account for approximately 65% of the world's production of active pharmaceutical ingredients, sometimes called “precursors”, do disruptions to these supply chains, such as geopolitical tensions or changes in export policies, have an impact on pharmaceutical security in Canada?

Dr. Stephen Lucas: Mr. Chair, as we've noted, the challenges with global supply chains and their exacerbation in the pandemic have been well noted and documented. We have worked with countries that produce those to sustain their importing, including for further fabrication in Canada, and we've worked as well to—

● (1135)

Mr. Don Davies: It was a yes-or-no question: Do they have an impact?

Dr. Stephen Lucas: Yes, they can have an impact. That's why we're working to diversify supply and strengthen manufacturing in Canada.

Mr. Don Davies: I'm going to get into what you're doing about it.

A recent article in Policy Options said the following: "Drug shortages have been a...fact of life in Canada for 10 years now." I think we've heard that it's for more than just pediatric pain medication.

It said:

> The causes are many and often opaque. Manufacturing issues are cited most frequently, often stemming from quality issues, and with the COVID-19 pandemic the manufacturing and supply issues have only multiplied.

That's coming up on almost three years now.

It continued:

> In fact, manufacturing disruptions now account for 62 percent of drug shortages, as per a recent Health Canada communique shared with stakeholders.

What are you doing to address the long-term structural problem of drug shortages in Canada?

Dr. Stephen Lucas: Mr. Chair, I'll highlight several dimensions.

One of them, as noted, is that we have over the past number of years built our internal capacity for forecasting and understanding supply and demand; early identification of potential risks and shortages; and changing our regulatory instruments to enable foreign importation. In addition, we have been working with regulatory partners to strengthen the diversification of supply chains.

Then, finally and importantly, the government has invested two and a half billion dollars to strengthen domestic biomanufacturing, both—

Mr. Don Davies: Here's where I'm going on that. I want to focus my last question on domestic supply.

In August 2020, an executive order in the United States directed the U.S. Food and Drug Administration to identify a list of essential medications and produce reliable long-term domestic supply chains for goods essential to public health.

Has Canada done the same thing? Is Health Canada taking any steps toward securing domestic supply chains of essential medicine in Canada?

Dr. Stephen Lucas: Mr. Chair, as I noted, the government has invested to strengthen biomanufacturing. A number of critical investments have been made, including in regard to future pandemic preparedness, but more broadly it's all components, from research through to fill and finish of product.

We have a strong generic industry that continues to grow. We are working to further strengthen innovator and domestic biomanufacturing throughout the entire chain, and we are looking at critical medicines that could be at future risk to make sure that we look at multiple strategies to address and preclude future shortages.

The Chair: Thank you, Dr. Lucas.

Next up we have Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you, Chair.

Thank you to the witnesses for being here.

Certainly we know that this has been a very, very difficult time for Canadian parents. Part of the issue, I think, is transparency. It took four months for this shortage to begin to be addressed. It started in April—you made that very clear—and nothing happened until August. When did the Liberal Minister of Health become involved in all of this?

Dr. Stephen Lucas: Mr. Chair, as I indicated in my opening remarks, Health Canada has been engaged since the spring, and we've been active since the spring in working with manufacturers, pediatricians, children's hospitals and provinces and territories on identifying the risk and encouraging the increase in domestic production, which has been significant and, as I noted, at a record level. As Dr. Sharma noted, demand increased significantly in August, and we further engaged and heightened the tempo of work with partners and encouraged foreign importation, which is happening.

Mr. Stephen Ellis: Through you, Chair, I think, Mr. Lucas, that clearly I asked when the minister became involved in this.

Dr. Stephen Lucas: Mr. Chair, we routinely brief the minister and, at instances where we work to further strengthen communication with the public—

Mr. Stephen Ellis: A date would be good.

Dr. Stephen Lucas: Mr. Chair, as I said, we routinely brief the minister and make information available to Canadians, both directly through Health Canada as well as through partner organizations, including the Canadian Pediatrician Association, as Dr. Sharma noted.

● (1140)

Mr. Stephen Ellis: Thank you.

Through you, Chair, if I could, we're talking about transparency here, and I'm finding it exceedingly difficult to get a transparent answer. Now we're blaming the parents by saying that we didn't want to talk about this to Canadians because we were concerned the parents might buy some more acetaminophen and ibuprofen. That, in my mind, would be almost victim blaming.

Good communication comes down to asking what our plan is. It would occur to me very clearly that the minister was not involved in this for a very, very long time, which is shameful, and that Health Canada had a very, very poor plan in place here, not to mention that I would suggest we should have anticipated that there might be a surge in the fall of the year and taken it much more seriously in April. I think that's shameful.

The second part of that would be that it's exceedingly important to rebuild the trust of Canadians. Part of that is not standing behind the fact that we can't share how many doses are coming, when they're going to get here or when they're going to be distributed. That would be an essential part of the plan of transparency to reassure Canadian parents that you're doing something. To me, standing over there and sitting over there and continuing to refuse to do that is absolutely unconscionable.

I guess my question would be, then, what are you going to do about that? How are you going to reassure Canadian parents that you've done something and that these medications that are essential are going to be on the shelves?

We do have a much bigger and looming problem, which we'll have to bring you back for, because clearly you don't appear to have the competence to do it yourselves. We're going to have to bring you back to talk about amoxicillin and azithromycin as we move into the fall and winter season.

That's a big question. Fill your boots.

Dr. Stephen Lucas: Mr. Chair, I and Dr. Sharma and perhaps other witnesses will respond, given the range of points that were made.

I will start by indicating, as I noted, that Health Canada, from the earliest indication of potential shortages in the spring, actively engaged manufacturers, of which there are about a dozen supporting the Canadian market, provinces and territories, children's hospitals, pharmacies, retail networks, pharmacists and pediatricians.

We continued to do that encouraging through the spring, based on our plan to increase domestic supply, which happened and is now at record levels. We have given throughout that time the opportunity to import available foreign product as an option, for which we have the regulatory tools, and indeed are now doing just that. We are importing foreign product to address that shortage for Canadians.

We have communicated with Canadians. I'll turn to Dr. Sharma to describe that. As I've explained, we have a drug shortages task force in place and a dedicated team, and we've worked to resolve literally hundreds of drug shortages every year so that there is no impact or visibility to patients. We transparently reported through our drug shortages website and have communicated with a range of stakeholders across the country to address this situation.

A very significant amount of work goes to protect the health and safety of Canadians, and for infants and children there has been a very focused effort since the spring.

I'll turn to Dr. Sharma now to speak to communication, including that which she has participated in to support information for Canadians both directly from Health Canada and through key partners, including pediatricians.

The Chair: Dr. Sharma, we are well past time, so please be concise. If you prefer to augment your answer in writing, that would be fine, as well.

Go ahead.

Dr. Supriya Sharma: Thank you, Mr. Chair.

First we would say that we feel for parents and caregivers. Being parents of young children is a difficult enough job. To try to figure out how to source medications to treat them for pain or fever is just adding to the stress. We're obviously dealing with situations with respiratory viruses now, so we understand that it's really challenging.

Health Canada's role really is a convening function to bring people together to make sure we're sharing information. In terms of Health Canada communications, as soon as we got a proposal from manufacturers to allow additional product to come in and that was approved, we communicated. Before that, we worked through our groups, like the Canadian Paediatric Society and the Pharmacists Association, to figure out what should be communicated to patients and who would be best placed to provide that information. When it's advice to parents about what to do about dosing and alternatives, it really is best placed coming from practitioners and people who are doing the health care delivery.

Certainly we can provide additional information about the communication that we did in Health Canada. Really it was a focus on what Canadians needed to know and who was best placed to provide that information to help them through this shortage situation.

● (1145)

The Chair: Thank you, Dr. Sharma.

Next we have Ms. Sidhu, please, for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair. Thank you to all the witnesses for being with us today.

I have a question for Dr. Lucas.

You said in your statement that demand increased significantly in August. Why did the demand increase in recent months? What factors are contributing to that?

Dr. Stephen Lucas: As we've noted, a number of factors are contributing to it. We have seen a more sustained level of viral infections in children, above the normal level. These are from COVID and other respiratory viruses that have increased in the fall, with respiratory syncytial virus, influenza starting now, and COVID as well.

Another dimension is that as people became more aware—and there was some communication on this in August, as Dr. Sharma noted—increased buying contributed to the demand.

It was a number of factors, but an unusually significant viral infection season impacting children has certainly been a major cause and one which we're very focused on addressing. Certainly we're doing everything we can to support children, infants and their parents and caregivers.

Ms. Sonia Sidhu: I'm wondering about the review process for importing medications.

Can you comment on the process of reviewing dosing, ingredients, cautions and warnings? What work has been done to improve the use of official languages on pediatric medication bottles?

Dr. Stephen Lucas: I'll turn to Stefania Trombetti and Linsey Hollett to talk about that process.

Ms. Stefania Trombetti: When we receive a proposal to import a foreign supply, we always review it very carefully for the safety, quality and efficacy of the drug. That involves reviewing the instructions for use, the dosing and frequency, and understanding the formulation and the ingredients that are used, because although you may have the same active pharmaceutical ingredient, it may be packaged at different dosage levels, and the other ingredients that go into making a drug may also be different. The excipients may include dyes that are not normally used. In this case I'm thinking about children's analgesics in cherry flavour, for example, or grape flavour. We really need to understand those differences and make it clear what those differences are for parents and caregivers so they know those differences and can dose at the appropriate level for the age and weight of their children and take into account any allergies that their children may have before administering the drug.

The other thing that we look at is the manufacturing conditions used in the formulation and the manufacturing and fabrication of the drug. As Dr. Sharma referred to earlier, there is an international standard called “good manufacturing practices for drugs” that we adhere to, and we make sure that any drug that is placed on the market in Canada is produced under those conditions. That is everything end to end, from how manufacturers are storing the active pharmaceutical ingredients to the training of the employees they have on the production line, as well as how they clean the equipment, the credentials of the quality assurance person who is signing off on the batches before they are released to the market, right down through to the distribution chain, making sure that any requirements related to temperature, for example, are observed and that those drugs are in full compliance with all of the requirements needed for the market here.

Maybe Linsey will want to add to that.

● (1150)

Ms. Linsey Hollett: I have nothing to add to what we look at, but I can address your question around official languages.

When we are looking at a shortage situation, our number one priority is to make sure that critical safety information gets to all the people of Canada in the language of their choice. That is why, when we have a shortage situation, the preference is always to use Canadian-authorized product to address the situation, since by law all information will be in English and French. However, when we have to consider foreign product, as Stefania mentioned, through that process, if the product coming in will not be labelled and contain all of the information in both languages, as Canadian product would, we look at how can we still ensure that the critical information is available to everyone in the language of their choice, English or French.

What we do there is look at a myriad of options. If product is going to hospitals then every unit or every shipment going to a hospital will have information in English and French.

In the situation we're talking about here, which is that there's also product on store shelves, we have multiple options to choose from, and we can implement some or all. When you purchase at a store, you can be given bilingual information. There can be signage on the shelf, a bar code or a code to scan, and as the deputy minister mentioned earlier, there's making sure on public-facing websites that information is available in all languages. When we work with companies with 1-800 numbers or help lines, we make sure that those are serviced in both official languages.

The Chair: Thank you, Ms. Hollett.

[*Translation*]

Mr. Garon, you have the floor for two and a half minutes.

Mr. Jean-Denis Garon: Thank you, Mr. Chair.

Earlier, my colleague Dr. Powlowski talked a little bit about drug prices. I've been talking to people in the industry recently, including drug distributors. They have told me that Canadian drug pricing regulations may be one of the causes of shortages, particularly because drug inventories are kept low.

If I am not mistaken, there has been deflation in the cost price of drugs in recent years, that is to say that prices have fallen. In the middle of the supply chain are the distributors. Essentially, they resell the drugs at the price they paid for them, but they are paid a fixed proportion of the price.

We have been aware for several years that stocks are getting lower and lower. Therefore, if there is ever an outbreak of respiratory viruses and demand peaks and there is a panic, such as that created by poor communication from the Government of Canada, we are going to find ourselves in a situation where stocks will drop rapidly and we will have fewer drugs.

In this whole issue, what is the responsibility of Canada's drug price regulatory system, particularly with respect to inventory?

Dr. Stephen Lucas: First of all, the key factors that have created the drug shortage situation, as I said, are the difficulties with the manufacturers—

Mr. Jean-Denis Garon: I apologize for the interruption, but I have very little time to speak and my question is not being answered. I want to know what role the drug price regulation system plays.

Dr. Stephen Lucas: First, the cost of drugs appears to be a key factor in creating shortages in Canada, plain and simple.

Second, the regulatory system in Canada, in this case the Patented Medicine Prices Review Board, or PMPRB, ensures that Canadian consumers are protected from excessive prices. The regulation in this case is clear. It is not a blanket regulation; it specifically protects against excessive prices. This has a direct impact on the quantity of drugs approved and used in Canada.

The Chair: Thank you, Mr. Lucas.

[*English*]

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

Mr. Don Davies: Thank you.

Ms. Hollett, I have sat on this committee since 2015 and through the entire COVID pandemic. When we asked for details about the COVID vaccines, the government always claimed commercial reasons for not disclosing information religiously, but one thing they always gave was the numbers.

I think when the government wants to release numbers to try to make itself look good, such as when it is procuring lots of COVID vaccines, commercial sensitivities don't seem to be a problem when releasing the number of doses. However, now there's a shortage, and all of a sudden the government is claiming commercial sensitivities to not release the numbers it had no problem releasing for vaccine doses. It's citing the exact same reason.

Can you explain that to me?

● (1155)

Ms. Linsey Hollett: One thing I should have added earlier is that while I am not able to share now, work is under way with the companies that we have been working with and are importing from to make public the information that is being asked for in very short order on the public-facing Health Canada website.

The need for that information and the importance of that information have been recognized. We're very close to being able to publish it again in a public forum.

Mr. Don Davies: Why would you say that? The customers for these doses are the people of Canada. They are paying for them. When there's a drug shortage, parents looking for drugs for their children have a right to know how many doses are coming, in my opinion.

Australia's medicine supply security guarantee requires that Australian medicine manufacturers hold four to six months' worth of stock of critical medicines, particularly those that have historically experienced shortages within the country, to provide a buffer in the event of global medicine shortages.

Do we have the same policy in Canada?

Dr. Stephen Lucas: Mr. Chair, what I would say is that we notably have a variety of strategies to both mitigate the risk of and address the event of drug shortages—

Mr. Don Davies: Mr. Lucas, with respect, I didn't ask what strategies we had. I asked if we have a similar policy.

Dr. Stephen Lucas: What I was working to say, Mr. Chair, is we have a variety of tools available now. We continue to look at other strategies, including essential medicines that we established during the pandemic—as has been transparently documented, a critical drug reserve—and we are learning the lessons from that as we consider it going forward.

Mr. Don Davies: You said that hundreds of drug shortages are resolved per year. That sounds like we have normalized a disaster. It sounds like we're used to having hundreds of drug shortages every year, and you're claiming success that somehow we can avert disaster on this one.

Isn't the fundamental problem that Canada does not have a domestic supply of critical medicines, and that's where we need to be addressing our efforts, not on better reporting of the shortages?

Dr. Stephen Lucas: Mr. Chair, I have spoken—

The Chair: You get the last word, Dr. Lucas. That was the last question.

Go ahead.

Dr. Stephen Lucas: I have spoken about multiple strategies being undertaken, including strengthening our capability, working with global regulators, working with manufacturers, strengthening domestic biomanufacturing as that strengthens work to resolve issues domestically, and looking at the experience from the pandemic in the critical drug reserves. We're looking at multiple strategies.

Obviously, our goal is to ensure that Canadians have access to the medications they need when they need them, and that they are safe, of high quality and effective. We will continue to work toward that, supporting, in particular in this moment, children and infants and their parents and caregivers to address this current challenge with pediatric analgesics as quickly as possible and using every tool possible.

The Chair: Dr. Lucas and your team, thank you so much for being here. We have another panel of witnesses who will be speaking to this issue in the second half of the meeting. As always, we appreciate your coming, in this instance on fairly short notice, and the patience you've exhibited with us on this very difficult issue. Thanks again.

Colleagues, we will suspend for five minutes while we bring in the next panel of witnesses. You can stretch your legs and get a bite if you want.

We stand suspended.

● (1155)

_____(Pause)_____

● (1205)

The Chair: I call the meeting back to order.

I'd like to welcome our witnesses for the second panel.

I have just a few comments for the benefit of the new witnesses, specifically Dr. Ahmed, who is participating online.

Dr. Ahmed, you have interpretation on your screen. You have the choice of either floor, English or French.

For those in the room, you can use the earpiece to select the desired channel.

[*Translation*]

Mr. Garon, I can confirm that sound and connection tests have been carried out with Dr. Ahmed and that the sound quality is good.

[*English*]

I would now like to welcome our next panel of witnesses.

From the Association québécoise des distributeurs en pharmacie, we have Mr. Hugues Mousseau, director general.

From Children's Healthcare Canada, we have Emily Gruenwoldt, president and chief executive officer.

From the Critical Drugs Coalition, we have Dr. Saad Ahmed, physician, appearing by video conference from Vancouver.

Finally, from Food, Health & Consumer Products of Canada, we have Gerry Harrington, senior adviser.

Thanks to all.

Mr. Mousseau, I invite you to begin. You have five minutes for your opening statement. Welcome to the committee, sir.

[*Translation*]

You have the floor.

[*English*]

Mr. Hugues Mousseau (Director General, Association québécoise des distributeurs en pharmacie): Thank you, Mr. Chairman.

[*Translation*]

Members of Parliament, thank you very much for welcoming me here today to discuss an issue as vital as the supply of medication for the children of Quebec and Canada.

My name is Hugues Mousseau and I am the director general of the Quebec Association of Pharmacy Distributors. In this capacity, I represent the distributor-wholesalers in Quebec, who provide more than 16,000 deliveries each week to all hospitals and pharmacies in the province, whether in downtown Montreal, Blanc-Sablon, the North Shore, or even the Magdalen Islands.

As Quebeckers and Canadians, we have made the choice that all our citizens have access to the medicines they need, when they need them, no matter where they live. This is no small decision for a territory with one of the lowest population densities in the world.

For nearly a year, in Quebec, demand for over-the-counter analgesics has remained at nearly double the historical demand for these drugs. Although the major manufacturers have also managed to double their supply to our distribution centres, the strength of demand is preventing us from replenishing pharmacy and warehouse shelves at this time.

In plain English, everything we receive is immediately shipped to hospitals and pharmacies. The imports recently confirmed by Health Canada are welcome, and I would like to confirm at the outset that the issue of the language of labelling on imported products is a false debate. I will come back to this a little later.

Since the drug supply chain is complex, my aim today is to give you a brief overview of its main components, and then to conclude by giving you some possible solutions to better combat drug shortages.

The starting point of the drug supply chain is provided by the active ingredient factories, mainly located in South-East Asia and Eastern Europe. The chemical compounds from these plants are shipped to the drug manufacturers, who also package and market the products.

The wholesalers I represent buy almost all of the manufactured drugs and resell them at cost to pharmacies and hospitals. The wholesalers are paid according to a model set by the provincial governments. In Quebec, this takes the form of a fixed percentage of the list price of each drug.

This funding model applies consistently regardless of the region of drug distribution and regardless of the type of drug, whether it is narcotics from secure storage, refrigerated products, or cytotoxic drugs whose handling parameters are complex and highly specific.

In fact, Quebec and Canada can count on a drug supply chain that is among the safest and most efficient in the world. This is perhaps one of the most overlooked strengths of our health care system.

Six companies manage drug distribution centres in Quebec. Our members alone represent the most important bulwark against drug shortages. With multi-week stockpiles, strategic stockpiling and a keen understanding of market dynamics, our members can continue to meet the needs of Canadians even if a supply disruption occurs upstream in the chain.

However, this bulwark is now under threat. In recent years, extreme downward pressure on drug prices and a lack of predictability regarding market conditions have weakened the drug chain, with the direct consequence of increasing the number, frequency and duration of shortages.

In fact, according to calculations made by our association, the number of prescription drug shortages has quadrupled in five years in Quebec.

Since then, the problems of price cuts and lack of predictability have been compounded by issues related to inflation and the skyrocketing cost of fuel, in addition to the ever-increasing regulatory burden. Faced with this critical situation, wholesalers will have no choice but to consider reducing the number of weeks of drug stock and reducing the frequency of deliveries to pharmacies.

If the government does not act soon, the reform of the Patented Medicine Prices Review Board and the negotiations of the pan-Canadian Pharmaceutical Alliance will lead to further reductions in the list price of drugs, thereby amplifying the shortage problem. Yet viable alternatives have been proposed to the government and the PMPRB for three years.

Let me be very clear: wholesalers are in favour of price cuts for drugs if they do not undermine supply and innovation. In fact, there is already a mechanism in place across the country called listing agreements, which is a viable alternative for achieving savings while isolating the effect on the drug supply chain and shortages.

I would like to conclude my remarks with some additional observations and suggestions in relation to the shortage of pediatric analgesics and other medicines.

In our view, three concrete solutions will better equip us to respond to shortages in the future.

First, we must put an end to successive and unpredictable price cuts by focusing on contractual and financial mechanisms other than a reduction in the list price, such as listing agreements.

Secondly, we need to stop the critical erosion of distribution funding and reinvest in our supply chain to allow wholesalers to play their full role as a bulwark against shortages.

Finally, we need to work with wholesalers to establish national stocking strategies for critical medicines with a view to optimal stock management according to expiry dates.

Thank you.

● (1210)

The Chair: Thank you, Mr. Mousseau.

[*English*]

Next we have Emily Gruenwoldt, president and CEO of Children's Healthcare Canada.

Welcome back to the committee, Ms. Gruenwoldt. You have five minutes.

Ms. Emily Gruenwoldt (President and Chief Executive Officer, Children's Healthcare Canada): Good afternoon, and thank you for the return invitation.

My name is Emily Gruenwoldt, and I am the CEO of Children's Healthcare Canada and the executive director of the Pediatric Chairs of Canada.

Children's Healthcare Canada is a national association. We represent all 16 of Canada's children's hospitals as well as community hospitals, rehabilitation centres, home care, and palliative centres caring for children and youth. We have a unique systems perspective on the continuum of care for children, a population of eight million and growing. The Pediatric Chairs of Canada are the 17 department heads of the pediatric departments in our medical schools across the country.

I'm pleased today to join you to provide input on how the shortages of children's analgesics are impacting the delivery of health care within our hospital settings and exacerbating strains on emergency departments and entire hospital systems.

It's no secret that a very large number of children across this country are very sick, Whether it is influenza, RSV or even COVID-19, parents and caregivers have their hands full. Typically, these respiratory infections can be managed at home with readily available, over-the-counter pediatric medications, including acetaminophen and ibuprofen. Of course, we know these products are and have been in short supply for several weeks and months.

Parents are struggling to alleviate symptoms at home and are seeking out the assistance of their primary care teams, community pharmacies and, increasingly, emergency departments.

From coast to coast, children's hospitals in particular, but also many regional community hospitals, are experiencing historic volumes of young patients visiting their emergency departments, in part due to the lack of formulations to treat the symptoms of this perfect storm of respiratory illnesses, which shows no sign of abating.

Here's what we are seeing and hearing across the country.

At the Janeway Children's Hospital in St. John's, Newfoundland, their emergency department occupancy topped 200% over the weekend. Their hospital is operating at over 100% capacity.

In Halifax, the IWK emergency department and ICU have declared a code census, which for 14 days reflects severe overcapacity. The IWK emergency department recently registered 200 patients in one 24-hour period, setting a hospital record. Making matters worse, that same day, the IWK saw their highest-ever number of patients triaged as seriously ill and requiring admission. Last week, between 11 and 32 patients left unseen each shift.

In Montreal last week, the emergency department at CHU Sainte-Justine was operating at 300% occupancy, and at Montreal Children's Hospital, it was at 250%.

In-patient occupancy at McMaster Children's Hospital in Hamilton hit 140% on Friday, November 11.

Yesterday, SickKids Hospital reduced surgical activity to focus exclusively on emergency and urgent surgeries to create capacity for critically ill children. Half of the kids in their ICU are on a ventilator.

CHEO, our children's hospital down the street in Ottawa, announced last week that they have opened a second pediatric intensive care unit to care for the most critically ill children. As of Friday, this new ICU reported 280% occupancy.

Ontario has created capacity for most critically ill children by now decanting pediatric patients over the age of 14 to adult facilities.

In Edmonton, wait times at Stollery Children's Hospital have reached 20 hours for care.

Many of our children's hospitals across the country are now activating emergency operation centres to better manage patient access and flow. These are only a few examples, but the story is consistent. Across the country, we are seeing record numbers of children visiting emergency departments, record numbers of admissions, record acuity of patients being admitted, record waits to be admitted, record wait times for time-sensitive surgical interventions, record staff shortages and mounting public frustration.

Beyond exacerbating challenges within the emergency setting, children's and community hospitals commonly rely on analgesics prior to and after surgical interventions to manage pain and also to reduce the use of opioids and reduce the likelihood of developing chronic pain. Some children's hospitals are now evaluating whether or not they can perform essential surgical interventions based on the availability of analgesics to manage patients' care before and after surgery.

As many in the room will know, the Canadian pain task force recently published an action plan for pain management in Canada. A foremost goal was to ensure access to appropriate pain care for all Canadians. The report shared three important recommendations that are relevant to our discussions today.

First, the report shares evidence that reveals that treating pain with analgesics is not only the right thing to do, it also spares the use of opioids. From an access perspective, the report underscores a necessity to ensure appropriate pain management for our most vulnerable populations, including children. Lastly, the report speaks to the moral and financial imperative to prioritize the prevention of chronic pain, which is not only disabling for children, but creates long-term health system challenges.

● (1215)

I think we can agree that the current situation is both unacceptable and unsustainable. Elongated shortages of essential medicines, whether over the counter or prescription, are inexcusable in a country like Canada. While this overnight crisis in pediatrics has been actually decades in the making, there are solutions that will provide much-needed relief, even if just in the short term.

I'd be happy to elaborate on some of these ideas during the question and answer period.

Thank you.

The Chair: Thank you very much, Ms. Gruenwoldt.

Next, from the Critical Drugs Coalition, we have Dr. Saad Ahmed, physician.

Dr. Ahmed, welcome to the committee. You have the floor.

Dr. Saad Ahmed (Physician, Critical Drugs Coalition): Thank you for having me.

Dear honourable members, in the context of the committee's urgent study on the shortage of pediatric acetaminophen formulations, and on behalf of the Critical Drugs Coalition, which is a nonpartisan and grassroots coalition of frontline physicians, pharmacists, academics and pharmaceutical industry experts, I'm speaking to provide recommendations for how the federal government can improve the resilience and security of Canada's drug supply chain.

I should note that the Critical Drugs Coalition and I have no conflicts of interest, financial or otherwise. I'm a lecturer with the University of Toronto's Department of Family and Community Medicine. I was also formerly a rural physician, having worked in remote settings all across northern Ontario, from remote indigenous communities in Moose Factory to small but very busy towns, particularly emergency departments in Kenora. I now work at the Vancouver General Hospital's ICU, as well as at the George Pearson Centre, which is a facility for patients with very complex disabilities. I have a breadth of experience. I've collated my personal experience from these settings and my colleagues' ongoing experiences with drug shortages.

I should add that I did have the pleasure of speaking to this committee in May of 2021 in the context of the critical drug shortages that occurred during the peak of the COVID-19 pandemic. At that time, the Critical Drugs Coalition made a number of recommendations to secure our drug supply going forward. Those included better data on the supply of such drugs, the creation of a critical medicines list, and the stockpiling of said critical medicines in a critical drug reserve, especially in anticipation of our respiratory flu seasons and further waves of COVID-19.

This was all included in a public open letter that we had issued to the Prime Minister in August of 2020. It had been supported and co-signed by multiple national bodies, such as the Canadian Medical Association and the Ontario Medical Association.

Our asks were very clear at that time. To reiterate, our asks were three points. We asked for a pan-Canadian critical medications list that the government commits to ensure is always in stock; public support for a generic critical drugs manufacturer to increase redundancy and capacity for said critical drugs; and greater transparency, data and communications to and from the governments and the health sector around the critical drug supply.

We did hear in April of 2021 from the minister, and there was an announcement around a critical drug reserve. Obviously, Health Canada folks have mentioned that billions have been spent on biomanufacturing.

However, my understanding is that the critical drug reserve has now been wound down. It is unclear to me at this point whether we do have any kind of policy and framework around strategic reserves of critical drugs.

I won't reiterate this, as I do know that we've spoken at length about the causes of the shortages. I will just mention that a cursory review of the drugshortagescanada.ca website for children's acetaminophen formulations states that the 80-milligram-per-millilitre suspension has been short due to manufacturing disruptions, so we've been really relying on the 160-milligram-per-millilitre suspension. From what I've heard from our industry sources, demand is up by about 400%, despite manufacturers having increased their manufacturing by about 200%.

Really, this is a perfect storm of supply strain and domino effects on other drugs. We're hearing about amoxicillin, azithromycin and ibuprofen shortages. It's really taxing our health care system, as we have also heard.

We are importing pediatric formulations and certainly folks have spoken about that. It's interesting because the United States has not experienced any significant shortages of acetaminophen. We've been hearing about people bringing bottles of acetaminophen back in the suitcases and other stopgaps, like going to compounding pharmacies, etc., to try to get some specific formulations made.

I do think that while we have an urgent importation order and a number of solutions for the crisis at hand, we must commit to addressing the root causes of such shortages going forward.

I'd like to reiterate what we said back in May of 2021, which is that we really need better data on the supply of such drugs. How much drug is inside of Canada at one time is something we need to know, as well as where the important components of our drugs are actually made. That's the first thing when it comes to better data.

● (1220)

We need a creation of a critical medicines list. I think people are using the words “critical medicines”, but what does that actually mean? You look at the UN list of essential medicines— there are thousands of them.

We actually truly need to understand what a critical medicine is, and then have policies, such as stockpiling of said critical medicines. It doesn't necessarily have to be physical stockpiling. It could be other sophisticated strategies, such as redundant manufacturing capacity in domestic or friendly countries' manufacturing plants, or strategic reserves of the active pharmaceutical ingredients that create these finished pharmaceutical products.

There are really the three points that we're going to continue to drive home, and something has to be done, because we are seeing rolling shortages of other drugs. People have mentioned azithromycin and amoxicillin. I really do think that if I were to bring it home, I'd say that we need to define “critical drugs”.

I would put in a plug here for a very sharp colleague of mine, Dr. Mina Tadrous, who is a pharmacist and a researcher at the U of T and the Canadian expert on drug shortages. He's been diligently plugging away at measuring the scope of the problem, spending lots of grants to define a critical medication list, and extensively collaborating with researchers in the U.S. where there has been a matter of national security for their drug supply.

They actually defined “critical inputs”, which I'll just end with here. They defined what the critical inputs for hospitals would be very early on and very clearly in the pandemic, and that included things from drugs to PPE to even oxygen.

As I said, something has to be done. We do have a number of points, and I'd be happy to elaborate.

The Chair: Thank you, Dr. Ahmed.

Finally, we have Gerry Harrington, senior adviser with Food, Health & Consumer Products of Canada. Welcome to the committee, Mr. Harrington. You have the floor.

[*Translation*]

Mr. Gerry Harrington (Senior Advisor, Food, Health & Consumer Products of Canada): Thank you, Mr. Chair.

Good afternoon, members of the committee.

My name is Gerry Harrington and I am the senior advisor at Food, Health & Consumer Products of Canada, or FHCP.

● (1225)

[*English*]

FHCP represents the companies that manufacture and distribute the vast majority of essential products found in Canadian households, including the children's pain relievers we're here to talk about today.

For Canadian families who have endured more than two years of the pandemic with school closures, illness and ongoing disruptions, the shortage of children's pain relievers has added to their anxiety. As a parent, I understand how stressful the situation is. However, I would add that the current shortage of these medicines is an unprecedented event in my 30 years in this sector, as is the level of mobilization across the industry to try to address it.

The major manufacturers of these medicines planned for higher than normal demand for these products in the 2022-2023 cough, cold and flu season. This forecasting was done with various factors considered, such as the severity of the cold and flu season in the southern hemisphere earlier this year, the expected prevalence of COVID in the community as we went into the season and the state of public health measures in place that might influence the spread of infections. Based on those forecasts, the production and allocation for Canada was increased substantially.

However, the infections came early. By late spring, as you've heard previously today, rates of respiratory infections in children were already far ahead of expectations and out of season, putting pressure on inventories just as they were being replenished. In August, a hospital's decision to require prescriptions for children's acetaminophen that had been compounded in their own pharmacy was widely misreported as applying to all such products being sold in community pharmacies. This, of course, caused an understandable degree of stockpiling by anxious parents. Indeed, demand spiked to three or four times above normal levels, quite quickly emptying supply chains and store shelves which, in turn, spurred more panic buying.

This has happened within the context of supply chains already being stressed and business still not being back to normal in our industry. Our member companies continue to face unprecedented and ongoing supply chain disruptions, including complex factors like transportation disruptions and delays, rising costs and shortages of inputs and labour. Despite these challenges, the manufacturers of children's pain relievers have already ramped up production to 30% to 40% above historic highs and plants are operating 24-7 as we speak.

Replenishing empty supply chains on the fly is always challenging, but as you know, the number of respiratory and virus cases has continued to climb through the fall, pushing ERs and pediatric ICUs well beyond their capacities, as you've just heard. Manufacturers will continue to work around the clock as long as this demand level continues.

It's important to understand that this outbreak of respiratory infections is a global phenomenon. Since late winter, sporadic shortages of these medicines have been reported in France, Ireland, Pakistan, Germany, Malaysia and Japan. Since this summer, industry has looked for opportunities, in spite of those pressures, to supplement Canadian production and allocations with new allocations from global supplies, but those supplies are tight.

As early as this summer, Health Canada was signalling to our members that it was prepared to offer regulatory flexibilities that would allow manufacturers to boost production or imports as long as these did not compromise consumer safety. Those flexibilities permitted two proposals for imported products directed to hospitals to be approved last month, as you are all aware, and I'm delighted to note that more recently we've had another proposal approved for a shipment of children's acetaminophen intended for community pharmacies within weeks.

In all three of these cases, the degree of supportive collaboration offered by Health Canada played a critical role in these successful outcomes, and I want to underline that. I want to emphasize that numerous manufacturers continue to explore opportunities to bolster supplies and are in regular contact with Health Canada to that end.

We believe these efforts will result in a marked improvement in access to these medicines in the coming days and weeks. That said, we still have no clear line of sight of the day when the number of these viral cases begins to normalize and demand for these products returns to something resembling normal. That remains, above all, the public health issue for all of us to address collaboratively.

Thank you. I look forward to your questions.

The Chair: Thank you, Mr. Harrington.

We're going to begin the rounds of questions now, starting with Mr. Jeneroux for six minutes.

Mrs. Laila Goodridge: Sorry; it's going to be me, and I'm going to split with Dr. Ellis.

Thank you, Mr. Chair, and thanks to all the witnesses for being here.

We heard from Health Canada that they actually were aware of this issue in the spring. In their mind, it only really became an issue when it was publicized in August, and basically only after we started bringing it up in question period did we actually see any movement from Health Canada to publicly address this issue.

I know as a parent that the worst thing in the world is having a sick kid. No one wants to bring a sick child to the emergency room just because they have a fever, yet I'm seeing countless reports of that happening because there is no other option, especially in many of our rural and isolated communities that don't have 24-hour compounding pharmacies and the families don't have the capacity of having this medication on hand.

Ms. Gruenwoldt, can you describe how many families are presenting simply with a fever at some of your hospitals just to get Tylenol or Advil and then going home?

● (1230)

Ms. Emily Gruenwoldt: Every single day now for several weeks, our emergency departments across the country are seeing these unprecedented demands. You heard me speak of capacity well over 100% very consistently from coast to coast.

I think the hard truth is that we have an undersized health care system to serve a growing number of children and youth in this country. Gaps exist in the community for families to access primary care services. The gaps that we're seeing in community hospitals are a result of some of the challenges they experienced over COVID in losing pediatric beds and losing highly specialized pediatric care providers. We're now seeing the impact of that, because families have nowhere else to go, so they are showing up in the emergency departments in unprecedented numbers.

Mrs. Laila Goodridge: That's troubling. I'm five hours away from the closest children's hospital, so it's not even a situation of saying we'll just tough it out. If something goes wrong in a northern and isolated community, it requires airlifting children. This is an exorbitant cost to provinces.

Would you agree that perhaps the drugs, the acetaminophen and Tylenol that have been procured by the government, should be prioritized to go into northern, isolated, rural and indigenous communities to ensure that the most underserved are having access to them?

Ms. Emily Gruenwoldt: I think we need to make sure that every child, youth and family has access to safe and effective medications for sick children, regardless of where they're located in Canada.

Mrs. Laila Goodridge: Absolutely, but given a lack of supply, would you agree that perhaps a prioritization should be placed on families in isolated, rural and northern communities?

Ms. Emily Gruenwoldt: I think we need to make sure that we have access to these medications in rural communities and retail pharmacies, as well as in our community hospitals, our children's hospitals, and wherever we're seeing children and youth across the country. This is an essential medicine that every child, youth and family needs to have access to.

Mrs. Laila Goodridge: All right. I'll pass it to Dr. Ellis.

Mr. Stephen Ellis: Thank you. Through you, Chair, to Mr. Harrington, can you tell us when you were first made aware of this critical shortage of acetaminophen and ibuprofen for children?

Mr. Gerry Harrington: The association did not become involved until the summer, but we know that our individual manufacturer members were contacted by Health Canada in advance of that, and there were discussions going on at that point.

Mr. Stephen Ellis: Thank you very much for that, sir.

Mr. Chair, I'd like to move a motion that we've had some discussion on here previously. I apologize to the witnesses for this but I think it is critical. The motion has been sent to the clerk in both official languages. The motion reads as follows:

> That for the next twelve months Health Canada table with the committee on a weekly basis the number of infant and children's acetaminophen and ibuprofen doses that arrived in Canada that week, the number of doses anticipated to arrive the following week; and, that this information be provided in both official languages, and the clerk post this information on the committee's website immediately.

The Chair: Thank you, Dr. Ellis.

The motion is in order, so the debate is now on the motion. The floor is open.

Go ahead, Mr. van Koeverden.

● (1235)

Mr. Adam van Koeverden (Milton, Lib.): Thank you, Mr. Chair.

First, I think the timing of the motion is.... It's always up to members when they move motions, but we haven't had an opportunity to ask our witnesses any questions on this side yet. I would like that opportunity before we suspend, because I think we have to suspend in order to see the motion to deal with the motion effectively. I haven't seen a copy of it.

I think out of respect for the witnesses, I reluctantly would suggest that we adjourn debate if necessary so that we can have a conversation about that, unless the mover of the motion is willing to allow us to continue the questioning round so that we can more fully take advantage of the situation today. I think this is a really important conversation that we asked for last week. Ms. Goodridge raised an important motion last week to bring witnesses to our committee, and I have questions for them, so before I make a motion to adjourn debate or even suspend.... I think this could have happened in 20 minutes.

Thanks.

The Chair: Dr. Ellis is next, please.

Mr. Stephen Ellis: Thank you, Mr. Chair.

I think that this is a pretty straightforward motion, and certainly I'm not entirely sure what was added by the intervention that just happened. We know we can vote on this very quickly. Why would we not want to be transparent to Canadians and say “Let's post the information” and move on? I don't see what's so difficult about that.

The Chair: Mr. Doherty is next.

Mr. Doherty, we can't hear you. It's been suggested that your microphone is muted at the source. Do you want to try it there now?

We can hear you now. You have the floor.

Mr. Todd Doherty (Cariboo—Prince George, CPC): Mr. Chair, thank you for that.

Thank you to our colleagues who are there.

We've heard some staggering testimony today. This is obviously an issue that has gripped our nation. I would say that as long as we have 10 minutes at the end of this session, we can have a thorough debate on this.

I think all colleagues can see that this is a non-partisan issue. We have some excellent subject matter experts on all sides of the House who can actually speak about this. I would agree with our colleagues: If we can agree through you, Mr. Chair, that we'll have at least 10 minutes at the end of this meeting to discuss this motion, I think that we should move forward with that.

The Chair: Go ahead, Dr. Powlowski.

Mr. Marcus Powlowski: I concur with that. If you want to postpone the debate and go on with another round of questioning, I'm happy to do that.

The Chair: Go ahead, Mr. van Koeverden.

Mr. Adam van Koeverden: I think we should adjourn debate. I think that's the only way to deal with this. We should deal with it right now.

The Chair: A motion to adjourn debate is not debatable. All those in favour of adjourning debate on the motion, please raise your right hand.

Debate on the motion is adjourned. We are going to return to rounds of questions.

Next up is Mr. Jowhari for six minutes.

Mr. Majid Jowhari (Richmond Hill, Lib.): Okay, thank you, Mr. Chair.

Welcome to our witnesses. Thank you for your testimony. Some of you are back for the second or third time, so welcome again.

I'm going to start with Mr. Harrington, and then I'm going to go to Ms. Gruenwoldt.

Mr. Harrington, in your opening remarks you talked about the fact that the number of children we see with the respiratory virus has increased dramatically, as well as that it is out of season. Can you expand on that one a bit?

Mr. Gerry Harrington: I'm not a public health doctor, but what we have seen and what has been reported back to us is that things like the RSV virus were appearing earlier in the season than expected. We've also seen that the uptick in flu infections was also earlier than expected, and the impact that has is called “demand shift”, so at the time when the industry was trying to rebuild inventories during the summer in anticipation of the flu season, inventories are being drained, and that's what landed us in this position.

● (1240)

Mr. Majid Jowhari: You made another comment that is really concerning. You said that there's—and I quote—“no clear line of sight” into when this might end. If I'm paraphrasing, I apologize, but I think that gives you the genesis. I understand the genesis of what you were trying to say.

What indicators are you using to say that there's no clear line of sight?

Mr. Gerry Harrington: That is the rate of infections in children.

Mr. Majid Jowhari: Okay. Thank you.

I'm now going to Ms. Gruenwoldt.

Welcome back to the committee again, on a different topic. I think you're becoming an honorary member of this committee.

I want to go back to the saying “the driver of the demand”, because the previous panel talked about how we realize there's a shortage and we have addressed that and we are trying to expedite that and we have looked at the domestic and the international sources. We looked at the driver of the demand, and now we have heard that the cases have gone up and also that it has come out of season.

Can you share your point of view as to why this respiratory virus is happening to the children and why it is out of season?

Ms. Emily Gruenwoldt: My perspective is quite consistent with Mr. Harrington's.

What we have also learned from speaking with international experts, particularly those leading children's hospitals in Australia, is that their experience largely mirrored what we're seeing now in terms of a larger than predicted number of children becoming infected and requiring hospital-based care or hospital admission. In fact, the experience in Australia was twice as bad as their worst model had predicted.

Our concerns are that we have not seen the worst yet and that the peak is still to come, so that's concerning when we look at the volumes of patients that our children's hospitals are experiencing today and we think about how we would manage additional numbers of very sick children.

Mr. Majid Jowhari: What I'm hearing is that we are basically ready to peak or are at the earliest stages of peaking, because with fall and with winter coming, this thing is going to get worse.

Ms. Emily Gruenwoldt: Typically, RSV would peak in the January and February time frame. Typically, our flu virus season would be a little bit later and towards the holiday season as well, so we're definitely seeing an early onset of both of these two respiratory illnesses.

I'm not confident to say that we're nearing the peak. I don't think we have the data to support that, but I do believe that the peak is still to come. We're already well above capacity in the vast majority of the children's hospitals and are taking urgent or unprecedented measures, including doubling the capacity of pediatric inpatient care units or looking at decanting children to adult care hospitals.

Mr. Majid Jowhari: Thank you.

Thank you for correcting me on being near the peak.

In your closing remarks, at the end you talked about how, if given a chance, you would be able to elaborate on some of the recommendations. Whatever time I have, Mr. Chair, it can be allocated to Ms. Gruenwoldt to explain or share with us the recommendations that she has.

Ms. Emily Gruenwoldt: Sure. Some of them are consistent with what we heard Dr. Ahmed, I believe it was, speak to earlier in thinking about how we create a pan-Canadian critical medications list specifically for children.

It's also thinking about how we coordinate education and communications campaigns for parents and caregivers to help them understand at what point they need to seek out urgent or emergent care and what sorts of symptoms they can manage at home safely and how.

As well, it's thinking about how we create a communications response not only for our children's hospitals but also for our community hospitals, and especially those in rural and remote communities, as well as our family health care teams and pediatricians, so that they have a line of sight into where are we today in terms of the shortages and when we can expect additional supply.

Then, lastly, I would say that we really still need a coordinated push on immunizations, generally speaking, whether it's a flu shot campaign or whether it's a COVID-19 booster or original vaccine for children. These are essential measures that we know work, just like we know our masks work.

There are lots of actions that we can take collectively at both the federal and the provincial level—and the local level—and we would like to see those measures put in place as soon as possible.

In the longer term, I think we do need to evaluate the merit of strategic reserves for these essential medications to make sure that we're not caught on our hind feet for shortages like these. I think we would also support a call from the Canadian Paediatric Society to have an expert pediatric pharmacological advisory committee tasked with reviewing these drugs that are in short supply and with considering a list of alternative agents.

● (1245)

Mr. Majid Jowhari: Thank you, Mr. Chair.

I'm not sure how much time I have, but I would like to ask the witnesses to formally submit their recommendations to the committee.

The Chair: Thank you, Mr. Jowhari.

[*Translation*]

Mr. Garon, you have the floor for six minutes.

Mr. Jean-Denis Garon: Thank you very much, Mr. Chair.

I would like to start by asking Mr. Mousseau a question.

I have in front of me an article from The Toronto Star, published on November 9, which mentions that the shortage of children's Tylenol is getting worse and that bilingual signage is part of the problem. Personally, this strikes me as a case of ordinary racism against Quebeckers and French-speaking minorities in Canada.

Mr. Mousseau, you probably know the subject better than the person who wrote this article. Can you confirm that this analysis is accurate?

Mr. Hugues Mousseau: The language question is certainly not an issue. I would even say that it is part of the situations we are used to dealing with.

At the beginning of the pandemic, there was no signage in both official languages for some of the early vaccines and rapid tests. It was the same recently, when Quebec and Canada experienced a shortage of infant formula.

There are solutions that are fairly easily put in place, so there's no problem there.

Mr. Jean-Denis Garon: Now that I am reassured, I will move on to the crux of the matter.

You talked about the price of drugs, the price of supply and the mechanism by which distributors are paid and drugs are delivered.

As I told the deputy minister earlier, drug prices have decreased in recent years. As a result, some distributors have less revenue, while the demand for drugs is increasing. Essentially, this is reducing margins and hurting the ability of companies to keep a reserve supply of drugs.

Can you explain how regulation, and particularly federal regulation of list prices, can contribute to further shortages?

Mr. Hugues Mousseau: Yes, of course.

There's a misconception that population aging has led to an increase in medication use, and by extension, higher revenues for distributors and wholesalers. That's not true. As you mentioned, the deflation of prices for patented and generic drugs is at play.

The distributor compensation model is based on a percentage of the drug price. Here's a real-life example. In Quebec, the distribution margin is 6.5%, but we have to apply a prompt payment discount, which lowers the actual margin to 4.37%. On a $50 drug, the distributor would get $2.19 no matter where the drug is distributed in Quebec.

Further to the reforms introduced by the Patented Medicine Prices Review Board, or PMPRB, the price of that drug could drop by 10%. Just like that, instead of getting $2.19, distributors would receive $1.97 for the same distribution activities, storage and reshipping.

Deflation translates into lower revenues for wholesalers. As a result, they need to think about the possibility of reducing inventories, because storage is expensive and inflation is high. That's where the problem lies.

Mr. Jean-Denis Garon: It's absolutely appropriate to regulate drug prices. As mentioned earlier, what the federal government is trying to do with these regulations is prevent excessive drug prices, but it almost seems as though the government forgot that the drugs have to be distributed. That's what you're saying.

Mr. Hugues Mousseau: I don't think people understand how the drug supply chain works.

As I said, a mechanism is available to reduce the actual price for the payer, whether it's a provincial government, the federal government or an insurance company. It's called a listing agreement. Under that mechanism, it is possible to lower the actual price, which is already well below the list price.

The fact of the matter is that the PMPRB's reforms will not result in any actual savings for the provinces or the federal government because the price in the listing agreement is already below the new list price. That means the reforms won't have the desired effect but will, as a direct result, put wholesalers in a weaker position.

Mr. Jean-Denis Garon: Have you discussed it with federal government or Health Canada officials? Are they aware of that? Do they have a plan to deal with it, or is their only answer to import Tylenol from Australia?

Mr. Hugues Mousseau: We've met with them a number of times. We've had many discussions. We've also had discussions with PMPRB representatives. We pay close attention to what the pan-Canadian Pharmaceutical Alliance is doing, because it's dealing with the same phenomenon, but its negotiations are confidential. At the end of all this, the reduction in prices will, once again, impede our ability to stock drugs and maintain regional service levels.

It's a real problem, but neither the federal government nor the provincial government has put a solution in place as of yet. We are in contact with the provincial government, as well. This is concerning because inventory levels may need to be revised given the new financial context. That's true for pediatric medications, but it's also true for all other medications.

● (1250)

Mr. Jean-Denis Garon: I'm going to switch topics now.

A shortage is always a possibility. I understand that. Even if we had a more effective, more responsive regulatory regime, a shortage could still occur in a country like ours. We belong to the G7, and an idea being floated around the G7 is a list of critical molecules, which refers to a reserve of critical molecules and inventory management capacity.

How long has that idea been around? Is it something the federal government is aware of? How long has the federal government known it could be a good idea? Why hasn't the government followed through?

When people talk to me about it, I don't see it as something futile. I see it as something doable in a G7 country.

How is it there's no more Tempra for children?

Mr. Hugues Mousseau: Some provinces have reserve inventory mechanisms in place for hospitals and institutional pharmacies. Those mechanisms aren't in place, however, for community settings. That's something we've recommended, and we are definitely putting the idea on the table. A discussion is certainly warranted to determine which critical medicines should be stockpiled. Inventories could be managed on a dynamic basis to take into account expiry dates and prevent wastage. Surely, that's a viable option.

That said, it's not the only option. A shortage can occur when supply drops or demand rises. The shortage in this situation is largely due to increased demand. While not every shortage can be avoided, this option would give the provinces and the country additional tools to deal with these types of situations.

The Chair: Thank you, Mr. Mousseau.

[*English*]

Next is Mr. Davies, please, for six minutes.

Mr. Don Davies: Thank you to all the witnesses for being here.

Dr. Ahmed, I have a couple of short snappers just to establish a context, and then I want to dig into some solutions. I want to check my perceptions.

Am I correct that Canada has had a long-standing problem with drug shortages?

Dr. Saad Ahmed: That's correct.

Mr. Don Davies: Am I correct that this is a fairly broad and pervasive problem? It's not just a drug here and there; it extends to literally hundreds of drugs in a given year. Is that correct?

Dr. Saad Ahmed: That is also correct.

Mr. Don Davies: Am I also on the right track if I suggest that Canada's pharmaceutical supply has become overly dependent on foreign imports and global supply chains?

Dr. Saad Ahmed: Particularly for IV drugs, which form the bulk of our critical drugs, that is correct.

Mr. Don Davies: Do you know if Canada's domestic production of pharmaceutical drugs has gone up or down in, say, the last 10 or 20 years?

Dr. Saad Ahmed: Generally speaking, it has gone down. If we dive into the weeds of it, we are quite vulnerable for IV medications, which, again, form the bulk of our critical medications in a hospital.

Mr. Don Davies: This is my final short snapper.

We're not talking about this as just an episodic problem right now because of flu season and Tylenol; we're talking about a systemic issue that cuts across antibiotics, pediatric oncology drugs and anaesthetics. It's across the board. Am I correct in that?

Dr. Saad Ahmed: That's correct.

Mr. Don Davies: In October 2020, you wrote the following in Policy Options:

> [W]e have given less thought to a key policy that could build redundancy in our critical drug supply and even create...well-paying jobs for that much needed COVID-19 economic recovery: manufacturing drugs in Canada. Until we domestically produce select, critical medications (and their precursors), we will not be able to secure our drug supply and will be left at the mercy of other countries when the future waves of the pandemic arrive.

Could you please outline for us why domestic manufacturing is necessary to ensure pharmaceutical security in Canada?

Dr. Saad Ahmed: Absolutely. I do think that when it comes to critical medications, we're seeing exactly what happens. We're seeing people going to emergency departments to get their hands on pediatric formulations of Tylenol. We saw shortages of key anaesthetics that I use in emergency care and the ICU.

Some kind of redundant capacity, some ability to make critical medications, really is an issue of security. In the U.S. they actually see it as a matter of national security. Hence, there was an executive order passed during COVID-19 that very clearly defined what those critical medications and other inputs in hospital were and how they could actually use the Defense Manufacturing Act to make them in the United States.

That's how they've dealt with it. They do have shortages, but it's just been managed much better, in that sense.

● (1255)

Mr. Don Davies: We're seeing Australia and the United States send a surplus of pediatric pain medications, so they clearly have enough for their domestic supply.

I want to ask you this quickly. We've already heard that Australia requires manufacturers in Australia to hold a four- to six-month stock of critical medicines. Is that something that Canada should do?

Dr. Saad Ahmed: I would agree with that. Yes.

As I said earlier, we can be quite sophisticated about stockpiling. We have to look at all the inputs. It's not just the fill and finish of the tablet and the drug itself; there's the active pharmaceutical ingredient, mostly sourced from India and China, that we know about. Oftentimes, that's a rate-limiting step in the manufacture of product, be it a supply of active pharmaceutical ingredient, be it some kind of manufacturing redundancy or be it true physical stockpiles of certain select critical medications.

That's something we definitely need to look into.

Mr. Don Davies: Mr. Chair, do I have any time left? I'd like to give my last question to Mr. van Koeverden if he....

The Chair: You have 40 seconds, Mr. van Koeverden.

Mr. Adam van Koeverden: Thanks, Don. I appreciate that.

I won't get a chance to ask any questions.

The Chair: You actually have a minute and 40 seconds.

Mr. Adam van Koeverden: Thanks.

I have a quick question for each of you.

Mr. Mousseau, you mentioned the PMPRB. These are non-patented drugs that we're investigating today. Does the shortage apply to the PMPRB?

Mr. Hugues Mousseau: No. The pan-Canadian Pharmaceutical Alliance looks at generic drugs. It's the same phenomenon.

Mr. Adam van Koeverden: I was confused. Thank you.

Mr. Harrington, it's sometimes tough to recognize when a severe crisis has been averted. In this case, I think it's fair to say you can't take a win, but we've done a lot. You've done a lot. I think it's impossible to claim a win when people are struggling and suffering, but I recognize there's been a lot done. I appreciate that.

Could you speak to what has been done and the degree to which you've been in touch with the federal government over the last couple of months?

Mr. Gerry Harrington: The challenge, when Health Canada communicated very early on that they were open to flexibilities for imports and manufacturing, etc., was making sure that we were able to channel and connect the manufacturers with Health Canada and identify which kinds of flexibilities would make a difference.

I'll reiterate what's already been said. So far, getting over regulatory barriers has not been a significant factor.

Mr. Adam van Koeverden: Thank you very much for that.

Ms. Gruenwoldt, thank you for being here. Thank you for your consistent advocacy for kids.

Do you think it was prudent to ensure that incremental supply was sent to hospitals, given the enormous surge in hospital visits?

Ms. Emily Gruenwoldt: Yes. We were seeing a large number of very sick, very young children who needed that level of care in the hospital. Their supply was critical.

Mr. Adam van Koeverden: Thank you.

We as MPs have the ability to communicate to lots of people. Do you have advice for us on how we can...?

You mentioned vaccination. It's flu season. We should be making information available to our constituents. Is there any advice to us as MPs on how to communicate that clearly and in a way that is efficacious in getting more people vaccinated?

The Chair: Answer very quickly. We're out of time.

Ms. Emily Gruenwoldt: I think clear and consistent recommendations from trusted leaders, whether those are health care professionals or folks like you, are really important to help parents make those decisions to immunize their children and themselves in a timely fashion.

It's the same with the masking. I think we lead by example.

Mr. Adam van Koeverden: Thank you.

The Chair: Thank you, Mr. van Koeverden.

Thank you, Ms. Gruenwoldt.

Colleagues, we have a couple of minutes left. We're going back to the Conservatives.

Dr. Ellis, knowing we have only a couple of minutes, go ahead.

Mr. Stephen Ellis: Thank you, Chair.

I'd like to move that we resume debate on the motion and that we move straight to a vote, please, sir.

The Chair: It's a non-debatable motion that we resume debate on the motion in the minute and a half that we have left.

(Motion agreed to)

The Chair: The debate is on the motion for the next minute.

We'll have Dr. Ellis, Mr. Davies—

Mr. Don Davies: Mr. Chair, can we excuse the witnesses?

The Chair: —and Mr. van Koeverden.

Go ahead, Dr. Ellis.

● (1300)

Mr. Stephen Ellis: I'd like to move straight to a vote on the motion.

The Chair: We can't do that until the speakers list is exhausted.

Go ahead, Mr. Davies.

Mr. Don Davies: Mr. Chair, I was going to suggest that we thank and excuse the witnesses while we debate the motion.

The Chair: To both the witnesses, thank you so much for being with us. There was a lot of information packed into an hour. We're very grateful for your time and respectful of it, which is why we thank you.

You're welcome to stay, but you're free to leave. Thank you so much.

Go ahead, Mr. van Koeverden.

Mr. Adam van Koeverden: I'm sorry, but that's all I was going to suggest.

The Chair: Is there any further debate on the motion?

Go ahead, Dr. Powlowski.

Mr. Marcus Powlowski: First, we need to see the motion in writing. Although I think the government certainly supports transparency, on this issue we've already heard the possibility of contractual obligations. The government is, to some extent, a business, and if there are contractual obligations that affect our ability to meet the requirements under this motion, we want to know about them.

The Chair: Go ahead, Mr. van Koeverden.

Mr. Adam van Koeverden: I agree with my colleague.

I would note that members are saying that there is no transparent information while at the same time also quoting the source of the transparent information on the Drug Shortages Canada website. In part, a lot of that information comes directly from Health Canada.

I would like to see this motion in writing. I'm happy to talk about this at another time. We have another meeting this week. It's 1 p.m., and we all have other obligations today. We can talk about this on Thursday when it's in writing, on paper, or perhaps in our inboxes, so I move to adjourn.

The Chair: The motion to adjourn is not debatable.

All those in favour of adjourning the meeting?

(Motion agreed to)

The Chair: The motion is carried.

The meeting is adjourned.