HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 042 • 2nd SESSION • 41st PARLIAMENT

EVIDENCE

Thursday, November 20, 2014

Chair

Mr. Ben Lobb

Standing Committee on Health

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● (1105)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good morning, ladies and gentlemen. Thank you for all being here today.

We're looking at the supplementary estimates (B).

We're happy to have the minister here today and all of her officials. I thank the minister for taking the time out of her schedule today.

Do you have your prepared statement ready, Minister?

Hon. Rona Ambrose (Minister of Health): I do.

The Chair: Okay. Thank you very much.

Hon. Rona Ambrose: Thank you, Mr. Chair.

It's great to be here in front of the health committee.

I want to start off by thanking you for all of the good work that you're doing. Thank you for the invitation to discuss supplementary estimates for the health portfolio.

We have a number of officials here that many of you know already: Alain Beaudet, from the Canadian Institutes of Health Research; of course, Bruce Archibald, who's here from CFIA; George Da Pont, our deputy minister from Health Canada; Gregory Taylor, our chief public health officer; and Krista Outhwaite, our newly appointed deputy minister for the Public Health Agency.

I'm going to provide just a short update to committee members on Canada's response to the Ebola outbreak in West Africa, as that I believe would prove helpful to all of you.

As many of you know, this outbreak is the most severe and complex the world has seen in 40 years of combatting the virus. The humanitarian, social, and economic impacts will be felt long after the virus is contained. Canada has been at the forefront of the international response to this outbreak, and has been since April. We are contributing funds, expertise, and equipment. To date we have committed over $65 million in health, humanitarian support, and security interventions. I'm pleased to report to the committee that 57 million dollars' worth of this funding has now been disbursed. This funding has gone to support the United Nations, the World Health Organization, UNICEF, and many others to improve treatment and prevention, improve health capacity, save lives, and support the basics such as nutrition.

Our efforts are directed at bringing an end to this outbreak, treating patients, assuring the availability of essential services, preserving stability, and preventing outbreaks in surrounding countries.

We've also now donated and delivered over 2.5 million dollars' worth of personal protective equipment to West Africa that was requested by the WHO, including 1.5 million pairs of gloves, two million masks, over 480,000 respirators, and over 1,000 beds and blankets. The Public Health Agency also has deployed our mobile laboratory again to Sierra Leone to provide rapid diagnostic support and infection control testing, and we're currently awaiting further direction from the WHO on where our second mobile lab can be deployed.

In addition to Canada's invention of an experimental Ebola vaccine, which is currently undergoing clinical trials, we've generously donated the Canadian Ebola vaccine, in the amount of 800 vials, to the World Health Organization in Geneva. This vaccine is a fine example of Canadian scientific innovation. It's our hope that if found to be safe and effective, it will be used in West Africa to help stop this outbreak.

To support this goal, we've recently launched a Canadian phase one clinical trial for the vaccine, led by the Canadian Immunization Research Network in Halifax at the Canadian Centre for Vaccinology in the IWK Health Centre. This trial will support concurrent trials elsewhere in the world by determining if lower dosages could be just as effective as higher ones, potentially multiplying the amount of doses in each vial. While there has never been a case of Ebola in Canada, we must of course continue to be prepared and take every precaution necessary.

I've now spoken with health ministers from across the country several times and we've held, I think, three meetings. Our chief public health officer is in regular contact with medical officers in provinces and territories, I think now meeting almost twice a week for a number of months. In the event of an Ebola case, the Public Health Agency is ready to support the provinces and territories by deploying our Ebola rapid response teams. These five teams are made up of a team lead, a field epidemiologist, an infection control expert, a biosafety expert, a laboratory expert, a communications expert, and a logistics expert, and they would be deployed immediately to support any local public health systems that would need our support.

Transport Canada is also supporting the Public Health Agency by having planes readily available to deploy at a moment's notice. These planes are also stocked with emergency supplies, including protective equipment, like masks, gloves, and gowns. Our government is also providing additional funding to support Ebola preparedness and response capacity here in Canada to further support the provinces. This includes, of course, the $27.5 million that will be directed towards domestic preparedness. This amount includes just under $25 million to support further research and development of Ebola medical countermeasures. This means more money for research of the Canadian Ebola vaccine and monoclonal antibodies.

● (1110)

Funding has also been set aside to support infection control training and equipment, and to deploy additional quarantine officers at Canadian airports.

We've also launched an online Ebola information campaign designed to help raise public awareness about the disease and its risks, through social media such as Facebook and Twitter. As we combat the disease, we need to fight the stigma around it. Canadians need to know the facts about Ebola, how the virus is transmitted, its symptoms, and any other information that will help them manage their fears of contracting this disease.

Of course, we are making a strong contribution to international efforts abroad and working together to prepare here at home. We are strengthening coordination across the federal, provincial, and territorial governments, and other important agencies, and doing everything possible to protect Canadians and fight the disease.

On a different subject, I'd like to commend and thank all of you for your thoughtful study of Bill C-17, Vanessa's Law. In addition to the many months of consultations—

The Chair: Excuse me, Minister, I've just had a request that you slow down a bit.

Hon. Rona Ambrose: Oh, for the translators?

The Chair: I'm sorry to interrupt you. We'll give you lots of time.

Hon. Rona Ambrose: In addition to the many months of consultations that we held with Canadians, this committee's careful review of this bill contributed to the successful passage of Vanessa's Law. I feel that we've made very real progress in the last year on improving public health and safety, and nowhere is this more apparent than with the royal assent of Vanessa's Law. Vanessa's Law contains some of the most profound changes to the Food and Drugs Act in more than 50 years. It's truly an historic step in our government's continuous improvements to patient safety, especially over the past several years.

Thanks to the hard work of this committee, and Vanessa's Law, Canadians can have renewed confidence that the medicines they are using are safe. As Minister of Health I now have the powers to recall a drug and take it off store shelves when it's not safe. For the very first time, serious adverse drug reactions and medical device incidents will have to be reported by health care institutions. As well, as you know full well, courts can now impose penalties on drug companies that include up to $5 million per day or jail time for distributing unsafe products. Also, we can compel drug companies to revise labels so that they clearly reflect health risk information, including updates for health warnings for children. We can direct companies to do further testing on a product, including when issues are identified with specific at-risk populations such as children.

Many of these new powers came into effect with the royal assent of Vanessa's Law, and we are moving quickly to put regulations in place to support other powers, such as the requirement for all authorized clinical trials to be registered, and some elements of mandatory adverse reaction reporting for health care institutions.

Canadians need access to information, especially when it comes to their health, and beyond Vanessa's Law we've made great progress in increasing transparency through Health Canada's regulatory transparency and openness framework and action plan. For example, Health Canada has begun to post summaries of drug safety reviews that both patients and medical professionals can use to make informed decisions. Patients can also check the clinical trials database to determine if a clinical trial they are interested in has met regulatory requirements. These concrete initiatives are making more information on departmental decision-making and results available to Canadians in an easy-to-understand format. More can always be done. I have asked my officials to accelerate the implementation of the transparency initiative.

I would also like to congratulate this committee on your report on the serious health risks and harms of marijuana. As this committee noted, smoking marijuana has serious health risks for youth. As many of you know, Health Canada launched an awareness campaign aimed at educating parents on how to talk with their teenage children about the dangers associated with prescription drug abuse and smoking marijuana, in line with recommendations included in your report. Television ads began airing in October focusing on the developing brains and bodies of teenagers and how marijuana use, as well as prescription drug abuse, can cause permanent damage to their development and put educational achievement and long-term mental health at serious risk.

The department developed web and social media content as well on the dangers associated with marijuana and prescription drug abuse in order to encourage parents to get the facts, and tips on how to speak with their children on drug use and abuse. As this committee will know, our government has also committed almost $45 million over five years to expand the national anti-drug strategy to now also include prescription drug abuse. The many dangerous and unpredictable consequences of drug abuse make this a very real and widespread public health issue, and no one feels that more acutely than Canadian families.

Over the past year I've met with health officials, physicians, pharmacists, first nations representatives, law enforcement, addiction specialists and medical associations to discuss how we can collectively tackle prescription drug abuse. I've issued a call for proposals to seek new ways to improve prescribing practices for opioids and other drugs that pose a high risk of abuse or addiction. Additionally, we are now providing funding to build on initiatives to support research on new clinical and community-based interventions for preventing and treating prescription drug abuse.

I'd like now to turn to innovation in health care, Mr. Chair.

● (1115)

As you know, Canadians benefit from a system that provides access to high-quality care and supports good health outcomes, but with Canada's aging population and a growing burden of chronic disease, we know we need to accelerate the pace of change. That's why I launched the advisory panel on health care innovation back in June. It's headed by Dr. David Naylor and this panel has truly hit the ground running.

The panel is consulting broadly across Canada, identifying promising areas for innovation, and determining how the federal government can help accelerate that progress. In fact, the panel is eager to hear from Canadians from across the country in an online consultation that runs until December 5. I anticipate the arrival of the final report by the end of May and I look forward to sharing this information with members of this committee.

Mr. Chair, Canadians expect their federal government to play a major role in sustaining our high-quality health care system. Today, I want to reinforce that our government is at the table and we want to make sure Canadians have the highest level of care.

Once again, thank you for inviting me to be here today to speak with you. My officials and I are pleased to take any questions that you may have.

● (1120)

The Chair: Thank you very much, Minister.

The first round of questioning will start with Ms. Davies. You have seven minutes. Go ahead.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Chairperson.

Thank you to Minister Ambrose for appearing before our committee today as we deal with the estimates.

Thank you to the officials who will be here.

Minister, I know you're here only for an hour so obviously we want to ask as many questions as possible. I'm glad that you began your comments with an update on the Ebola situation because I do think that has been a very urgent matter and as you know, we've raised it in the House a number of times with you and also with the parliamentary secretary. There have been a lot of concerns about delays from Canada, both in terms of getting equipment and protective gear out the door, and there have certainly been significant concerns around the vaccine. So I'm glad to hear you say today that now $57 million of the federal commitment has actually been disbursed.

I do want to come to a question, though, on the vaccine itself. You're probably aware that the contract with NewLink, which is the company in Iowa that received a contract from the federal government in 2010. That's four years ago, and that contract requires the company to commercialize the made-in-Canada vaccine, and within that contract there are specifics that outline that any parking, shelving, or lack of diligently and aggressively commercializing the vaccine is considered to be a fundamental breach of contract.

The question that I have is whether or not you as the minister, or the federal government, have given notice to NewLink Genetics outlining the concerns that many Canadians have—certainly we have—with the apparent parking of the vaccine development over the last four years, and the lack of urgency this summer to conduct the clinical trials. The contract says that 90 days' notice has to be given for required inactivity to be considered a sufficient cause for termination. Basically we want to know, have you given notice of breach of contract? Have you been seeking alternate sources to ensure that this vaccine is commercialized, given that now we're looking at four years since this contract was initiated?

Hon. Rona Ambrose: First of all, I think we're all very proud that Canadians and Canadian taxpayer money has paid for the research over 10 years to develop this vaccine. As you know, this outbreak has become urgent in the last year. I have absolutely no evidence that there is any lack of urgency around commercializing this vaccine. In fact it's the opposite. I've asked many times. I received very clear reassurances—and I'll be happy to allow Dr. Taylor and Krista Outhwaite to speak to this—that this process is moving at an unprecedented pace.

Ms. Libby Davies: Why is it taking the company so long then?

Hon. Rona Ambrose: The words that have been shared with me are that the international community has been brought to bear to support the rapid commercialization. Let's remember this is an experimental vaccine. We are in phase one clinical trials. We're still testing for safety and efficacy. Let's hope that it is safe and that it is able to be deployed quickly once we do know that it is safe to be used.

Ms. Libby Davies: Minister, I think we all share your concerns about safety, so I want to ask you again. You have no concerns whatsoever that this company has been parking or shelving or has lacked any diligence in terms of aggressively commercializing this very desperately needed vaccine, no concerns with the company whatsoever.

Hon. Rona Ambrose: I'll allow Dr. Taylor to give you as much detail as we're able to give you.

Dr. Gregory Taylor (Chief Public Health Officer, Public Health Agency of Canada): I don't think we have concerns with this company. They've been working diligently. Some of the delays have to do with a production process to produce a large amount of vaccine for clinical grade. That took some time. We placed our order with them initially so we would have some vaccine. We just received that batch early this year. I think it was around February, so it took a long time for the production to get going.

As for the clinical trials, I think it's worth remembering that typically this process takes five years or more from the beginning. Prior to this outbreak there had been only 2,500 cases in the world—

Ms. Libby Davies: But they did have the contract since 2010, so that's four years.

Dr. Gregory Taylor: That's 2010. So it took a long time to get the production facility in place. Once the vaccine was produced and we had some of that early this year, there have been no less than six clinical trials they've engaged with.

They have another manufacturing system on line. They've produced some for this year and there will be some in early March 2015, which could be as many as 100 million doses. We don't know that. We go by vials. We purchased initially 1,400 vials, but with some of the testing in the Canadian clinical trials using a very low dose, as the minister suggested, it could be much longer.

They've invested well over $10 million, and they've leveraged as much as $42 million. million from the U.S. Department of Defense, National Institute of Allergy and Infectious Diseases, etc.

● (1125)

Ms. Libby Davies: Dr. Taylor, perhaps I could just do a quick follow-up to you. As you know, we have the visa ban that was initiated by Canada from affected Ebola countries, and I'd like to ask you as the chief medical health officer for Canada, do you support the visa ban from affected Ebola countries? What evidence supports the decision that was made?

Dr. Gregory Taylor: The balance we have to take between protecting Canadians and trying to assist and trying to deal with the outbreak is always very difficult to do. It's not an outright ban. It's a pause in issuing new visas. In my understanding there are about 1,700 to 1,800 existing visas that will continue to be valid.

It's very difficult to get exactly the right balance. It's not like it's a border closure; it's a pause in issuing that. My understanding as well is that the—

Ms. Libby Davies: What evidence supports that?

Dr. Gregory Taylor: —minister can issue them on an exceptional basis.

Ms. Libby Davies: Do you support it yourself as the medical health officer?

Dr. Gregory Taylor: Personally I think it's the appropriate balance to take, and yes, I support a very measured approach like this.

Ms. Libby Davies: What evidence is it based on?

Hon. Rona Ambrose: MP Davies, I think there's been some misinformation. The media, I think, didn't do Canadians a service on this. This is not a travel ban. This is a pause in new applications of visas. Just to put it into context, we get very few visa applications from even the three combined countries—

Ms. Libby Davies: But it's anybody coming with visas, is that correct?

Hon. Rona Ambrose: Existing visas, and there are about 1,900 of them that are active today from people who have visas from those countries. Many of them are multiple-entry visas. People will continue to be able to travel back and forth from those West African countries, and Canadians can travel in an unlimited way. But we have told Canadians not to travel there unless they need to, unless they're humanitarian workers or it's essential business travel.

We've done the same thing in reverse. In a very practical way we said we'd look at it case by case. If it's essential travel for economic purposes, we're honouring the visas that exist, both single entry and multiple entry, and the Minister of Immigration has the discretion to look at these on a case-by-case basis. It's a cautious, prudent, and practical approach. We're taking the same approach with Canadians.

The Chair: Thank you, Ms. Davies.

Thank you for the explanation, Ms. Ambrose.

Ms. Adams, you have seven minutes, please.

Ms. Eve Adams (Mississauga—Brampton South, CPC): Thanks, Mr. Chair.

Thank you, Madam Minister, for joining us here at the committee today. It's our great pleasure to have you.

I'd like to follow up and ask some additional questions regarding Ebola. I want to thank you for your comments and for focusing on the significant contributions that Canada has made to date.

This is, in our lifetime, one of the most significant health crises that the world is facing. Perhaps you could provide some additional detail on the leadership role that Canada has played in fighting the Ebola outbreak in West Africa.

Hon. Rona Ambrose: Sure, I always appreciate the opportunity to speak about Canada's response to the Ebola outbreak in West Africa. It also allows me to correct some of the misinformation that exists and combat the stigma that we're seeing in some places, especially for returning health care workers.

It's clear that we're in the midst, as you said, of the largest outbreak ever in the four-decade history of this disease, but for all the headlines and the horrifying statistics, there is a great deal of misinformation about Ebola, and that persists. Because the virus has never actually been present in Canada, the facts about what Ebola actually is and how it spreads might not be top of mind for many Canadians. That's why earlier this month we announced that throughout November we're broadcasting a public awareness campaign to communicate the facts on Ebola and combat stigma. This includes the basics on what the virus is, how it spreads, and what people should do to be prepared.

What was of significant concern to me after speaking to the heads of our aid agencies was that many aid workers were returning home to Canada and not being treated like the heros they really are. The head of Doctors Without Borders was particularly concerned about how people in neighbourhoods were reacting to returning doctors, how hospitals were reacting, and even other health care workers were reacting to people who were returning.

The truth is that these people are putting their lives on the line at great personal risk, and the aid agencies are managing their health care workers with very rigorous rest periods and self-isolation. They're taking all the precautions necessary. The Canadian public needs to have the facts on the virus should there be a case of Ebola ever occurring here in Canada, but we also need to make sure that the public is well educated, and as a country we need to be prepared.

In terms of our preparedness, I feel quite reassured about the level of preparedness in the provinces and territories. I speak regularly with my provincial counterparts, and Dr. Taylor speaks almost twice a week with his counterparts. Our provincial colleagues feel very confident about their preparedness or their readiness. The Public Health Agency has now provided updated guidance to provincial and territorial health authorities.

Of course, they are responsible for training their health care workers, but we've really seen them step up to the plate and offer the necessary training to nurses and doctors. What I've said to the heads of the nurses union and nurses association is that if any of their members still feel vulnerable to step up and speak to the people in their organization, make sure that the training is offered and that it's hands-on training, not just a video, and that they feel completely confident putting that equipment on and taking it off. It seems to me from the feedback I've received that this is happening. People are speaking up should they feel they need more training and the provinces are working hard to make sure that training is available.

As I mentioned earlier, the Public Health Agency stands ready with all our expertise. Our five rapid response teams are ready to support the provinces should they have to receive a patient with Ebola. Our teams are ready to deploy at a moment's notice. We've been provided with the aircraft necessary to make sure we're able to get to any point in Canada should we need to do that.

We also have set aside $3 million for the provinces and territories to support them in their preparedness on the community side.

As committee members will appreciate, I want to thank my officials from the Public Health Agency. They've worked very collaboratively with the provinces and territories and with front-line health care workers. At every point that there have been any concerns, they have been invited in to be heard. We've done our very best to respond to everyone, whether it's the provincial-level officials or nursing associations. Even though nurses may not be our jurisdiction we wouldn't even think about not having them at the table. We've worked very hard to make sure everyone is included at every step in the guidelines we've been providing. We've communicated directly with not only the provinces and territories but with many front-line organizations as well so that we can support them directly.

We'll continue to take all steps necessary, and we continue to respond to requests.

● (1130)

Canada's response has been very significant and very effective, and it has been based on requests. As requests come in from the World Health Organization, such as for protective equipment, we'll continue to respond.

Ms. Eve Adams: Thank you.

Let me move on to food safety, Minister. We had some wonderful news this morning as we opened up *The Globe and Mail*. Canada has tied for first place in food safety, along with Ireland.

It's of paramount concern to ensure that the food we're placing on the table before our families is safe. I can tell you that it's something I'm concerned about as a mom and that my girlfriends are concerned about as they prepare meals for their families.

Could you update us on Canada's food safety system and what the next steps might be?

Hon. Rona Ambrose: I'd be happy to, and I'd like to take this opportunity to congratulate Bruce on the number one position—no pressure on the head of the CFIA, but it's obviously great news. A lot of work has been done at the Canadian Food Inspection Agency over the last few years to continue striving to be the best.

It's obviously wonderful to be recognized. It doesn't mean that we won't stop working very hard, because this is an issue that matters to all of us, as you said. In the last budget, we reinforced our commitment to food safety by investing another $400 million to strengthen our food safety regime. We hope this will give our inspectors and those who work in this area the tools they need to continue to ensure that our food safety system remains the best in the world.

In addition to that, of course, our government has now invested more than half a billion dollars in various safety initiatives since 2008. These also include enhancing food inspection programs and hiring more inspectors. The significant funding being delivered through our economic action plan over five years is further strengthening our food safety system, and it will include resources to hire 200 additional food safety inspectors and staff.

We're also establishing the food safety information network, which is a network among federal, provincial, and territorial food safety partners and laboratories. What it does is it helps better protect Canadians from food safety risks by improving our ability to anticipate, detect, and respond to food safety hazards.

The funding will also—

● (1135)

The Chair: Ms. Ambrose? Minister, we're way over time. I'm sorry to cut you off. It's just to be fair to everybody.

Hon. Rona Ambrose: I'm sorry; I didn't look at you.

The Chair: Ms. Fry, go ahead.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much, Mr. Chair.

I want to thank the minister for the presentation. I've always felt that health is too important for us to play political, partisan games with, so I will start by congratulating the minister on what I consider to be now—in the past, the minister knows how I felt about certain of the Ebola initiatives—a very excellent response, including the vaccine.

The only question I have to ask with regard to that is this—and I'm going to ask the questions, and maybe you can answer afterwards, so that we can get a fulsome answer. Who did you consult with concerning the pause in visas? I know that the World Health Organization and many other public health officials felt that it created a bit of an anxiety in the public when you did that pause because they felt people would believe that travellers could in fact be a risk.

That's the first question I want to ask. Other than that, good work on Ebola, I say to Dr. Taylor and to you.

I also want to bring up the issue of marijuana. As you well know, I felt that the marijuana report.... We had a report that suggested that the study was very flawed, because you cannot look at risks without looking at benefits, and there was very little done to look at benefits.

We felt that much of the contradictory evidence that came from many of our expert witnesses was not reflected in the report. We also felt that there were a couple of pieces, including looking at some studies and some research that would eventually talk about risks and benefits and at long-term and short-term effects of marijuana both on youth and on others, that were very important things to do. That was not accepted as a recommendation. So we feel that the report leaves a lot to be desired.

What I want to ask, though, is very simply this. There are ads out there now, and I know that the minister is asking for more than $5 million to present the ads. Given what we heard in the testimony, that the evidence was not really out there suggesting that the long-term effects of marijuana use are so absolutely awful—we know the short-term effects—who did the minister consult when she put those ads out? Would she tell us who they were, list them, and table the list to the committee at some point in time?

Hon. Rona Ambrose: Sure, no problem.

Hon. Hedy Fry: That's the second question.

The third question is about PHAC. Again, while I congratulate you on how well you have responded to Ebola—although we thought there was a bit of foot-dragging at the beginning, now I think the response is good—I wanted to know if you could tell us who you consulted when you created the changes in the chief public health officer's position within Health Canada.

Not that this has anything against Dr. Taylor or Ms. Outhwaite, but I do think that the concept of the chief public health officer having a deputy minister position was one that was studied really well as a result of some of the things that we found after SARS and after H1N1. This all came together with a lot of public health officials coming up with this particular way that Health Canada had existed, and now this change, I think, brings down the chief public health officer's ability to respond quickly to get the resources he needs. Currently that may work if he and Ms. Outhwaite get along really well, but when changes occur.... It shouldn't be personal; it should be objective.

I want to know who the minister consulted with. I have heard from many public health officers across the country that they think this is a bad decision, so I wanted to know who the minister consulted with. Could she table the list of people she consulted, because I do think it's a major problem?

Finally, actually, no, that's it. Those are the questions.

● (1140)

Hon. Rona Ambrose: Do I have time to answer?

The Chair: Yes.

Hon. Rona Ambrose: Okay.

Sure, I'm happy to answer.

Thank you for your compliment on the Ebola response. The Public Health Agency has worked very hard. We have tried, as a government, to.... I shouldn't say try, we've supported them in every possible way with any requests that they've had to make sure that they're able to respond appropriately, and we'll continue to do that.

On marijuana, who did we consult? I held a number of round tables that I'm happy to share with you. Actually, I think we put out a press release after the expert round table we had with researchers and physicians who have studied this issue for many years, addiction specialists. When I asked them, overwhelmingly their message to me was that the evidence is absolutely irrefutable. Of course, the same message has been made publicly by the head of the Canadian Medical Association, that the evidence is irrefutable about the harm of marijuana to youth and the developing brain.

I asked the researchers point-blank, “What can we as a government do? If you had your wish, what would you ask me to do to help you?” They said that we needed a national marijuana smoking cessation campaign, a national one. Kids don't know how harmful marijuana is to their health. Parents think it's the same as what they smoked 30 years ago. They have no clue about how this could harm their kids. We've seen psychosis; we've seen mental health issues.

I said, “Okay, we're going to try to do that”, and we did. We put together an awareness campaign, focused on the impact on the developing brain of youth. Health Canada did a lot of work with researchers to make sure that anything that was said in those campaigns was backed by research, and we can table that and give it to you should you want to see it. We can provide you a briefing. There's no question about the harmful effects of marijuana on the developing brain. The science is irrefutable.

To your point about people wanting to know what the benefits are, if there are any legitimate researchers who would like to do a clinical trial, I haven't met them yet. They haven't come forward to me and said, “We have the funds and the backing of a company or someone who wants to do clinical trials.” There's no evidence right now, and you know that from the recent report of the *Canadian Family Physician* and from the guidelines that are being given to doctors to prescribe marijuana across this country. We don't have the evidence that it's actually—

Hon. Hedy Fry: Minister, I sat through the committee hearings. The recommendations from many of our experts was that we do research on the benefits and risks of marijuana, the short- and long-term effects of marijuana on the developing brain. There's only one study that said irrefutably that there were very long-term effects.

The idea of saying that the CMA, etc.—and I think that's unfair to them—have decided that you should do this ad, when they refused to do the ad with the Ministry of Health—

Hon. Rona Ambrose: I did not say that. What I said is—

Hon. Hedy Fry: It's not true.

Hon. Rona Ambrose: —that the president of the Canadian Medical Association is on the record saying, “especially in youth, the evidence is irrefutable—marijuana is dangerous.”

What I'm telling you is that I think the experts told me loud and clear what we needed to do, so we have a public awareness campaign to support parents who are struggling with trying to help their kids get off marijuana.

The Chair: Thank you, Minister.

Next up for seven minutes is Mr. Wilks. Go ahead, sir.

Mr. David Wilks (Kootenay—Columbia, CPC): Thank you very much, Mr. Chair.

Thank you, Minister, for being here today.

I'll go down that same road with you, Minister, with regard to Health Canada and their running of a series of TV ads warning children and parents about the serious health risks involving both prescription drug abuse and smoking marijuana.

As MP Fry has indicated, the committee recently concluded our study on the serious health risks and harms of smoking marijuana, in which we recommended that a public awareness campaign be undertaken. During that study we heard from doctors and researchers on the serious and harmful effects associated with marijuana use, especially on teens.

Could I add that in my previous career I did three years of drug work, predominantly on marijuana? I can rest assured that not only with regard to teens, but well beyond that, there are some significant problems and we need to deal with them. So I'm very happy to see that we ran this series of TV ads.

Could you update the committee on how this campaign has been received?

● (1145)

Hon. Rona Ambrose: It's interesting, because someone approached me the other day and said, “I didn't know that marijuana is so much stronger today than it was when I was a kid”. In fact, there are experts who think that we've underestimated, and that it's actually much stronger, but we used very credible researchers, very credible experts, to ensure that what is in these ads is completely defensible. I'd be happy to share any of that information from Health Canada.

I commend Health Canada for doing this. I don't think we've had an anti-marijuana smoking-cessation campaign for a.... Well, I don't even know if we've ever had one in Canada. What we know, I think it's from UNICEF, is that our kids are smoking more pot per capita than anywhere in the world. We know that the experts are saying very clearly that it's harmful to the development of their brains. That's not only in terms of mental health issues, but serious mental health issues such as psychosis and the onset of schizophrenia.

I could give you reams of documents from very credible experts who say the same thing. The former head of the CMA said it's dangerous. The current head of the CMA said, “Any effort to highlight the dangers, harm and potential side effects of consuming marijuana is welcome”. Addiction specialists are struggling, people who are dealing with these kids in their offices are struggling, and rehab specialists are struggling.

Kids are using more and more of this. People are putting it in the form of candy now, and giving it to kids in grade school. I mean, this stuff is more addictive. This is not the pot of the 1960s, and it's really difficult for parents because they're up against the idea that it's normal, that it's like smoking cigarettes, and that it's not as harmful as alcohol. Well, alcohol is harmful; smoking cigarettes is harmful. We have smoking-cessation campaigns for tobacco. We don't want people to drink a lot. We have all kinds of ad campaigns about alcohol abuse, yet somehow we're not supposed to have an ad campaign about kids smoking pot. It's nuts.

I can't believe the reaction of people from a partisan point of view. This is based on science. Parents are struggling with their kids, who are clearly being impacted mentally and physically, and it would be irresponsible for us not to do a public awareness campaign. So I think in the face of accusations where the Liberals are normalizing marijuana so that somehow this is a partisan campaign, this is absolutely ludicrous. It's based on science, it's necessary, and we'll continue with it.

Mr. David Wilks: Thank you very much.

Prior to the marijuana study, we did a study on Vanessa's Law, on which I must congratulate my colleague Terence Young for his admirable work and years of getting it to where it got to. We heard testimony from several witnesses who are experts in the field of drug safety on the need to ensure that Health Canada shares information in an open and transparent manner.

As a former police officer, I know that there are a number of inherent risks present in many drugs, including those that are freely available over the counter. That is why I was very pleased to be part of the committee's deliberations on Vanessa's Law and of amending the legislation to include a greater degree of transparency.

Can you update the committee on what is being done to ensure that drug safety information is being made available to those who need it?

Hon. Rona Ambrose: Sure, but here is just one more thing about marijuana.

It's really important that everyone, as health committee members, remember that marijuana is not an approved drug in this country. It has never gone through any rigorous approvals or scientific clinical trials to show that it is safe to take as a medicine. Let's all remember that. Think about it as health committee members. It's very difficult, because that message is out there, and kids have a sense that somehow it's safe because it's "a medicine", whereas it has never gone through any approval processes at Health Canada, is not an approved drug, and is not an approved medicine.

Going back to your question about Vanessa's Law, I again commend the committee and all members of Parliament who worked so hard in a multi-party, non-partisan way to make these important improvements.

The legislation, as you know, updates the Food and Drug Act for the first time in 50 years, something which is incredibly important. The sound amendments that were made by the committee..... Again, I want to thank each and every one of you for having been a part of this achievement. You laid it out quite well. Nowhere is confidence and transparency more important than in the decisions made that affect the health and safety of Canadians.

Vanessa's Law will ensure that additional details on Health Canada's drug approval process are made public, concerning both those that receive approval and those that do not, which was, I know, an important point brought to light when the legislation was first tabled. I was happy the committee was able to amend it.

We now have a world-leading regulatory transparency and openness framework and action plan, and I will continue, as I said, to work with Health Canada to further our transparency in the way we approve drugs. I'm very pleased to report that, as of November 5, Health Canada has posted a list of all of its inspections of drug manufacturing plants over the past three years, something that I know Canadians were looking for. I applaud them for their level of transparency.

● (1150)

The Chair: Thank you very much.

Mr. Kellway, go ahead, sir, for five minutes.

Mr. Matthew Kellway (Beaches—East York, NDP): Thank you, Mr. Chair.

Thank you, Minister, for coming today and spending some time with us and answering questions. I have two questions for you today. Let me set them both out and leave you to determine how to judge your response times.

The first has to do with the Mental Health Commission of Canada and mental health as an issue that we need to deal with. Of course, Minister, our job in the opposition is always to be critical, but when asked whether I can say something good about the government I always happily refer to the Mental Health Commission of Canada. It's accomplished a great deal in a very short period of time. It's put in place a national strategy, as you know, and has moved beyond that to do a lot more in terms of policy and best practices and training, and so on.

But the issue, Minister, as you know, is not going away. One in five Canadians is living with mental illness and it's costing our economy $50 billion a year, and it's anticipated that those costs are going to rise significantly as we move forward. It's time and the Mental Health Commission of Canada has asked to put in place a renewed mandate to turn their strategy into an action plan and extend the funding to support a new mandate for the Mental Health Commission of Canada. So my first question is this. Will your government do that, extend the mandate of the commission, and of course provide funding to support that mandate?

The second question has to do with food labelling. We know that chronic diseases are the leading cause of death and disability in Canada and are among the most costly but also preventable diseases. We know that part of that equation is an unhealthy diet and that they are in fact a public health risk to Canadians with 60% of adults suffering from obesity and nearly a third of kids. We know that Canadian diets do not meet national recommendations. We also know that your department has put forward some recommendations or proposals with respect to food labelling, but those proposals seem to have some glaring omissions to us.

First is that they continue to give, on the front of food packaging, priority to the marketing claims of the producer as opposed to nutritional information. Second, the labelling doesn't deal with added sugars, and we know that research is showing that excess sugar from added sugars can triple the risk of dying from heart disease. Lastly, we ought to have on those labels standardized serving sizes that actually reflect consumption, so that we don't have to reach for calculators to figure out what it is we're actually taking in.

Have your proposed changes to food labelling gone through, been approved, or are they outstanding? Depending on your answer to that, will you make some further changes to those proposals or why didn't you include these three issues in your proposals?

● (1155)

Hon. Rona Ambrose: Sure. Maybe I can get more specifics from you offline, but standardized serving sizes is one of the things that we're looking at and we went out to consult with Canadians at large and then also to consult with health groups. In the industry we've done focus groups. The consultation is just wrapping up. But by all means, if you have some ideas you want to share with us we're happy to take them. But standardized serving size was something we heard loud and clear about from people. I use the example of one of my staffers who said when she buys two different brands of perogies, one serving size is six and one serving size is two. Trying to figure out the calorie content—and who eats two perogies, nobody does—it's very confusing. When you're buying bread it's by one slice. Normally people eat two.

People want consistent, realistic, relevant serving sizes to what they actually eat, so we've been looking at that and I hope we can make progress on it. Sugars is a big one. We heard that loud and clear from moms—I say moms, because moms apparently do almost all the shopping as we found out through a lot of questions—and they said loud and clear they want to know about added sugar and how much sugar is in the food. So that was one of the things we had on our proposed label change.

In terms of front-of-package labelling, I might ask Bruce to speak a bit to that. But if a company or a manufacturer does make a health claim they do have to come through Health Canada. They have to show evidence of that health claim if that's what you mean. If it's just marketing, different kinds of marketing.... Do you want to be more specific, maybe?

The Chair: Sorry, we're quite a bit over time. Maybe the NDP should have one more round before we conclude today, so maybe Mr. Archibald can pick up there if you like, but it's up to you.

Next we have Mr. Young for five minutes, sir.

Mr. Terence Young (Oakville, CPC): Thank you.

I was tempted to ask a question about when you buy hot dogs and there are 10 in the package, and when you buy buns, there are only eight, so you always have two hot dogs—maybe that's not a federal responsibility, I don't know.

Voices: Oh, oh!

Hon. Rona Ambrose: I hope not.

Mr. Terence Young: Minister, I'd like to expand on my colleague's previous question on transparency and delve a little more deeply into the mechanics behind Vanessa's Law. Like you, I was extremely pleased to see it receive royal assent three weeks ago.

A number of measures contained in this bill are effective immediately upon the Governor General signing the bill into law, while others will take some time to come into effect. I get a lot of questions about that. We know there's a need for more consultation. Health Canada has done a superb job on consultation on this bill over the years, which I much appreciate.

Can you please update the committee on what measures in Vanessa's Law are law right now, immediately, and which ones will require some ongoing consultations and come into force over time.

Hon. Rona Ambrose: Sure, I'd be happy to.

First of all, thank you for the many years of your work on this. I think it provided all of us with the knowledge, but also the inspiration, to work together across parties to get this done.

With royal assent, I can tell you that the new authorities for me and any future ministers as Minister of Health, would be the ability to compel information, recall unsafe therapeutic products, impose tougher fines and penalties, incorporate by reference, disclose confidential business information, direct package label changes, and seek an injunction.

In terms of regulations that are not in force and that we will be developing and are already developing to ensure they come into force soon are the ability to require tests and studies, order a reassessment, and attach terms and conditions to market authorizations. I would say they still need further work in the regulatory process. They're important, but I think the ones that matter the most, as you know, are the ability to recall products quickly, compel information, direct label changes, and tougher fines.

For the things that really impact consumers and those who are using the product, we have the power today, thanks to all the work you and the committee did, both here in the House and the committee in the Senate. I would say it also saves us a great deal of time. I know I spent some time speaking about this in the Senate, but the fact that we now have the power to do this means we don't have to negotiate with pharmaceutical companies. Our officials spent literally hundreds of hours negotiating with companies to change their labels, to pull unsafe products off the shelves. Of course, the longer they can keep them on the shelves, the better for them, and the more profits. It was very frustrating.

The fact that this law has passed will not only allow us to act more quickly in the public interest, but also frees our officials to do the work they should be focused on instead of negotiating with companies.

● (1200)

Mr. Terence Young: Thank you, Minister.

Dr. Beaudet, I'd like to refer to the Ottawa statement, which was put together by some Canadian scientists in Ottawa, I think it was four years ago. It's a very high standard for clinical-trial transparency, and it makes reference to.... I'll just read a section from it, because I respect it so much.

> Protocol information and results from all trials related to health or healthcare—regardless of topic, design, outcomes, or market status of interventions examined—should be registered and publicly available....

I'm familiar with CIHR's standard for trials on transparency that CIHR funds right now. I want to refer to any changes that might happen with regard to how you enforce transparency in CIHR-funded trials, and how you intend to enforce those changes, please.

Dr. Alain Beaudet (President, Canadian Institutes of Health Research): First of all, I thank you for this question and for your comments.

You should know that some of these new regulations will be incorporated in the TCPS, which is the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans. We're again tightening some of the screws in the policy, which as you know is really the guideline used universally in Canada for ethics regulating trials. Obviously, what we can regulate are the trials we fund.

Mr. Terence Young: The trials that are registered but not completed....

The Chair: Okay, Doctor, we are over time, so to be fair to everybody, maybe we can pick that up in the second hour of our meeting.

For the last questions of the day, we'll go to the NDP and Ms. Davies.

Ms. Libby Davies: Thank you very much.

I know we just have a few minutes left with the minister, so just to follow up on a couple of things.... We didn't actually get a response and maybe Mr. Da Pont could respond about the question on the Mental Health Commission of Canada. We know that they're seeking a new 10-year mandate. They have put in a funding request. We'd like to know if the minister specifically is supporting that new mandate and the funding request. Obviously, it goes through the finance department but it's very important to know if the minister is supporting that. Then I have a quick second question.

So if you could just answer briefly, please....

Hon. Rona Ambrose: If the question is about me, then I'd be happy to answer it and George can follow up if he wants.

The Canadian Mental Health Commission's mandate is over in 2017, so I do know that they are starting to talk about a new mandate. I haven't had a chance to meet with them directly. I do know that there is that request but there is still time obviously for—

Ms. Libby Davies: The material that we got that was sent around says that they're seeking a new mandate of 10 years, 2015 to 2025. I think it is coming up earlier and that's why they put in the prebudget consultation this year because they know it is coming up.

Mr. George Da Pont (Deputy Minister, Department of Health): Actually both points are correct. The current mandate does run longer and you're correct that they have come in with a proposal for an earlier renewal of their mandate, a proposal both for funding and the mandate. We're working with them on that. Their mandate doesn't end in 2015. It does run later. They just would like an earlier renewal.

● (1205)

Ms. Libby Davies: So we can assume that this mandate is going to continue. They're not going to get chopped off in 2017.

Hon. Rona Ambrose: I would just say that obviously they've done incredible work and we'll consider this. But I would just say that they're still working hard. Their mandate ends in 2017 and we'll obviously take a look at what they.... But regardless, I think it's clear from not only the investment in the Canadian Mental Health Commission but billions of other investments that this government has made that—

Ms. Libby Davies: Okay, thank you.

Hon. Rona Ambrose: —mental health is a huge priority for us.

Ms. Libby Davies: If I could move on to my last question, just to come back to the medical marijuana, you might have seen a story yesterday on CBC. It was called “My QP”. It was a very compelling story about a young mother who has a very young son who suffers from a rare condition that results in multiple seizures. The only thing that's proved effective is to take medical marijuana but not in a smoked form. The question arose from this mother as to why the rules from Health Canada are so rigid and inflexible that it doesn't allow her to use an ointment or a tincture, which is a much better product for her son.

I know that you're totally opposed to medical marijuana and it's only there because it's being compelled by the courts. But it seems to me that there is evidence and there are compelling situations where different kinds of products are needed. I want to ask if Health Canada and you as minister are prepared to consider these kinds of situations so that Ms. McKnight can actually get the help she needs. What she's doing now is basically illegal. She said that publicly. Of course, she doesn't want to do that, but what is she left to do to help her young son? So I wonder if you would respond to that.

Hon. Rona Ambrose: Sure, I would be happy to. I have a lot of sympathy for what she is dealing with, obviously. But we do consider these things. We consider them through the special access program. The special access program is there for drugs that have not been approved or are experimental or are not available in Canada. That decision is made by experts and researchers and scientists within Health Canada. My understanding is that when these requests have been made, the researchers, the scientists have said there is no evidence. I don't know what to say to you. What we need is research. We need clinical trials to show that these kinds of alternatives are actually—

Ms. Libby Davies: But the government hasn't wanted to do any research.

Hon. Rona Ambrose: We put money towards research.

Ms. Libby Davies: You could initiate that yourself.

Hon. Rona Ambrose: We did initiate a number of years ago through Health Canada and when I asked what happened, they said that basically the clinical trials fell apart because the research that was happening wasn't valid.

Ms. Libby Davies: Do you think it's important to do research and clinical trials?

Hon. Rona Ambrose: Pardon me?

Ms. Libby Davies: Do you think it's important to do clinical research?

Hon. Rona Ambrose: Absolutely; without clinical trials, without research, we have no evidence that these things work. So this mom comes to Health Canada and says, “Can you give me special access to this drug?”, but the researchers look at all the evidence and say, “There's no evidence that this works”.

We're the government. We don't do clinical trials. You know how it works. There needs to be evidence and research and clinical trials. There needs to be clear scientific evidence that this is not harmful, and that it's useful and effective.

The Chair: Thank you very much.

Again, I'd like to thank the minister for taking a full hour today to review the supplemental estimates.

I'd also like to thank all the committee members.

For anybody watching at home today, just to see an hour of good, friendly debates and questions...in a very respectful manner.

We'll suspend for a couple of minutes to allow the minister to leave. If any other officials need to to come up to the table, we'll allow them the time to bring up their binders.

Thank you.

● (1205)

(Pause)

● (1210)

The Chair: We're back in session.

We finished off our last round of questioning with the NDP, so Conservative members will be next.

I believe next up on our list is Mr. Lunney.

Go ahead, sir. You have five minutes.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you very much.

Thanks to our officials. To the new faces who've just joined us at the table, welcome. We appreciate your being here today.

One of the issues that's top of mind for everybody in health care right now—and I didn't get a chance to address this to the minister—is of course the subject of innovation. Actually, everybody seems to have an opinion on where we're going with innovation. We have an advisory panel to which the minister has appointed some very capable Canadians. About eight distinguished Canadians are joining Dr. Naylor on the panel.

But Dr. Chris Simpson from the CMA spoke here in Ottawa just a couple of days ago on a national strategy for seniors. The minister mentioned in her remarks the challenges facing us with chronic diseases and managing those. Dr. Simpson's remarks had to do with the contribution of chronic illnesses to occupying hospital beds, creating gridlock in the hospitals, and tying up whole facilities because there's no place to move people. *The Hill Times* has about 20 pages of opinions on how to get through some health care innovation.

By way of background, I'll just say that in my own province, I think we're at about 45% of the provincial budget. Most of them are at 45% or 46% right now of their entire provincial budget. But going back to 2000, when I first ran for office, in my province, when you added education and social services, you were at 85% of the entire provincial budget on those three alone.

So we know that health care, as we've been practising it, is not sustainable. Dr. Simpson's take is that we have to dehospitalize health care. We're hoping that the panel, as they hear lots of opinions from across the country, will come up with some useful suggestions. The minister mentioned briefly in her opening remarks that Dr. Naylor's committee has hit the ground running, that they're doing consultations.

The minister is not here now to answer this question, so Mr. Glover, Mr. Da Pont, or whoever wants to address this, can you please give us a review of where Dr. Naylor's committee is at, how this is playing out, and how those consultations are taking place?

● (1215)

Mr. George Da Pont: Thank you very much.

As the minister indicated, the panel is now out in full force in its consultation process. There are several different avenues under way. As the minister mentioned, there is an open, online consultation available to any Canadian who wants to offer ideas to the panel.

The panel has been meeting various health care stakeholders and associations on an individual basis. They also have been and are planning to meet at various regional levels with a broad section of stakeholders. For example, I believe just a couple of weeks ago they had their first such meeting in Halifax, well attended by 25 to 30 key health care stakeholders in that province, including a good representation by provincial officials. They're intending to have similar sessions over the next month or so in various other parts of the country. I think they have sessions set up for Toronto, Vancouver, Winnipeg, and a couple of other cities.

Dr. Naylor and his panel have been doing work with provincial governments seeking input from them as well. They will be doing the same with territorial governments. Finally, they are looking at and working to see if there are any international examples or models of innovation that could possibly be considered or applied here in Canada.

One of the things that I certainly am aware of and the panel is seeing is that there's a great deal of innovation going on across the country in almost every single jurisdiction. There are many effective pilots that have been done or are under way. I think one of the biggest challenges is that it seems so difficult to take those effective pilots and scale them up on a broad basis. I think those are some of the issues that are coming out in the discussions that they're having.

Mr. James Lunney: Thank you for that.

I know time is short, so I quickly want to review an issue that I've raised before with officials for a number of years, and that's the proton pump inhibitor issue. I want to ask if it is under PHAC, the Public Health Agency of Canada, or under CIHR, that the CNISP program is managed.

It's PHAC, okay.

The Chair: Mr. Lunney.

Mr. James Lunney: I'll just pose my question quickly.

The Chair: Okay, very quickly.

Mr. James Lunney: We know that there is a 40% to 275% increased risk when patients are on those medications. The CNISP program has been reviewing this for a number of years. They haven't been collecting data on the medications the patients are on at admission. That's an issue I've raised with the department before.

Do you feel, Dr. Beaudet, or the two of you as clinicians, that in fact collecting data would help clarify the role of proton pump inhibitors in contributing to C. difficile cases?

The Chair: Thank you very much.

I'm sorry, we are over time, and I'm trying to be fair to all members.

Mr. Morin, go ahead.

[*Translation*]

Mr. Marc-André Morin (Laurentides—Labelle, NDP): Thank you, Mr. Chair.

My question is for the deputy minister.

The government receives $700 million in supplementary revenue because of the increased tobacco tax, but it does not use that money to reduce smoking. Instead, the government has cut funds set aside for reducing smoking.

The government has also put forward weak regulations against flavoured tobacco. It isn't following the lead of other countries, like Australia, that impose regulations on uniform packaging.

When will the government get serious about reducing the biggest predictable cause of death in Canada?

● (1220)

Mr. George Da Pont: Thank you for your question.

The government launched a very good campaign to reduce the number of smokers here, in Canada.

[*English*]

When you look at the results, today we have among the lowest smoking rates in this country that we've ever had, both among youth and among adults. They're among the lowest in the world, and that is an indication of the many years of work and campaigning—education and other campaigns—not just by Health Canada but by many other organizations.

At the same time we've taken a leadership role in dealing with issues of flavoured tobacco, which appeals to children and has a significant risk of renormalizing smoking. As you're aware, a few years ago Canada was the first country in the world to put these sorts of measures in place, and the minister has recently announced an intent to augment those measures even further to deal with the innovation of tobacco products by some of the major companies.

[*Translation*]

I think we are seeing very good results. We are continuing to invest in this program. I am really encouraged by the results we are getting, which are among the best in the world.

Mr. Marc-André Morin: Of course, there has been a drop in tobacco use, but the costs for smoking-related health care resulting from smoking are still quite substantial. When you see people smoking outside hospitals with their IV drips, you have to wonder how many of them are unaffected by this government action and find themselves in this situation.

Shouldn't extra effort be made?

Mr. George Da Pont: I will repeat the same answer and say that we have made a lot of progress in this area.

[*English*]

Right now smoking rates among Canadians are down to 16%. Smoking rates among young people are down to 7%. Both are record lows, and I think they show the effectiveness of the work that has been done and continues to be done not just by Health Canada but by many medical organizations, provincial governments, and many others.

We are continuing to see a steady reduction. As I mentioned, we are putting more effort into an area where we think there is risk, and that is flavoured tobacco. It appeals to children, and in our view, it has a very high risk of renormalizing smoking.

The measures the government put in place a few years ago and the enhanced measures the minister announced a few weeks ago are good demonstrations of continued effort. From the work we are doing, we are getting very good results.

The Chair: Thank you, Mr. Morin.

Thank you. Welcome to the committee.

Mr. Lizon.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much, Mr. Chair.

Welcome to all the witnesses. Thank you for coming.

The first question I have is related to supervised consumption sites. How would Bill C-2, the respect for communities act, change the process for exemptions related to supervised consumption sites?

● (1225)

Mr. George Da Pont: Thank you very much for the question.

The proposed legislation that is before you for consideration would essentially create two separate exemption regimes: one for licit substances, which are defined as substances obtained in a manner authorized by the Controlled Drugs and Substances Act or its regulations, and a second for illicit substances, generally street drugs.

The new regimes will strengthen the safety and security provisions for licit substances—the authorized uses—as they would obviously be for medical and scientific research and other things that are in the public interest. For activities involving licit substances, the categories under which applications would be considered would be medical, law enforcement, or prescribed purpose.

As I'm sure you and members are aware, there was a Supreme Court decision around some of these issues that set some broad principles and categories of things that would be taken into account in assessing applications, and those are set out and expanded upon in the proposed legislation.

The other significant piece is that the proposed legislation would authorize the minister to publicly post a notice of application for an exemption for a supervised consumption site and invite comments from the public on that application for a period of time. The purpose of that is to ensure that the broader community has an opportunity to express its views on an application as obviously it would be affected by the outcome.

Mr. Wladyslaw Lizon: Thank you.

Actually, I would like to go back to the question of marijuana and the clinical studies that were conducted.

Are you familiar with any study anywhere in the world that would prove or suggest that either marijuana or a substance derived from marijuana can be used to treat certain medical conditions?

Mr. George Da Pont: Yes, there are actually some studies under way. Maybe I'll go back and use the example that Ms. Davies referred to.

My understanding is that the U.S. has six clinical studies under way right now looking at a derivative product that is being tested for safety and efficacy for just that type of condition. I think, at least for that specific case, as we begin to get the results of some of these clinical trials, obviously it may lead us to reconsider the approach, depending on the outcome.

We are seeing a few other applications for clinical trials, but not, as the minister said, on a widespread basis. I think everyone's aware that there may well be benefits to some drugs, but also there are significant risks. The purpose of the clinical trials is to assess whether potential benefits outweigh the risks. That's the sort of evidence that just doesn't exist at the moment. It'll hopefully begin to come in over time as we see more clinical trials.

Mr. Wladyslaw Lizon: Thank you.

How much time do I have?

The Chair: Thirty seconds.

Mr. Wladyslaw Lizon: Well, maybe quickly, on another topic, what progress can you report following the last implementation of the health agreement with the First Nations Health Authority in B.C.?

Mr. George Da Pont: Again, I would say that really is a landmark tripartite agreement that has seen the responsibility for design and delivery of programs and services that previously came from Health Canada now being turned over to a newly created First Nations Health Authority. That authority has gotten off, we think, to a very good start.

One of the early things we notice is that now they have developed stronger relationships with the province, so with regional medical delivery mechanisms, and are taking a more integrated approach. They now have the ability, really, to redesign programs, get better integration and consistency with the province, and hopefully, get much better outcomes for first nations people in B.C.

Obviously, it's only been a year that it's been in place—

● (1230)

The Chair: Mr. Da Pont, sorry, we're over time here, just to be fair.

Mr. George Da Pont: All right.

The Chair: Mr. Young, you're next.

Then, Ms. Fry, you'll be after Mr. Young.

Mr. Terence Young: Thank you, Chair.

For Dr. Beaudet, again, please, when people drop out of clinical trials early on, the researchers call that microdata. Sometimes it's because they're reacting to drugs. I call that life-saving information, and the drug industry sometimes just calls it CBI, confidential business information. This is a big problem for patient safety.

How will the requirement in Vanessa's Law to register all clinical trials change the way you enforce transparency in CIHR-funded trials?

Dr. Alain Beaudet: In CIHR-funded trials it's very clear. The requirement for registration and reporting of adverse effects is mandatory. It's part of the contract that we sign with the investigator when we give out the grant. Should the terms of the contract not be respected, they would be in breach of the contract, actually. They would be in breach of the TCPS's tri-council policies on ethics for trials, in which case that would come under the secretariat on ethics, which would recommend—would recommend to me, actually—a number of sanctions, the first one usually being non-eligibility for future funding at CIHR.

Mr. Terence Young: You would cut them off from future trials?

Dr. Alain Beaudet: We'd cut them off—

Mr. Terence Young: Is that your only tool of enforcement?

Dr. Alain Beaudet: Our only tool for enforcement is not being able to fund them in the future, indeed.

Mr. Terence Young: Thank you.

Thank you, Chair.

The Chair: Mr. Young, you have more time, if you like.

Mr. Terence Young: Thank you.

Mr. Da Pont, could you describe what administrative changes at Health Canada will support the enforcement of Vanessa's Law, perhaps with specific reference to adverse drug reaction reporting for health care institutions? How are you going to make it work?

Mr. George Da Pont: Again, thank you very much for the question.

We will be putting in place a regulation and a framework to define the reporting of adverse drug reactions. We will have to, and want to, engage in discussions with provinces, local hospital authorities, and other institutions that we would be asking to report, to work out the mechanics of what exactly gets reported: the timing, the mechanism, and the frequency of reporting. Obviously we want to get any severe reaction, any serious reaction.

A lot of those discussions have started. We want to move this along as quickly as possible because obviously it's one of the critical new components of Vanessa's Law. We need to work out the nuts and bolts of how that information is going to come, when it's going to come, and in what form. That will significantly enhance our ability to make assessments and take action when we see patterns or trends.

The Chair: Mr. Lunney, you have just two minutes, sir.

Mr. James Lunney: Thank you very much.

I asked a question earlier about the proton pump inhibitor, about CNISP, and collecting the data.

Dr. Taylor, increased risk of 40% to 275%—is that clinically significant? Compared to other things I've heard, it's over the top.

Dr. Gregory Taylor: Thank you for the question.

We're looking at CNISP and re-evaluating that surveillance system right now to see if we can add those kinds of questions to collect and answer that. CNISP wasn't originally created for research. It was created for surveillance, but it's nice to be able to use that network to do that.

That's a work in progress. We have to work with our partners to see if it's feasible to add those questions.

Any clinical change of 200% to 400% certainly seems clinically significant to me, but we're certainly working on that and hopefully the information will be able to address that.

Mr. James Lunney: Thank you for that.

I have the study here. They collected all kinds of information, including the genetic variations in the bug. That sounds like research to me. So saying that it's not set up for research.... I think it shouldn't be that hard to collect the data; it's already in the hospital records. It's costing us a lot of money—hundreds of millions of dollars. We're talking about innovation. There ought to be some way of moving forward there.

Dr. Beaudet, there was a change in the mandate of CIHR to reserve some funding for priorities, including those of the Government of Canada. Might this be a place where CIHR might be useful in doing a study to investigate not only that but what the hospital in Quebec's been doing for nine years, giving a potent probiotic 24 hours after they start antibiotic therapy and eliminating C. difficile infections with probiotics? Might that be something CIHR could help with?

● (1235)

Dr. Alain Beaudet: This is something CIHR is already helping with. We're funding some work in that area.

As you may know, DSEN, the Drug Safety and Effectiveness Network, has looked at this issue of the proton pump inhibitor and the relationship to C. difficile. We funded a number of studies looking not only at probiotics but at other approaches to treating C. difficile in the hospital.

Mr. James Lunney: Are you familiar with the Bio-K+ program with 50 billion CFUs?

The Chair: Thank you.

Ms. Fry, you're up now for five minutes.

Hon. Hedy Fry: Thank you very much, Chair.

I just wanted to follow up on some questions that I didn't think the minister was able to answer because of time limits, but before I get there I would like to ask the minister to table three particular things. One is the consultation on the marijuana advertising. Could the minister list who was there, and to table it with the committee? The second one is the consultation with regard to the visa denial. Who did the minister consult with? Could she table that, please? I just wanted to put that on the record. The final one is the decision to change the chief public health officer's position. Who did the minister consult with, and could she list those people for me, please?

Now I want to go to the question with regard to the chief public health officer. Again, I have the greatest respect for both Dr. Taylor and Ms. Outhwaite. Sometimes things work when the people and the stars are aligned and get along well, and they're willing to look at the problem. My concern here is that we have had the Public Health Agency of Canada, and I have heard from many chief public health officers from provinces and territories that they are not happy with this decision. The problem is that if there is a mistake, there may be delays in making decisions that are required of a chief public health officer who is waiting on red tape. We were in government during SARS, and we saw that actually did inhibit our ability to have quick responses to the problem and to have scientific evidence guiding us on what should happen. There is a huge concern by everyone involved.

Now I know that this is done, and I don't usually see this government going back on anything it does. However, if evidence shows—hopefully without harming Canadians if it does happen—that the chief public health officer is not able to do the work that he needs to do in a quick and scientific manner due to the requirements of what his responses must be, would the government consider rescinding this decision, which I consider to be potentially risky? That's my first question.

Finally, I wanted to talk a little bit about marijuana ads. My concern isn't that marijuana doesn't have an impact on the brains of youths. We all know that. We heard it from everyone. There was no contradiction on this particular issue. My concern is whether long-term effects do carry through from childhood smoking into adulthood. What I consider to be a panicky ad that is out there makes parents believe that their children are harmed irreversibly and are going to lose all their ability to perform at school, etc. It's a panicky ad. It's not based on good evidence, since there is still a question of whether this is so.

My question is, again, for the CIHR. Would you, and could you, do those clinical trials without someone coming and asking you to? Could you do it? Do you not believe...? Well, you shouldn't have to answer that question, since it puts you in a difficult position, but do you not believe that the government should have done that work before it brought out what I consider to be panicky ads based on what most physicians believe is flawed evidence? It's over the top in terms of what it's saying. Everyone thinks we should stop young people from getting access. Right now they are getting access and we are not even considering how to stop that access. We're just going around scaring everybody to death with this panicky ad.

Would, or should, CIHR and the government do those kinds of studies and perhaps tone down the ads until they're done?

● (1240)

Dr. Alain Beaudet: The short answer is yes. Any proposal for a clinical trial that is scientifically sound and has clear objectives could be funded by CIHR. I can only repeat what the minister has said about the importance of getting more scientific evidence on both the negative and the therapeutic effects of marijuana, because as the member said, there are very few clinical trials out there. You know that they are very difficult to do for a number of reasons, such as the mode of administration of the drug, the variety of strains out there, and the variety of products, with the result that there are huge discrepancies in the results of these clinical trials, even though there are therapeutic benefits.

I suggest that you look at all the Cochrane systematic reviews of all the trials for all the indications on the therapeutic use of marijuana. None of them comes out with a significant result.

Hon. Hedy Fry: I think, though, there's actual medication based on cannabis that is out there as a drug, an actual drug in a pill form. So I don't think that those two arguments, and I still would really like to hear about the—

The Chair: Thank you very much, Ms. Fry. We're over time.

The NDP have one quick question in here just to be fair.

Ms. Libby Davies: We have one question that we're going to try to split.

Ms. Outhwaite, I just want to very quickly ask if you'll table with the committee the job description, responsibilities, lines of reporting, and any communication protocols for the chief public health officer position, the new position that's being created, and the new president of the agency, so we can look at both and see what the differences are. Could that be tabled with the committee, please?

Mrs. Krista Outhwaite (Associate Deputy Minister, Public Health Agency of Canada): Yes.

Ms. Libby Davies: Okay.

I'll turn it over to Mr. Kellway.

Mr. Matthew Kellway: Thank you, Ms. Davies. I was concerned about the non-response by the minister to my question about the Mental Health Commission and then the response to Ms. Davies' question. There has been a lot of dancing, if I can call it that.

There are emerging issues in mental health and they're set out by the commission. They are serious issues in many different ways including economically. If not the Mental Health Commission, then can you tell us what plans the department has, because 2017 is just around the corner, to tackle these emerging issues? I'll say editorially, I look at the estimates and this is a department that is dropping FTEs. So what are you going to do about mental health issues in Canada?

The Chair: Very briefly....

Mr. George Da Pont: On that, as I said, and as the minister said, the Mental Health Commission has done very good work. Their mandate runs for a little bit of time yet. They put in a proposal for an early renewal and funding. We are working with them and we are looking at the proposal. I think it just wouldn't be appropriate to speculate much further, but I think there is a broad sense that the Mental Health Commission has been very effective and has done very good work.

It's not the only avenue of investment. Dr. Beaudet may want to talk about it a bit more, but through CIHR there is a considerable amount of money being invested in research around mental health. There are other expenditures even in Health Canada. For example, significant components of our first nations programs try to address mental health and addiction issues.

There is a very concerted effort around things like the Indian residential school program to help people who went through the residential schools. There is a very concerted effort on mental health on a wide variety of fronts including the Mental Health Commission.

The Chair: Thank you very much.

Thank you to all the officials who have appeared today. We do need to make sure that we have heard all the evidence and heard all the numbers. Now we actually have to put it in motion and do a few votes here. Without further ado, we are looking at the supplementary estimates (B) for 2014-15 and there are five questions I need to ask.

Shall votes 1b and 5b under Canadian Food Inspection Agency carry?

CANADIAN FOOD INSPECTION AGENCY

Vote 1b—Canadian Food Inspection Agency—Operating expenditures and contributions.....$21,605,828

Vote 5b—Canadian Food Inspection Agency—Capital expenditures..... $630,703

(Votes 1b and 5b agreed to on division)

The Chair: Shall vote 5b under Canadian Institutes of Health Research carry?

CANADIAN INSTITUTES OF HEALTH RESEARCH

Vote 5b—Canadian Institutes of Health Research—The grants listed in the Estimates.....$11,143,000

(Vote 5b agreed to on division)

The Chair: Shall votes 1b, 5b and 10b under Health carry?

HEALTH

Vote 1b Health—Operating expenditures.....$23,956,508

Vote 5b—Capital expenditures.....$1

Vote 10b—Health—The grants listed in the Estimates and contributions.....34,987,989

(Votes 1b, 5b and 10b agreed to on division)

The Chair: Shall votes 1b, 5b and 10b under Public Health Agency of Canada carry?

PUBLIC HEALTH AGENCY OF CANADA

Vote 1b—Public Health Agency of Canada—Operating expenditures..... $1,624,812

Vote 5b—Health Agency of Canada—Capital expenditures.....$1

Vote 10b—Public Health Agency of Canada—The grants listed in the Estimates.....$1

(Votes 1b, 5b and 10b agreed to on division)

● (1245)

The Chair: Shall the chair report the same to the House?

Some hon. members: Agreed.

The Chair: Mr. Wilks.

Mr. David Wilks: Mr. Chair, I move that we go to committee business.

The Chair: Thank you very much. I think we'll do that. What we'll do is suspend for a minute to let our officials leave and then we'll return back in camera.

[*Proceedings continue in camera*]