HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 084 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Thursday, December 7, 2017

Chair

Mr. Bill Casey

Standing Committee on Health

Thursday, December 7, 2017

● (1535)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call our meeting to order. Welcome, everybody, to meeting number 84 of the Standing Committee on Health.

Today, we are going to have a study of the supplementary estimates. We welcome our Minister of Health, the Honourable Ginette Petitpas Taylor, to join us here today.

I see in your notes, Madam Minister, that you are going to introduce your colleagues beside you, so I am going to leave that to you. Normally I introduce them.

You can open up with a statement of 10 minutes, if you would. We would appreciate your comments. Then we'll go to questions.

Hon. Ginette Petitpas Taylor (Minister of Health): Thank you very much, Mr. Chair.

Thank you for inviting me today to present the health portfolio financial overview of supplementary estimates (B) for the period 2017-18.

I am thrilled to be accompanied today by my deputy minister, Simon Kennedy; Dr. Theresa Tam, our chief public health officer; Carolina Giliberti, executive vice-president of the Canadian Food Inspection Agency; Yves Bacon, CFO and vice-president of the corporate management branch of the Canadian Food Inspection Agency; and Michel Perron, executive vice-president of the Canadian Institutes of Health Research.

[*Translation*]

We are pleased to have the opportunity to discuss the resources that we are requesting to maintain and improve the health needs of all Canadians.

[*English*]

The health portfolio continues to deliver on several priority initiatives for our government. In these supplementary estimates (B), the health portfolio's budget will increase by just over $297 million, raising its proposed authorities to date to $7.16 billion. This constitutes an increase of approximately 6% over our authorities to date.

This funding will allow the health portfolio to achieve several key objectives in several priority areas, which I will now briefly address.

[*Translation*]

Our government recognizes that Canadians expect the health care system to adapt to their changing needs. They also expect federal, provincial and territorial governments to work together to strengthen our health care system.

In August, the Government of Canada and the provinces and territories agreed to a common statement of principles on shared health priorities. This common statement of principles outlines the priorities for federal investments in mental health and addictions as well as home, palliative and community care. It commits governments to work with the Canadian Institute for Health Information on a set of common indicators to measure progress in these areas. And it reaffirms a shared federal, provincial and territorial commitment to improve the affordability, accessibility and appropriate use of prescription drugs.

Every province and territory has also agreed to its share of $11 billion over 10 years in federal funding for home care and mental health. They have also agreed to the broader funding arrangements under the Canada Health Transfer, which will provide more than $200 million in federal health funding over the next five years.

Health Canada is now in negotiations with each province and territory to develop multi-year bilateral agreements that will outline the terms and conditions for the remaining funding over 10 years.

[*English*]

The Government of Canada is committed to a renewed nation-to-nation relationship with indigenous people. Part of that commitment involves ensuring that first nations and Inuit have access to culturally appropriate health programs and services.

In December, the Government of Canada announced the formal creation of the new Department of Indigenous Services Canada. This is truly an important step in the government's transformation of services to indigenous peoples. By consolidating services into one department, we will be improving the sharing of information and strengthening our capacity to meet the needs of the people we serve.

Therefore, significant funding associated with indigenous programming included in these supplementary estimates will now fall under the purview of Minister Philpott.

I truly remain committed to supporting our government's important goal of improving indigenous health. Throughout this transition period, I will support my colleagues, Minister Bennett and Minister Philpott, to help ensure that first nations and Inuit continue to have access to high-quality health services and programs. I will also work to ensure that we maintain effective relations with our indigenous partners.

[*Translation*]

Another key file under the health portfolio is the legalization and regulation of cannabis. We know that the current approach to cannabis does not work. It has allowed organized crime to profit while failing to keep cannabis out of the hands of our young people. This is why our government introduced Bill C-45 to legalize and strictly regulate access to cannabis.

In these supplementary estimates, we are requesting $39.1 million to develop, implement and administer a federal framework to legalize and regulate cannabis. This will include the licensing and oversight of producers of cannabis for medical and non-medical purposes.

[*English*]

Another health priority that we are addressing is the opioid crisis. We continue to use all the tools at our disposal to address the growing number of overdoses and deaths caused by opioids. As you know, there were more than 2,800 apparent opioid-related deaths in Canada in 2016, and the preliminary data for 2017 suggests that the number of opioid-related deaths will exceed 3,000. These estimates include an increase of $6.2 million to address the crisis. This includes funds to support increased access to harm reduction measures and to prevent infectious diseases that may result from sharing drug-use equipment.

This is a complex health and social issue, and it will not be fixed overnight. This is why our government will continue to work with partners from across the country to take action on this public health crisis.

[*Translation*]

With respect to the impact of climate change on the health of Canadians, I am pleased that Budget 2017 allocated $47.1 million over five years to Health Canada, the Public Health Agency of Canada and the Canadian Institutes of Health Research to address the health risks associated with a changing climate.

The Public Health Agency of Canada recently accepted proposals for the Infectious Diseases and Climate Change Fund. These proposals will address gaps in knowledge related to climate-driven food-borne, water-borne and zoonotic infectious diseases in Canada. This includes preparing for and protecting Canadians from climate-driven infectious diseases, including Lyme disease and the West Nile virus.

● (1540)

[*English*]

Our government is also committed to promoting and improving public health and increasing vaccination rates across the country. Vaccination remains one of the most effective public health tools to protect Canadians, which is why we are allocating $1 million in funding towards an advertising and public education campaign to help Canadians make informed decisions on vaccinations.

Vaccines are effective and safe, and they play an important role in the protection of our health and of our communities. I am pleased that the government, in partnership with the provinces and territories, has endorsed new vaccination coverage goals and targets for reducing vaccine-preventable diseases by 2025.

[*Translation*]

These supplementary estimates reflect an increase of $7 million in the budget of the Canadian Food Inspection Agency, which will support the CFIA's important ongoing work in plant protection, animal health and food safety.

Safer food remains a top priority for the CFIA. While Canada already has one of the safest food safety systems in the world, our government is dedicated to improving that system so that Canadian families continue to have confidence in the food they eat.

The CFIA has increased its focus on prevention, preparedness and response to minimize risks to human, animal and ecosystem health. This includes plant protection and animal health, the first links in the food chain.

In conclusion, I am confident that the amounts noted in these estimates and the funds identified in Budget 2017 will allow the health portfolio to continue to support better health outcomes for all Canadians and to build a healthier country.

Thank you again to the committee for inviting us to join you today. I look forward to answering your questions.

[*English*]

The Chair: Thank you very much.

Now we'll go to seven-minute rounds of questions, starting with Dr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Chair.

Thank you so much, Minister, for coming. We appreciate your doing this today.

As you know, I'm a recovering emergency physician. I spent 20 years working in emergency departments. Any problem with public health often came down on our departments first, and we would see trends. Among the trends we would see was the detrimental health effects when people couldn't afford their medications and became ill simply because of that.

As you know, we're studying the structure and implementation of a national pharmacare program. One of the things we've found is that Canadians pay the second-highest drug costs in the world. Although the report is not out, we have a parliamentary budget office report that says that if we had a national pharmacare program, the nation would save roughly $4 billion a year.

Could you share with us what steps you, and Dr. Philpott before you, have taken to reduce the costs of medications to Canadians?

Hon. Ginette Petitpas Taylor: It's certain that our government is committed to strengthening Canada's health care system, and that includes enhancing accessibility and affordability, and appropriate prescription drug use. At the end of the day, that's absolutely a priority of our government.

In budget 2017 we were able to invest $140 million to lower drug prices, improve access to prescription drugs, and support the appropriate use of medication. We were also able to join our provincial and territorial partners, and we became members of the pan-Canadian pharmaceutical alliance. This enabled us to actually do bulk buying when it came to prescription medication. As a result, we've been able to save a significant amount of money with respect to the costs related to that.

As I'm sure you're aware—because you've been doing some studies—we are in the process of modernizing the patented medicines regulations in the Patent Act, and that is certainly going to be very helpful in the work that needs to be done. When we look at the Patented Medicine Prices Review Board, modernizing it is something that hasn't been done for many years, so it is certainly a step in the right direction. I look forward to the continued work that's going to be done there.

I'm also aware that your committee has done in-depth research on this issue, and once again I'm really looking forward to reviewing the recommendations brought forward by the committee, as I think we can certainly continue our conversation.

Finally, I'd like to say that in October I had the privilege, for the first time, of having a meeting with the provincial and territorial health ministers. The issue of drug prices came up, and both the provinces and territories and the federal health department have indicated that it's a priority of ours to improve access to medication. We recognize that Canadians pay way too much for drugs, and that is certainly something we want to address.

Taking these steps to start off is certainly a step in the right direction.

● (1545)

Mr. Doug Eyolfson: Thank you very much.

I've also noted the good work that's been done by the ministry regarding addressing the opioid crisis. Again, I keep coming back to what I was doing in my previous life. It was something I saw a lot of in that job, and sometimes with very tragic results, which I had to witness.

I was very pleased that the government was able to pass Bill C-37, which increased the ability of community health groups to make safe consumption sites available. We know this is something that would save lives. The initiatives making naloxone more available have been a very important life-saving tool as well.

We undertook a study of the opioid crisis, and we produced a report that had 38 recommendations. Would you be able to tell the committee what progress you've had in implementing that series of recommendations?

Hon. Ginette Petitpas Taylor: With respect to the work that we've done in the opioid crisis, first of all, as indicated in my opening statement, we recognized as the government and as all Canadians have that we're faced with a public health crisis when it comes to the opioid situation. Again today, we've seen some numbers that have been released from Ontario, and the numbers are devastating. We recognize that they're not just numbers. These are people's children, their mothers, their fathers. They're personal stories, and the damage that is created by these losses, the collateral damage, is huge to families and to communities. It's certainly an area of priority of mine as Minister of Health.

I have to say that the first briefing that I received as Minister of Health was specifically on the opioid crisis and it's my number one priority, which I'm dealing with on a regular basis, on a daily basis. As you've indicated, in terms of some of the key steps that we've been able to take so far, when it comes to Bill C-37 that was certainly an important step in the right direction in order to streamline the application process for the consumption sites that are out there.

We certainly need to make sure that we have a harm reduction approach when it comes to dealing with these situations and we are pleased to see the progress that has been made.

When we formed government, we had one of these sites available in Canada and now we have a total of 28 supervised consumption sites available. Those are certainly, again, steps in the right direction.

Also, when you mentioned about making naloxone more readily available, ensuring that it's a non-prescribed medication certainly allows many individuals to have access to that tool. That's exactly what it is, something they need to effectively deal with the situation on the ground. Certain provinces make sure that is available free of charge, but again, that's a decision that's brought forward by provinces and territories. We certainly need to do all that we can to ensure that the naloxone product is more readily available.

We've also made significant investments as well when it comes to addressing this situation. When the Health accord was being negotiated last year, there are a few provinces that indicated that the opioid crisis was an absolute priority in the areas that needed to be addressed. Above and beyond the monies that they received for the health transfers, if we look at the Province of British Columbia, for example, they received $10 million in direct funding to deal with this crisis on the ground.

If we look at the Province of Alberta, they received, I believe it was $6 million to deal with this crisis on the ground. There's also Manitoba, there was a series of targeted issues that they needed funding for but opioids was certainly one of those as well that was listed. They received additional funding as well.

Aside from that, we also can't forget that Canadians as a whole have told us that mental health and addictions is absolutely a priority for them. Through our budget in 2017 and with the health care agreements, we recognize that we made significant investments, $6 billion in the area of mental health.

Again, they're steps in the right direction, but I can't say enough that we recognize that we cannot be complacent when it comes to this crisis. We have to continuously monitor the situation. We have to address the needs that are out there. We have to be progressive. Also, we can't deal with this alone. There's no one single solution to this, and we recognize that we have to work with the provinces and the territories and front-line workers. That's going to be key.

● (1550)

Mr. Doug Eyolfson: Thank you very much.

The Chair: Mr. Webber.

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

Minister, you alluded in your presentation to the topic of Lyme disease briefly. Of course, after almost six months, this committee did finally just yesterday get your letter, your response on the Lyme disease investigation that we did here in committee. The response from you, Minister, is certainly not going very well in the Lyme community and I'm not surprised.

There are hundreds if not thousands, as you know, Minister, of Canadians suffering daily from Lyme disease. We know that there are likely many more that have been misdiagnosed or are not getting the treatments that they need. There have been conferences. We studied it here in committee. There have been experts who provided their opinions and recommendations, and we've had public consultations as well. Enough talking has happened and now it seems that no action is really taking place. Without proper funding, nothing is going to happen.

The government of course, as you know, has set aside $4 million. Let me put that into perspective. We spent more on a hockey rink out on Parliament Hill than we are now spending on this major public health issue. Why do you, Minister, believe that proper Lyme disease research can be done for less than the cost of putting up a patch of ice on Parliament Hill?

Hon. Ginette Petitpas Taylor: I'm pleased to hear that you did receive my letter that was provided I believe late this week.

First of all, I have to take a step back. Our government certainly recognizes that Lyme disease is an emerging infectious disease in many parts of Canada. I know, coming from New Brunswick, there are certain hot spots that have been identified in our province alone. I'm certainly quite aware of it. I'm also aware that the long-term impacts and the physical impacts on individuals who live with Lyme disease are tremendous.

In my riding of Moncton—Riverview—Dieppe, I had an opportunity to attend a support group last year because I received several emails from individuals who live with Lyme and suffer from Lyme disease. I wanted to have an opportunity to meet these individuals and to hear their stories because I really didn't know a lot about the topic. To hear those testimonies certainly hit home for me.

I also recognize Ms. Ludwig on your committee has done a lot of work in the area of Lyme disease as well. Again, we certainly recognize the devastating impact that Lyme disease can have on families

Mr. Len Webber: Minister, do you think $4 million is adequate funding for this disease?

Hon. Ginette Petitpas Taylor: To address your question on the investment, I'm sure you're very much aware that in May 2017 we were able to release the federal framework. The federal government's role, as I see it, has three pillars, three priority areas where we have to lead. When we look at the issue of surveillance, we recognize that we have to gather better data to get a clear picture of exactly what is going on and the magnitude of all this.

Mr. Len Webber: We certainly understand that here on this committee.

● (1555)

Hon. Ginette Petitpas Taylor: Another pillar that I believe is very important is the issue of education and awareness. Many Canadians perhaps are aware but we also know that we have to provide more information on detection and awareness, and the list goes on.

Finally, another area where I believe we have a role to play is in the area of guidelines and best practices. Those are the key areas we know the federal government certainly wants to focus on. With the investments we've made with respect to the federal framework, it's certainly a beginning and a step in the right direction.

I would like to ask Dr. Tam if she could provide a bit more information on the work that's being done.

Mr. Len Webber: We've been through this already. We've had a study on this, Minister, but thank you anyway. Perhaps you can answer my question, Dr. Tam.

My concern and many people's concern with the blood system is its safety.

Minister, you said in your letter, “there is no evidence that Lyme disease can be transmitted through the blood supply.” This is very different from saying science has proven that Lyme disease cannot be transmitted through the blood supply. It's like saying, I haven't seen it happen, so it can't happen.

I would like to know from Dr. Tam, or you, Minister, what is being done to scientifically prove that Lyme disease cannot be transmitted through the blood supply. Can the minister unequivocally state it is impossible to get Lyme disease through the national blood supply?

Hon. Ginette Petitpas Taylor: Dr. Tam, would you mind taking that question, please?

Dr. Theresa Tam (Chief Public Health Officer, Public Health Agency of Canada): I believe the Canadian Blood Services has provided some of the response to this question as well.

There has been no evidence to date of any Lyme disease in the blood supply. While not every blood donor is tested, Canadian Blood Services screens out people who are sick. They also do studies intermittently to look at the donor group. They haven't found any evidence.

I also want to go back to the fact that we are investing $4 million in research, together with CIHR. Some of the investments are in diagnostics. Some of the investments in other areas of research will bring us more evolving information.

Mr. Len Webber: Do you believe that $4 million is adequate, not only for research but now we have surveillance, the education, and the guidelines and best practices, the three pillars the minister has mentioned? I don't believe it is.

Dr. Theresa Tam: Certainly from the Public Health Agency, and I can probably say from the CIHR perspective, we welcome the dedicated funding. That's the first time we've received it. We announced the $4 million for the research network. On top of that there is $3.7 million for other activities.

Only part of the $4 million goes to research. Very importantly the rest funds the education of front-line medical professionals and also patients. We are also leveraging the responsible parties like the health professional societies who do have a role to play, and also surveillance.

Mr. Len Webber: I can't say enough about how inadequate this funding is. It seems there's more priority for a 150th celebration on our front lawns here on Parliament Hill.

Minister, I am sure that your office, like mine, is being inundated right now with emails from folks who are unhappy about an excise tax on medical marijuana. These Canadians point out that no other prescription medication is subject to an excise tax.

Minister, why is this government taxing one prescription medication and not any others? Is it the government's intention to maintain this policy or bring medical marijuana's tax treatment in line with all other prescription medication?

Hon. Ginette Petitpas Taylor: As you're aware, the health committee worked very hard at studying Bill C-45, and you did tremendous work at the beginning of the summer. If my memory serves me well, you were here well before we were all here, and you heard from many witnesses over five long but very interesting days, I was told. We also have to recognize that the task force has met people from coast to coast to coast and provided some recommendations to government with respect to some areas that we should consider.

With respect to the area of taxation, as you're very well aware, Minister Morneau is meeting with his provincial and territorial colleagues next week, I believe, and the issue of excise tax is certainly going to come up with respect to where the profits are going to be going, or where the monies collected are going to be going. That is a conversation that is ongoing with them as well. I don't know if my deputy minister wants to add anything to that.

Mr. Simon Kennedy (Deputy Minister, Department of Health): In terms of the minister's comment, tax policy matters are generally the purview of the finance department, so in those areas we defer to them. That would be a good question to raise with colleagues from the finance ministry.

The Chair: Time's up.

Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you for being with us, and thanks to your staff.

Minister, in 2009 the H1N1 flu virus caused 428 deaths in Canada. In response, the federal government mobilized an emergency operations centre 24 hours a day, seven days a week. This provided more than 6,000 person-days of assistance to help coordinate emergency responses across the country. Now, in comparison, we had 2,800 deaths in 2016 and 3,000 deaths this year from the opioid overdose crisis, yet only 113 person-days of assistance have been reported by the Public Health Agency of Canada, and that's to help write two reports.

In addition, during the H1N1 outbreak, the Public Health Agency of Canada spent $322 million on communications and advertising alone. In contrast, your government's total commitment to fight the opioid crisis is $123.5 million, and that's spread over five years.

Minister, given the longer, more entrenched, and more serious death toll of the opioid overdose crisis, why has your government's response been so substantially less than what was done for the H1N1 health crisis?

● (1600)

Hon. Ginette Petitpas Taylor: We've had an opportunity to discuss this one on one, and I'm happy that you bring up the question again today. We also have to recognize that the issue of the opioid crisis, as I've indicated in my earlier remarks, is quite devastating when you look at the numbers that are coming in right now. Again, with the report that came out from Ontario, it's very alarming to see the numbers that are coming up.

I have to say that our government certainly has taken steps so far in order to address the situation. When we formed government, one of the first bills that was brought forward was Bill C-37, a bill that really streamlined the application process to make sure that individuals had access to supervised consumption sites, and we recognized that saves lives.

Also with the issue of naloxone, we know that making sure that naloxone was a non-prescription type of medication that was available for people also saves lives. When the provinces and territories told us they were dealing with a targeted situation in their provinces, again, a specific funding was given to them. If you look at British Columbia, your province, they received an additional $10 million with respect to targeted funding and also, with respect to Alberta, they received some additional funding.

Just last month when I was in Calgary, we made some announcements. When we look at the Canadian youth substance abuse strategy that was put in place, we've also made some investments there as well to look at the issue. Again, when it comes to services that are on the ground, it's truly important to make sure that we continue to work with provinces and territories. The federal government absolutely has a role to play, and we certainly cannot be complacent when it comes to this crisis.

Mr. Don Davies: No, absolutely not.

Hon. Ginette Petitpas Taylor: It is absolutely for me, as I say, as health minister, my number one priority, and when I say this situation keeps me up at night, it really does.

Mr. Don Davies: Minister, the question was asking you to contrast why the federal government spent triple the amount of money on H1N1 than today, and I didn't hear an answer to that, but I'm going to move to medicinal cannabis. My colleague brought this up.

From a health perspective, we know that medicinal cannabis is not zero rated. Already medicinal cannabis users have to pay GST and HST. We know that most prescription plans in this country don't cover medicinal cannabis, so already men and women who are struggling already have to pay extra money for medicinal cannabis.

Ironically, opioids are covered by most plans and are zero tax-rated exempt. Ironically, patients are incentivized to pursue a riskier option, and that's even compounded by the fact that studies are now showing that medicinal cannabis is proving very effective at helping people wean themselves off opioids. It's clearly a flawed policy to make medicinal cannabis more expensive than opioids.

I'm just wondering, at the cabinet table, Minister, would you advocate, from a health perspective, to at least treat medicinal cannabis the same as opioids.

Hon. Ginette Petitpas Taylor: As the previous speaker indicated, with respect to tax policy, that's absolutely the Minister of Finance's area and the work that he is doing.

Again, next week the finance minister will be meeting with his territorial and provincial counterparts. I am certain this issue is going to be coming up. If the finance minister appears before the health committee, this would certainly be a question to be asked.

Mr. Don Davies: We know that the federal government covers the cost of medicinal cannabis for over 3,000 Canadian veterans. We heard testimony at this committee on September 14 from the first nations regional director Chief Isadore Day that the government does not cover the cost of medicinal cannabis for indigenous patients at all.

Can you explain that discriminatory policy to me?

Hon. Ginette Petitpas Taylor: To be frank, Minister Philpott's department has been working on that. Perhaps I could ask my deputy minister to address this question.

● (1605)

Mr. Don Davies: Minister, if I may, I want to direct my questions to you. I think we'll have the staff staying after, and we can follow up then. We only have you for an hour or so. I'll just defer that, if that's okay.

Hon. Ginette Petitpas Taylor: Sure, absolutely.

Mr. Don Davies: I want to move to prescription drugs. I want to read a passage:

> Prescription drugs....
>
> Our current system provides full coverage for institutional care, including all drugs administered during a hospital stay. Once patients go home, however, they are not guaranteed public coverage for medically necessary drugs.
>
> Although some public coverage is provided for specific groups and situations, prescription drugs have yet to be fully incorporated into provincial health insurance schemes. Many Canadians have limited drug coverage through their employers, but a full 12 percent of Canadians have no coverage at all for prescription drugs.
>
> This situation is plainly inconsistent with the values upon which Canadian medicare is based. It is both unfair and illogical to guarantee access to medical diagnosis but not to the associated treatment. Neither does it make economic sense. Those who cannot afford to fill their prescriptions tend only to get sicker and require more costly treatment later from the public system....
>
> Public coverage of medically necessary prescription drugs, as recommended by the National Forum on Health, would not only ensure universal access to treatment, it would also reduce the amount of money that Canadians are already spending on drugs....

The Chair: We need your question.

Mr. Don Davies: I'll get to that, Mr. Chair.

> These advantages include simplified administration, volume discounts for bulk purchasing, and improved monitoring of best practices in prescribing....
>
> A new Liberal government will pursue a strategy—together with representatives—

The Chair: We need a question.

Mr. Don Davies: —of provincial and territorial governments, health service providers, private payers (employers and unions), and consumers—to address the fact that drugs have become an essential component of health care. We will develop with these groups a timetable and fiscal framework for the implementation of universal public coverage for medically necessary prescription drugs.

Minister, I'm reading to you from the Liberal platform in 1997, promised by Jean Chrétien. We've heard the PBO report. It's already been shown that we can cover every Canadian and save $4 billion a year.

I introduced a motion in the House of Commons asking your government to start discussions with the provinces in the next 12 months, and you called that proposal “premature”.

Minister, can you explain to me, after 20 years of promising national pharmacare, what you are waiting for?

Hon. Ginette Petitpas Taylor: I'm assuming that most members on the health committee have read my mandate letter. I'm going to quote from it:

> Work with provinces and territories to:
>
> ...improve access to necessary prescription medications. This will include joining with provincial and territorial governments to negotiate common drug prices, reducing the cost Canadian governments pay for these drugs, making them more affordable for Canadians, and exploring the need for a national formulary....

When I had the opportunity and the privilege to meet with the ministers of health for the first ministers meeting, we were able to come up with a consensus that we all want to work on improving access to affordable medication for all Canadians. When we look at enhancing our health care system, we want to make sure that enhancing the affordability, the accessibility, and the appropriate use of prescriptions is absolutely mentioned in that.

The Chair: That's all we can handle.

Now we're going to go to Ms. Sidhu and I understand you're going to split your time with Ms. Ludwig.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Minister, for being here today.

Earlier this week, your officials were here, and we talked about the food guide and working on a healthy eating strategy. This is a very important issue. On the healthy eating strategy, how can we improve the health of Canadians? The obesity rate is getting high. How can we decrease obesity rates, especially in our youth?

Hon. Ginette Petitpas Taylor: Thank you so much for the question.

Another portfolio that I became quickly briefed on and versed in is our healthy eating strategy. As probably many of you are aware, last year the previous minister of health, Minister Philpott, launched the healthy eating strategy. Certainly some progress has already been made with respect to work that needs to be done.

When I look at the healthy eating strategy, I really look at three pillars, three areas in which work needs to be done. The first one is Canada's food guide, which I believe is the one you guys are studying right now. Another one is marketing to kids, and the third one would be front-of-pack labelling.

We recognize that as Canadians we are facing an obesity crisis, really and truly. One in three children are either overweight or obese. Two out of three Canadians are either overweight or obese. We recognize that what we eat certainly contributes to the chronic health crisis that we're faced with, as well as the level of chronic disease in our country.

We also recognize that as a government we're spending over $26.7 billion a year when it comes to chronic health conditions in this country, so work needs to be done.

With respect to our healthy eating strategy, we recognize that it's not the only avenue that will help address this health crisis, but it's certainly a step in the right direction.

When we look at the issue of Canada's food guide, I'm really excited to see the review that's under way right now, and I'm really looking forward to the results of the study you guys are doing, as well. We recognize that Canada's food guide is a bit dated now, but it's certainly a document that many Canadians use because it's the second most requested document from Canadians, so we certainly know that people still feel the value of having Canada's food guide.

What I would say is that we certainly have to make sure that our food guide is modernized and up to date. We live in a multicultural country right now, and there are many different diets out there, so it's really important to make sure the research is done. For Canada's food guide, I really see it as a model to be able to tell Canadians not what to eat but the types of things they can eat to get the nutrients they need. At the end of the day, that's really what the new version of the food guide is going to be all about.

With respect to the food guide, that's really the work that's being done there and I'm very pleased that the department, hopefully by mid-2018, will be able to give an update as to where we're at there.

● (1610)

Ms. Sonia Sidhu: Canada has a large population of seniors with varying health needs. I'm happy with the investment made in home care across Canada. Could you tell me what impact this has had and how else we are helping to support the health of seniors across Canada?

What steps are we taking to improve the health of seniors? Are we taking any more steps for an innovative health system? Can you tell me about that?

Hon. Ginette Petitpas Taylor: We've certainly heard loud and clear, when negotiations were under way last year about the health transfer payments, that when it came to seniors, long-term care services, mental health, and palliative care, they're certainly priority areas that Canadians are absolutely concerned about.

We were pleased to be able to provide some funding for providing home support care services to provinces and territories to allow them to really develop services and models that work best in their provinces and territories. We certainly don't want to have a top-down approach and tell them what to do, but if we can provide them with funding, then from there they can put in place what best meets their needs in that area.

We also recognize that seniors want to live longer in their homes, and we really have to make sure that the appropriate services are put there. Many of those responsibilities fall under the provinces and the territories, but providing additional funding for health care transfers can certainly help them and help the provinces and territories take the steps they need to effectively deal with the growing aging population we have.

The Chair: Okay, we now go to Ms. Ludwig.

Ms. Karen Ludwig (New Brunswick Southwest, Lib.): Thank you, Madam Minister, for being here today.

I actually have two questions. I'll give them to you up front. The first one is following my colleague's question on healthy eating. I'm wondering how much funding will be devoted to public awareness and education regarding the healthy eating strategy on an annual basis.

The second one is about Lyme disease. I was truly surprised this summer, after the federal government and the Province of New Brunswick partnered on the surveillance program, how little money it actually took to get results regarding identifying broader endemic areas. I'm wondering if you could also please describe the activities and incentives the Public Health Agency of Canada intends to undertake to raise public awareness and support education regarding Lyme disease, particularly in endemic areas.

Those are my two questions. Thank you.

Hon. Ginette Petitpas Taylor: Thank you very much, Ms. Ludwig.

With respect to the area of public education around our healthy eating strategy, no specific amount has been identified yet, but I can tell you that through the many consultations I've had with many of my caucus colleagues—actually, not just caucus but members of Parliament from all parties—and also hearing from many Canadians, we certainly know that providing tools for Canadians to make sure they can make informed decisions is very important.

We've also heard that the education component is very important. That is certainly something that we are prepared to look into when we look at our rollout of the strategy, making sure that some services are put in place there.

With respect to the issue of Lyme disease—I know that's a passionate area of yours—I may ask Dr. Tam to provide a bit of an update as to where we're at with respect to the surveillance results.

● (1615)

Dr. Theresa Tam: Public awareness and detection of Lyme disease is a really important aspect of the federal framework. As you've said, it may not cost very much, but you can actually do quite a bit by looking for positive ticks, for example, in the community and by partnering with different organizations, whether they be Parks Canada, family physicians on the front line, or patient groups. There have been some very good examples—you've just cited one of them—where partnerships really worked. In Ontario and Manitoba, Lyme patient groups said that has worked really well for them—how they've been engaged to increase public awareness of this growing issue.

At the Public Health Agency, we've been doing enhanced surveillance activities and also projections in climate data so that we can actually see where the frontier of Lyme disease is pushing into different areas of Canada. I believe that with this further funding support we'll continue to improve on awareness campaigns.

The Chair: Your time is up.

Now we're going to go to our five-minute round.

I have to say that we're a little long-winded today, so if you could all tighten up your questions and your answers, we'll all get another kick at the questions.

We've all been over.

Mr. Don Davies: Mr. Chair, I have a point of order on that.

The Chair: You're going to take up the time of the minister, you know that, right? You're taking it from everybody.

Mr. Don Davies: So be it, Mr. Chair. I have a point of order.

You interrupted my question three times when I was in my seven-minute time period, Mr. Chair. Now you have every right to tell me when I'm out of time, and you have every right to tell me that I'm nearing the end of my time. However, with respect, you have no right to try to censor me or cut off my preamble. I can use my seven minutes any way I like. I can speak for seven minutes if I want to. It is not for you to determine the length of any of our preambles or the timing of our question. It's a violation of my privilege as a parliamentarian and as a member of this committee.

With respect, Mr. Chair, we have five minutes, and you can ruthlessly cut us off at five minutes if that's your choice, although I would expect that you be consistent with everybody. But with respect, you cannot interrupt within the body of our time and tell us to ask a question at a certain point because you think the preamble is going on too long.

The Chair: You went nine minutes and 15 seconds on a seven-minute question.

Mr. Don Davies: Pardon me?

The Chair: You went nine minutes and 15 seconds on a seven-minute question. I just asked you to submit your question, but when I raised the issue, you were a minute over. You made a point of saying that the minister is only here for an hour and that we should all get our questions in. However, you're taking up time now, and you took much more time than you were allowed.

Mr. Don Davies: Well, Mr. Chair, then you should have told me that I was out of time.

The Chair: I did tell you to put your question.

Mr. Don Davies: That's not the same thing. I thought I was within my seven-minute time period—

The Chair: Well, you weren't.

Mr. Don Davies: —and you were urging me to get to my question.

All I want to make clear, Mr. Chair, is that we all have our time period and we should have our ability within that time period to put whatever preamble we want. That's all I want to make clear with the committee.

The Chair: You were far beyond your time period, but let's carry on. The minister has to go at 4:30 p.m., and we've wasted enough time.

Ms. Gladu, you have five minutes.

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Thank you, Mr. Chair. I'll be right to the second.

Thank you, Minister and staff, for being here today.

In budget 2016, there was $3 billion announced for home care. In 2017, that was expanded to $11 billion for home care, palliative care, and mental health care. My question for the minister is this. Can you tell me how much of that money has actually been spent, and can you give some examples of where it has gone, especially the palliative care part?

Hon. Ginette Petitpas Taylor: I am going to have to defer that, actually, to my staff, so my apologies.

Simon, would you be able to take that?

Mr. Simon Kennedy: I'm not sure, Minister, if I have the specific breakdown here. What I can say is that the $11 billion is over a 10-year period. The first-year payments have all been made to all jurisdictions. That was done in one of the two budget implementation acts. We're now in the final strokes of negotiating agreements to transfer the next tranche of money to every jurisdiction. We're hopeful to have some of those signed before the end of the year. The objective is to have all those signed before the end of March so that we can start flowing the payments for the second year as of April 1, which is a new fiscal year.

I can provide the details of the first year of money to the committee. They may be in my book, but I have to find them. I don't want to take up more time.

● (1620)

Ms. Marilyn Gladu: That's okay. You can send it to us. That would be great.

My second question is about the remaining thalidomide victims. There are not very many but there are a number whose cases are outstanding. I know that I've talked to the minister about this before. Could you give an update on when we plan to have those resolved?

Hon. Ginette Petitpas Taylor: Thank you so much, Ms. Gladu, for the question. You may or may not be aware, but last week I had the opportunity of meeting with one of the thalidomide survivors while she was in Ottawa. It certainly again provided me a good opportunity to hear about her situation and also the struggles that many survivors have to live with on a daily basis. The time that I spent with Ms. Sampson was very precious to me because she certainly shared with me her perspective and some of the needs that they have as well.

With respect to that, as you're aware, I'm sure, the thalidomide survivor contribution program is helping 122 Canadians at this point in time, and out of those 122 Canadians, 25 have been identified using the objective review process, so that was a step in the right direction. I recognize as well that the committee has put in place recommendations, because you've studied this at the committee level, and once again I'm looking forward to reviewing those recommendations.

Also, when I met with Ms. Sampson, I indicated to her that I personally want to look into this matter to see exactly what else can be done in order to effectively help individuals.

Ms. Marilyn Gladu: Another issue I wanted to bring forward was that there was a tainted-blood payout a number of years ago. The case was settled, and it came to my attention through some of the stakeholders that there's $65 million outstanding in the claim payments that are due to the people who were the successful claimants. I didn't know if that was on your radar screen so I thought I'd just put it out there.

If you know anything, let me know, and if you don't, then check it out and see what can be done.

Hon. Ginette Petitpas Taylor: I can check it. I could ask my officials as well.

Are you aware...?

Mr. Simon Kennedy: Yes, we're aware of that. There are two different settlements that were reached with regard to the blood issue, and for one of the two settlements there is a question as to whether there is sufficiency in the funding. I think some of the debate has been whether or not there can be a transfer from one of the funds to the other. I think the simple explanation is that these are independent settlements that are governed by the courts and there's no legal authority. These are settlements that were made 20 years ago, that actually are governed by a court process, and they're separate so there's no way to move money from one to the other.

But I know that issue has been raised previously.

Ms. Marilyn Gladu: Yes, it would be nice to get that resolved for the claimants.

With respect to the opioid crisis, I saw the numbers as well today showing a 68% increase in the opioid deaths in Ontario, and we know that B.C. was on the front lines of this, and 16 Canadians a day are dying from this. I heard about the amount of money that the federal government is putting forward, the $6.2 million, and then some of the payments that went to the different provinces, but when I compare that with the $500 million that the government is spending to legalize marijuana, it just seems like those two are perhaps not in balance.

Minister, what are the actions being taken in the opioid crisis to prevent the drugs from coming into the country, to prevent the over-prescription of drugs, to make sure our first responders are well protected, and to invest in treatment to get people off drugs ultimately?

Hon. Ginette Petitpas Taylor: When we look at the situation that we're facing right now, absolutely, as indicated, we are certainly faced with a public health crisis when it comes to this situation. Again, when I heard the numbers this morning, it is devastating to see the number of lives lost in this situation.

We cannot minimize the actions that our government has taken to date with respect to regulatory changes and also the issue of Bill C-37. Once again, providing access to individuals to supervised consumption sites saves lives. We know that. Also, ensuring that naloxone products are readily available to individuals as well saves lives.

Also, with respect to the changes made with respect to providing provinces and territories with the opportunity to open overdose prevention sites, that was an announcement that I made, I believe, about two weeks ago. When we met with the health ministers at the meeting in October, some provinces had indicated that they thought it would be appropriate if the provinces had more powers. Again, they're closer to their constituents and they know what's going on on the ground. We took that back, and just two weeks ago we indicated that we were prepared to look at providing class exemptions to provinces if they choose to open overdose prevention sites.

There is a difference between an overdose-prevention site and a supervised consumption site. Sometimes we talk about these terms and people aren't aware of the difference. On the supervised consumption site, when they choose to apply, the municipalities or the areas will get in touch with Health Canada and then from there the licensing will go through that department. It can take a bit more time.

When it comes to overdose prevention sites, however, we can certainly go through those requests in a very timely fashion. Minister Hoskins got in touch with us yesterday, and just today we were able to approve a class exemption. From there, the Province of Ontario will be able to determine what services need to be put on the ground in order to provide services to the individuals in their community. At the end of the day—

● (1625)

The Chair: We have to move along.

Mr. McKinnon, you have five minutes.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you, Chair.

There have been media reports that law enforcement is still unaware of the Good Samaritan Drug Overdose Act, which became law in the spring, so that they've charged people with possession by accident, only to have the charges reversed. Everyone who assiduously hung on every word of my member's statement earlier in the House will know that today the Canadian HIV/AIDS Legal Network and the Waterloo Region Crime Prevention Council released a wallet card and fact sheet funded by the the Law Foundation of Ontario. This information will be provided to people who use drugs; service providers and volunteer organizations serving people at risk of, experiencing, or witnessing an overdose emergency; and stakeholders in health, social services, government, and law enforcement across Ontario.

Minister, can you explain what efforts Health Canada is undertaking to promote the provisions of the Good Samaritan Drug Overdose Act more broadly across Canada, so that drug users and law enforcement are well informed?

Hon. Ginette Petitpas Taylor: First, I have to congratulate you on bringing this bill forward. If my memory serves me well, we had unanimous consent. It passed with flying colours. We certainly recognize that there's a need, so job well done.

Earlier on in the year, I was in Kelowna, British Columbia. I was visiting my first supervised consumption site. As I was there speaking to the nurses, I see a poster that talks about your bill exactly. We see that the word is getting out there and we certainly need to make more efforts to ensure that Canadians are aware of this legislation.

To answer your question, I can say that Health Canada is working with partners, not only law enforcement officers, to inform Canadians of this new legislation. We've done so by using social media, public spaces, and also web content. We certainly want to continue the work because it's a really important piece of legislation. As you've indicated, we truly want to make sure that there are no barriers for people to call 911, if it's about saving a life. At the end of the day, we will continue to make sure that our front-line service providers and Canadians at large are aware of the regulations.

Mr. Ron McKinnon: Thank you, Minister.

Health Canada, Canadian Institutes of Health Research, and the Public Health Agency of Canada are requesting approximately $11.8 million in supplementary estimates (B) to support the Canadian drugs and substances strategy, which will support harm reduction activities, public education, expansion of drug science, monitoring activities, and research.

Can you explain why there is a need to expand drug science and how it will be expanded as a result of these funds?

Hon. Ginette Petitpas Taylor: Absolutely. I'm very pleased to take this question.

Having been in Alberta not that long ago, we were able to meet with many individuals, especially individuals with lived experience. They shared with us their personal stories and their challenges, but also what worked and what didn't work for them. With respect to the investments that we're making in health research, we really want to look at pilot projects or programs that are happening on the ground and from there, to find out what the best practices are. If we can learn from those best practices, we may be able to adapt them in other parts of the country.

It's truly important to ensure that we get the data because if we don't have a scope of the situation, we're certainly not going to be able to effectively deal with it. Investing in research is paramount and it's certainly a priority of our government.

● (1630)

Mr. Ron McKinnon: Thank you.

Under the Canadian drugs and substances strategy, what proportion of these funds will be made available to support increased availability of treatment options?

Hon. Ginette Petitpas Taylor: For the strategy itself, $100 million has been earmarked. With respect to the actual breakdown, I may defer that to Mr. Kennedy.

Mr. Simon Kennedy: Regarding the additional funding coming in this year for the drugs and substances strategy, we have a program called the substance use and addictions program, which has funding of about $28 million a year. There is additional funding that comes in over the next number of years, as part of the strategy, to top up that program.

On top of the existing dollars, which are permanent this year, the additional funding is $2 million, with another $2 million next year, and then an additional $3 million ongoing. Through that program, that's extra money that we'll be putting out for piloting innovative treatment projects.

Mr. Ron McKinnon: Thank you.

The Chair: Your time's up.

Minister, are you good for another round of questions?

Hon. Ginette Petitpas Taylor: I've just been told I have another —

The Chair: You were to be here until 4:30. That was our understanding. It is 4:30.

Hon. Ginette Petitpas Taylor: If I receive another invitation, I'm more than happy to come again.

The Chair: All right.

Thanks very much for coming. We appreciated your answers.

We'll go to Mr. Van Kesteren, for five minutes.

Mr. Dave Van Kesteren (Chatham-Kent—Leamington, CPC): Thank you, Chair.

I'm sorry to see the Minister go because I had some really important questions for her.

I wanted to talk about Bill S-5 and the plain packaging. I sometimes wonder who would want to smoke when they see the proposed new packaging. It's a great approach. I think it has been effective. I think we have done a great job as a society to reduce the harm in smoking.

In light of that, I'm wondering if Health Canada is going to do the same thing with the marijuana packaging. One of your own Health Canada reports states quite emphatically that no one under the age of 25 should use this product.

Would that be part of the new packaging we will be seeing when marijuana is put out for public sale on July 1, 2018?

Mr. Simon Kennedy: This is one of the areas where we are out for consultation right now. We put out for discussion a fairly detailed regulatory consultation paper about two weeks ago, and the consultations will proceed until late January. There's a lot of detail in there about what the government has suggested as the restrictions that would be placed on marketing and advertising.

Generally the intention and the scheme that's laid out in the proposed paper is to take a fairly strict approach to marketing and branding and so on with cannabis. Certainly there would be extraordinarily strict provisions for people who are not of legal age to consume it.

The details are in the paper. At this point, obviously, we haven't gone out with final regulations, but that's part of what we're talking about to Canadians and the industry and others.

Mr. Dave Van Kesteren: Will some of that packaging warn about driving once somebody has smoked marijuana?

Mr. Simon Kennedy: I don't want to get out in front of the government, but the intention is to have appropriate warning labelling, if you like, health information and so on. That would be a requirement that would accompany the sales of these products.

Again, there is going to have to be consultation, sir, before that's finalized, but the idea would be to make those kinds of warning messages available as part of the packaging.

Mr. Dave Van Kesteren: Will there be a direct effort to get this out of the hands of teenagers or younger people because that same report that came from Health Canada states that the younger the smokers, the more likely they are to become addicted to it?

Will that be part of the packaging as well?

Mr. Simon Kennedy: I think the general intent of the regulatory scheme and the work that Health Canada is certainly doing in partnership with other departments to get ready for the legalization of cannabis is that all of this is being undertaken with a public health approach in mind. Our organization is certainly well aware of and seized with the research around the potentially deleterious effects on young people.

If you take tobacco as a good example, there has been very good success over the last 20 years through a strict regulatory approach of driving down usage rates quite substantially to the point where you see instances with young people where the usage rates of things like cannabis are now higher than the usage rates of tobacco.

To be quite frank, our hope would be that a very strict regulatory approach, with the kinds of restrictions we're talking about, would render it more difficult for children and youth to get access to it, with the objective of driving down usage rates.

● (1635)

Mr. Dave Van Kesteren: Will you disallow cannabis marketers to target younger users as has been done, and rightfully so, with cigarettes as well? Will that be part of your focus as well?

Mr. Simon Kennedy: It might be prudent to offer the committee that we could provide a more detailed written response to your questions. It's not to dodge the question, but I think it almost merits a more detailed response than I feel confident to give.

The very clear objective here is to strictly prohibit and avoid directing this kind of stuff at people who are not of legal age. Where that age—19, 18—has been fixed by law by a provincial jurisdiction, below that there would be very strict prohibitions and efforts made to ensure that product does not make it into the hands of those young people.

It might be useful to come back with a little more verbiage than I could give in this discussion.

The Chair: Your time is up.

Mr. Dave Van Kesteren: You're very strict with me, Mr. Chair.

The Chair: You're beyond, but not as far as some others.

Now we'll go to Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you very much.

My first question is around health research and whether we are making adequate investments in health research and support to CIHR. We've heard from virtually every study we've done that research is required. On antimicrobials, we heard how important it was. Because the pharma companies were not investing in that, there had to be investments made for antimicrobial research. On the cannabis bill, we heard about the need for research now around cannabis, its health effects, and the longer-term consequences of it. On the opioid study, we heard from virtually every person that there was a need for treatment, and research into treatment protocols and directions, yet I didn't see where you sit on research, Mr. Kennedy and Mr. Perron.

Do you feel that CIHR is adequately funded? I have to say that the majority of groups that come to see me do not feel that there are sufficient funds through CIHR and the other granting bodies to cover the degree of research that's needed.

Mr. Michel Perron (Executive Vice-President, Canadian Institutes of Health Research): Thank you, Mr. Oliver, for the question.

Clearly, with regard to the supplementary estimates that this committee is examining, we were delighted to receive an additional $5 million, which has gone to some of the items that you indicated. One is the funding for the Canadian drugs and substances strategy, which the deputy referred to earlier. This is very much to address many of the issues specific to the opioid crisis.

This is in addition to our annual grant funding level of approximately $1.1 billion in available authorities. This is a significant amount of money that we try to invest as wisely as possible, given the very significant expectations and pressure on health research generally in the area of antimicrobial resistance that you referred to. For instance, in the past five years, we've spent well over $100 million in AMR research, an average of $22 million a year. We work very closely with the Public Health Agency and the like.

With regard to opioids, I would just indicate that many of the investments recently—whether through the Canadian drug strategy or our funding more generally—are to provide clear evidence of what works best in what setting and to provide the direct kind of clinical guidance required for clinicians and first-line providers to ensure that those efforts are well done. For instance, there's a study under way right now to evaluate models of care. Is it methadone or —

Mr. John Oliver: I understand that some research has been done.

Correct me if I'm wrong, but I think the overall transfer to CIHR is about $1 billion, and you had a $5-million increase. Is that about right?

Mr. Michel Perron: That's correct. It's $1.1 billion annually, with a $5.5-million increase for the—

● (1640)

Mr. John Oliver: It's interesting. We heard from one of the researchers from McMaster who said that after he had made a discovery of a new possible antimicrobial agent in some fungus in some soil from Nova Scotia, they needed $600,000 to bring it to market. They couldn't do it because, in 2014 or so, they weren't able to secure funding. Most of his graduate students—I think he said all —are leaving for the U.S.

I'm worried that we're losing our research, but more importantly, we're losing our capacity, our next generation of researchers, because we don't have adequate funding. Do you have a sense of what's needed as an investment into CIHR to regain our leadership role in health research in Canada?

Mr. Michel Perron: Specifically to the matter that's raised, I can underscore the importance of early-career investigators and the pipeline of researchers. That is a very significant area of attention for ourselves. We've directed an additional $20 million per year specifically to ensure that those young investigators have a chance to get into the health research system and to go forward.

As members here may well know, there was a fundamental science review undertaken that was tabled with Minister Duncan, which Ministers Petitpas Taylor and Duncan commented on recently in terms of some improvements to the coordination of the Canada Foundation for Innovation and the tri-agencies comprised of CIHR, NSERC, and SSHRC.

We know that the amounts tabled in that report are very significant, and underscored by a number of fairly in-depth analyses that we know the government is examining now. We'll wait for further information as that unfolds.

Thank you.

Mr. John Oliver: I have a really quick question for Mr. Kennedy.

In the minister's new mandate letter, there is a requirement that she review the need for a national formulary. Where do you stand on the issue of the requirement of a national formulary, and how would you undertake that review?

Mr. Simon Kennedy: We're doing work with the provinces and territories now to look at issues around a drug formulary. This is obviously a big policy question that all governments have to grapple with, so I can only speak as an official about some of the possible efficiencies. Certainly, there are a number of aspects to a formulary. One of them is what drugs are on the formulary. Almost more importantly, what are the conditions of access? What conditions are actually authorized by the province or territory for access to the drug?

In the work we've done, one of the things we discovered that's actually quite complicated, if you like, is that it's not just a matter of comparing what kinds of drugs are available in each jurisdiction, but under what circumstances the payments will be made.

If we could advance that kind of work and start to have greater harmonization of the drugs available and the manner in which they're used, the conditions of access, that would start to make it a lot easier to have joint negotiations to move forward in a common way to procure these kinds of products. There's a lot to recommend. Working with the provinces and territories to try to have a more harmonized approach, I would say, might be a way to respond.

The Chair: Your time's up.

Okay, Mr. Davies, you have three minutes.

Mr. Don Davies: I'll try some short snappers.

I'd like quick answers, if I could.

The mandate letter mandated the minister right from the beginning of this government to reduce drug costs for Canadians. Have drug costs for Canadians come down?

Mr. Simon Kennedy: I think what I would say to that is that there is a very ambitious agenda. We feel there is very good analytical evidence to suggest that once the measures that have been proposed are in place—and we just had draft regulations gazetted for the Patented Medicine Prices Review Board—they will lead to meaningful reductions in drug prices.

Mr. Don Davies: Mr. Kennedy, I have another short snapper.

They haven't come down yet. Would that be a fair comment for me to say?

Mr. Simon Kennedy: I think what would be fair would be to say that developing the changes to the way in which drug pricing is managed in this country, and the way in which purchasing and all the various machinery that's actually involved in the pharmaceutical system.... That's a significant undertaking. We're well under way, but it's going to take some time to see the impacts.

Mr. Don Davies: I'll try a third time. Have drug costs come down today from where they were two years ago for Canadians?

Mr. Simon Kennedy: Drug costs have certainly come down in a variety of areas. I have my own experience, for example, at Health Canada, where we manage a fairly large drug plan for first nations and Inuit. I can tell you very forthrightly that our joining the pan-Canadian pharmaceutical alliance has actually led to meaningful reductions in the prices we pay for some of the pharmaceuticals by virtue of the work we're doing with the provinces and territories.

Mr. Don Davies: Okay.

With regard to indigenous health, the Prime Minister has famously said that it's the most important relationship to him. The state of health among indigenous people in Canada, I think we can all agree, is greatly concerning. In response to the 2015 spring reports of the Auditor General of Canada, report 4, "Access to Health Services for Remote First Nations Communities", Health Canada pledged to conduct a comparative analysis of access to health services in remote first nations communities and non-indigenous remote communities. Health Canada set a deadline of summer 2016, but we learned last spring at main estimates that this report was never, in fact, written.

Why wasn't that report written?

● (1645)

Mr. Simon Kennedy: I'm sorry, I'll have to maybe defer that—

Mr. Don Davies: Get back to us?

Mr. Simon Kennedy: No, I think that's a question that would be better directed, actually, to the ministry of indigenous services. By order in council—

Mr. Don Davies: It was Health Canada.

Mr. Simon Kennedy: Yes, but by order in council, now the first nations and Inuit health branch is actually no longer the responsibility of Health Canada, and I'm no longer the deputy head responsible for the organization.

Mr. Don Davies: Okay.

Mr. Simon Kennedy: I'd be answering for a colleague at this point.

Mr. Don Davies: If I have time.... With regard to Bill S-5, we know that every day we wait on plain-packaged tobacco, young Canadians start smoking, get hooked, and will die—every single day. Why is Bill S-5 languishing on the Order Paper?

Why aren't we moving forward with Bill S-5 when every day counts?

Mr. Simon Kennedy: That would be a question probably better put to parliamentary officials than to bureaucratic officials. What I can say is that we're doing a lot of work to get ready for the eventual deployment of regulations once the bill passes. I would say that I could give assurance to the member, just in terms of the parliamentary process, that it's not slowing down the work in Health Canada to prepare for the eventuality of this legislation coming into place.

Mr. Don Davies: I'm sure I'm out of time now.

The Chair: You have 15 seconds.

Mr. Don Davies: Is the federal government giving any direct funding to overdose prevention sites in Canada?

Mr. Simon Kennedy: The funding we would be providing would be funding that we would be providing, as the minister explained, to provinces and territories. They, in turn, would be making those sorts of allocation decisions.

Mr. Don Davies: There's no direct funding.

Mr. Simon Kennedy: Not that I'm aware of, sir, no.

The Chair: Okay, your time's up.

Thank you very much, everybody. That concludes our session.

We're going to suspend for a few minutes and then go into committee business.

Mr. John Oliver: I have a point of order, or I think it's a point of order. I want to reflect on the sort of boondoggle we had in the first hour with the minister in terms of timing of questions. With the questions we have, the way they time out, and the 10-minute introduction, we have, within one minute—if people respect it—sufficient time for everybody to have their questions asked and answered. That's if people respect it.

To be fair to you, Mr. Chair, I know that generally as a committee we're pretty relaxed on this. We often have time left over, so you're very lenient, and sometimes you let people ask their questions after their minute, their time frame, is up, or you let the person responding go on, because they're good questions, we want to hear the answers, and we're interested.

But when we have the Minister of Health here and we have exactly one hour, I think it's important that you keep everybody to their exact time frame. We had one member who framed a question almost 30 seconds after their time ran out. We had another member who framed a question a minute and a half after their time ran out. We had another member who framed a question exactly as their time ran out. We were almost 15 to 18 minutes short of time. Mr. Davies' point of order was not that long. He was on his point of order for maybe two minutes. We really lost close to 15 minutes of committee questioning for those who didn't get on, because there were two five-minute blocks and a three-minute block that didn't get up.

When the Minister of Health or any minister is here and we have a one-hour time block to pose our questions, I'm going to ask that you keep us rigorously to those time blocks. If members want to make a long statement, great, but they're not going to get an answer.

The Chair: That's their time.

Mr. John Oliver: Their time has gone to their statement, and they can pose a question at the very end. I've been at other committees where the chair says, "Sorry, time's up. There's no time to answer the question", and we move on.

For these important sessions where we have a minister at the committee, we all have things we want to ask and talk about, and I think you need to keep us to our time blocks.

The Chair: Just to answer that, we've previously discussed this. My policy is that if there's time left for a member to ask a question.... I never allow a question to be asked after the time is up, but if there's time left, I let the question be asked. Mr. Davies started his question within his time, but it was a long, long question and that took a lot of extra time. He's not the only one—

Mr. John Oliver: That goes to my point. I think that in these—

The Chair: I know. I hear you.

Mr. John Oliver: I understand that's your practice—

The Chair: I'm at the will of the committee. It's if you want me to, however you want me to do it.

I have found that has worked, but I agree today that it didn't work. If the minister is here and we only have an hour, then I'll keep at the time, if that's the wish of the committee. I think it's a good suggestion.

Mr. Davies.

Mr. Don Davies: Thank you.

I want to somewhat apologize, because what I thought, Mr. Chair, when you were interrupting me was that I was still within my seven minutes. That's what I thought.

I have been at other committees where the chairs—you've never done this—try to interfere with the questioning by directing. I have actually had chairs say, "Put the question, put the question." I was standing up for the principle that each member of this committee can do what they wish with their time, and that's on all sides of this.

I was going to say that I think you've done an excellent job in using your judgment, and I think everybody goes over.... Every single member of this committee has gone over at one time—

The Chair: Like today.

Mr. Don Davies: —or the witness has been allowed to go over. You've been very fair about that.

What I would say is this. Quite honestly, I think the minister should be asked to come for two hours next time, not one hour. Surely the Minister of Health has two hours every six months for the Standing Committee on Health. I would rather see that happen so that members would actually have a chance to put their questions more fulsomely to the minister.

Some of my questions to the very able staff quite rightfully were deferred, as in, "You should have asked that to the minister." I would like to have the chance to put those questions to the minister. The next time we ask the minister to come here, rather than try to truncate seven minutes or three minutes, I would rather ask the minister to come for two hours.

Finally, what I would say is that I also think the practice of the minister asking her officials to answer questions when she's here is inappropriate, because the staff usually stays after. Usually they stay for the second hour. That's when we have a chance to direct our questions to the departmental staff, but we only have limited time to put our questions to the minister. If the minister doesn't want to answer or wants to defer it to later, that's her prerogative, but to have our time taken up with the minister deferring to the ministerial staff takes the five minutes or seven minutes and makes it even less.

Those would be my suggestions.

● (1650)

The Chair: The last thing the minister said was that she'd be glad to come back any time, so when we invite her back, we can ask her to come back when she can have two hours, if that's the wish of the committee.

Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair.

On that same point of order, I want to say that I enjoy your usual collegial latitude with respect to the way we answer questions, and I would just provide some sage wisdom that I gained on the status of women committee. I found that over time the more latitude that was provided, the more likely it was that people were going to ask a question with zero seconds left, so that they could then hear the answer. Sometimes we began to chop them off at the knees and not allow the answer if they used up all their time asking the question. That could be a tactic you may enjoy.

The Chair: I'll take that under consideration.

Mr. Oliver.

Mr. John Oliver: I just wanted to be clear again regarding the way we normally run our committee process and the latitude you show. You're fairly generous with people answering once the question is put. That's fine for our general purposes, but when we have a time-limited window with our main minister, then I think the rigour of holding answers and questions to it.... Most ministers generally come to committee for an hour. I think that's generally the rule. We've only had our minister here for one hour.

What I would like to see is a full round of questioning with the minister and then a full round of questioning with the executive branch and the others, so that we can do one round with one and one round with the other. That would be a more robust approach.

The Chair: I found the answers long today too, not only the questions.

Mr. John Oliver: You had to cut the answers.

The Chair: Mr. Van Kesteren.

Mr. Dave Van Kesteren: Thank you, Chair.

One simple solution, when we know we have the minister for one hour, would be to just get a consensus to go to five-minute rounds. Part of the problem is the seven-minute rounds.

You do a great job, but you're absolutely right, oftentimes the answers get a little long. Maybe at the beginning of the meeting we could just remind everybody that opening statements, whatever they are, would be followed by questions and answers, and that we're trying to stay within five minutes. Whoever is answering the question sees the clock there as well. It's just co-operation between everyone, but if we went to five minutes—if we had that consensus —that would free up enough time that everybody would have time.

The Chair: We have established a set of rules, but if we're going to change them we have to do that through a proper—

Mr. Dave Van Kesteren: Before the meeting...yes.

● (1655)

The Chair: Mr. Davies.

Mr. Don Davies: I would add just one point, and that is that we have to recognize there are two tangoing here, so it's not just the questioner. It is the answerer as well. The thing is, if you tighten up and get strict on the time period for questioning, then what will also happen is that we, as questioners, will tighten up on controlling the long, rambling, and sometimes completely unresponsive answering of the minister. That also has to be noted as well. I asked several questions that the minister simply did not answer. That's her prerogative, or maybe she decided to give an answer she liked.

The Chair: I don't know if you noticed, but the witnesses we've had that answered the shortest were the RCMP and the police. They are very short with their answers.

An hon. member: Just give me the facts, madam.

The Chair: That's it.

We got the message. The chair has the message.

Yes.

Mr. Simon Kennedy: Mr. Chair, I wonder if you might indulge me. I found a figure that Ms. Gladu asked for. I could read it into the record now, which would avoid my writing to the committee later.

The Chair: Fire away.

Mr. Simon Kennedy: The figure that the government has put into home care in the current fiscal year is $200 million. The total amount for home care, mental health, and so on is $300 million. That money ramps up over the next 10 years, but the initial amount is $200 million this year.

Ms. Marilyn Gladu: Does that include palliative care?

Mr. Simon Kennedy: Palliative care would be within the home care amount of $200 million.

Thank you.

The Chair: We're going to suspend now for a few minutes. Then we'll come back and go into committee business, which we've already been in now for about 10 minutes.

● (1655)

(Pause)

● (1655)

The Chair: Okay, let's reconvene.

On our committee business, we have Mr. Davies' motion.

Before you get carried away or anything, Mr. Davies, I'm just going to read the motion so everybody knows what it is. I'm going to make some comments, because I've had discussions with the chair of the indigenous affairs committee, and even today we learned some things both from Mr. Kennedy and from the minister's statement.

The motion is:

> That the Standing Committee on Health study the status of health and health care within Indigenous communities in Canada, including status, non-status, on-reserve, off-reserve and urban Indigenous populations, with the objective of better understanding the particular health care needs of this population, the gaps in service delivery, review the effectiveness of the First Nations and Inuit Health Branch of Health Canada, and report its findings to the House.

I've had discussions with the chair of the indigenous affairs committee, and they intend to do this. They've done two studies already on it, and they want to continue. This is the third study.

Also, Mr. Kennedy just said a minute ago.... He wouldn't even answer a question about indigenous health, because that's all over to indigenous health. In her opening statement, the minister said, "Therefore, significant funding associated with indigenous programming included in these supplementary estimates will now fall under the purview of Minister Philpott." It sounds like indigenous health is moving to the Minister of Indigenous Services.

Those are just my comments.

Mr. Davies, go ahead.

● (1700)

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

I want to briefly review a bit of the record. I am going to quote from the meeting on February 17.

You said:

> On another issue, I agree with Mr. Davies on indigenous health. It's come up from some members in talking to me. I haven't had any direction at all from the minister, by the way. I've not had one ounce of direction from the minister on this, and I'm pleased that we haven't. Eventually we will have, because there will be legislation, and hopefully she'll come here and make a presentation and tell us her direction, but nobody is trying to direct this committee. We're on our own, and I hope we stay that way. I appreciate that.
>
> I did talk to the Minister of Indigenous and Northern Affairs because the aboriginal issue had come up, and I wondered if it would be a problem for her if we did this. She said, "No, I'd love you to do a study on aboriginal health." Just to let you know, she said that to me, and I was very pleased to hear it.

That was February 17, 2016. On February 22, 2016, our subcommittee met, and that's where we prioritized some issues. We came back with five issues, which included pharmacare, antimicrobial resistance, community care, blood supply, and one other issue. We've done all of them except home care and aboriginal health. On March 7, 2016, this committee adopted the subcommittee's report, formally adopting those five priorities. There is no question that this committee has already adopted the priorities we set forth.

On the question you raised about whether we can or should undertake this study, as you have long stated—and very correctly, Mr. Chair—in these committees, we are masters of our own affairs. We don't take direction from anybody—not the minister, not other committees. There is nothing that prevents us.... I think it's important for my colleagues to understand that whether or not any other committee is studying something, that's not a barrier to our undertaking a study if we want, although it might be instructive.

Number two, I checked with Charlie Angus, our critic, and he told me that no motion has been made before the indigenous.... You said you spoke to the chair of the committee, Mr. Chair, but—

The Chair: She is my seatmate.

Mr. Don Davies: —my understanding, unless I'm mistaken, is that no motion has been made before the indigenous affairs committee to study aboriginal health. We have an outstanding motion that has been here for quite a long time.

I wanted to mention one or two other things. Mr. Oliver mentioned a couple of concerns last time. He was wondering whether we were duplicating what the indigenous affairs committee studied up to now.

I have a copy of its report, “Breaking Point: The Suicide Crisis in Indigenous Communities”. The focus of the report was on suicide. I think the committee did look at some of the social determinants around that, for sure, but it was not looking at broad health indicators of indigenous people in this country at all.

The second concern was whether the federal government has jurisdiction over indigenous people when they're not on reserve. I could find the actual information, but my understanding and information is that absolutely the federal government retains jurisdiction over indigenous Canadians wherever they are in the country. So I don't think those are barriers.

The final question remains of whether we should do it.

I think I mentioned last time that the average life expectancy of first nations people in Canada is five to seven years less than the Canadian average. That is the number one health indicator: life.

Number two, the rates of tuberculosis are 37 times the national average. In terms of mental health issues, the suicide rate among indigenous people is five times higher. We know that there are chronic problems with diabetes, with obesity, and with a range of health issues that arise from living in poor housing and not having access to clean water.

The Prime Minister has said that no relationship is more important to this government than that with first nations. I would like to take him at his word on that.

I think that, as a health committee, if we're looking at studying health in this country, we should start with the single largest group with the biggest challenges facing their health and start to tackle the causes of this, broadly speaking, the real experience that they're having, and what recommendations we can make to the government to address them, as the health committee. I would respectfully suggest that it is our number one priority as a health committee, and we have many important issues that come up.

As I said last time, this committee has done zero travel. We have not left Ottawa. I don't think you can understand real health care problems in this country without actually getting into communities and experiencing it a bit. Particularly, that's the case in first nations communities.

Just at the last meeting, we had representatives of the health department tell us that the oral health of first nations is quite appalling. We know that studies were ordered to be done within the health department that looked at comparing services indigenous people have in remote communities versus other non-indigenous communities in remote communities. They weren't done.

I was really disturbed to see a report today of a young woman who committed suicide in Attawapiskat. She was 13 years old. Leaving aside the suicide and mental health component of it, when you read the story of this young woman, this young girl, it's an absolute microcosm of everything wrong with the health care system and indigenous people in this country. She lived in a house with 20 people. There was a mould problem in the house, and she had asthma. It was exacerbating her asthma. The sewage system backed up, so they were living in this house with the smell of raw sewage, which impacted her health in other ways. She was not able to access health care for her specific conditions. All of this led to a situation of despondency and depression, causing her to take her own life. I don't think that story is uncommon.

For all those reasons, this committee's prioritization, the priority the government has given to indigenous health, the crying need in this country to study....

● (1705)

Even if, by the way, the indigenous affairs committee does choose to study some aspects of health, I don't think that's a reason for us not to do it. Perhaps we can even join in some way. We could coordinate our services, because it's such a broad area that neither committee is going to be able to cover everything in health.

I'm sure the indigenous affairs committee will be looking at other things, perhaps the legal structure, perhaps constitutional issues, perhaps provincial or federal.... They could be looking at other areas that are specifically of interest to the indigenous affairs committee that we wouldn't be looking at as the health committee.

I'm going to ask my colleagues to support my motion that you've already read out, basically to study indigenous health in Canada as our next major study undertaken by this committee.

Thank you, Mr. Chair.

The Chair: Dr. Eyolfson.

Mr. Doug Eyolfson: I agree wholeheartedly with the need for the study. I flew with air ambulance for 13 years and spent a lot of time going to remote northern communities. I've seen the appalling conditions that this population lives in and the state of the health and all the other services available to them.

However, what exists now, which did not exist when we first brought this up in February, is that there is a new ministry to deal with all of these services, the all-encompassing services. From chair to chair of the committees, that committee has expressed an interest in doing that.

I'm not saying this would be a barrier to it, but it may be an unnecessary duplication of services. Should their study start and it turns out that there is something that they are unable to do, or find that it would be best suited for us to do, then we could revisit this topic. But right now, I think given what has been stated from the chair of the indigenous affairs committee, the indigenous affairs committee is the most appropriate committee to study this.

● (1710)

The Chair: Mr. Davies.

Mr. Don Davies: I'm not 100% sure of it, but I'm pretty sure—and I stand to be corrected by this chair or the clerk—but for the new ministry that is headed by Dr. Philpott, which is handling that part of the health aspect of indigenous affairs, I don't think there is a ministry there and I don't think there is a committee.

As far as I know, Health Canada—and maybe the analyst can help us out with this—is still responsible for the delivery of health care to indigenous people. If it's not Health Canada, where has it gone? I don't think there is another department and I don't think there is another parliamentary committee?

Can someone help me understand that aspect?

The Chair: I can't help you. First of all, I haven't talked to anybody except the chair, who is my seatmate. I am really proud that in our committee we determine our own agenda. Nobody has talked to me, or I haven't talked to anybody other than the chair of the other committee.

Those are good questions, but I do.... Mr. Kennedy just wouldn't answer a question on indigenous health care because he said that's now in the indigenous portfolio. He just did that a minute ago. He wouldn't answer the question.

I don't know. I can't answer the question.

Mr. Don Davies: If I just might, Mr. Chair, it was unclear to me. First of all, one answer by a bureaucrat to one question should not be enough to derail our committee. I was unclear where that.... He was deflecting a question to some other department. I'm not quite sure, but I'm pretty sure that health care for indigenous people in this country has not been now delegated to the ministry of indigenous affairs.

I know there has been a split in terms of services. In fact, I'm not even quite sure what the split is in the government's indigenous affairs, but I don't think that health care has been taken away from Health Canada.

The Chair: I'm with Dr. Eyolfson on this. I do think a study should be done, whether it's us or the other committee.

Here is what the minister said in her opening statement. I underlined it when she read it. She said, “significant funding associated with indigenous programming included in these supplementary estimates will now fall under the purview of Minister Philpott.” These are health dollars under the Minister of Indigenous Services.

Mr. Don Davies: I am only finishing this. I realize there are other people to talk, but it's on the same point, Mr. Chair.

Yes. That may be, but Dr. Philpott is not the minister to whom the indigenous affairs committee reports, I don't think, and she has no ministry or department. It's a bit of a fuzzy area there.

The Chair: Mr. McKinnon.

Mr. Ron McKinnon: I was just going to comment that what I heard the deputy minister say was that an order in council or a memorandum had been signed that did, in fact, transfer this over to this other new ministry. As well, it is my understanding that the indigenous affairs committee doesn't report to a minister—and of course the minister reports, if anything, to the committee—but it will be related to that new ministry.

I'm very comfortable with what Dr. Eyolfson said and the priorities you mentioned from back in February of 2016. I wasn't here at the time, but the terrain has shifted since then. We have a new ministry. I'm very comfortable giving them the lead on this and seeing where they take it. I agree that it's an important study, but I will be voting against the motion.

The Chair: Seeing no other voices, I'll call a vote.

Mr. Davies.

Mr. Don Davies: I don't want to put the analysts on the spot, but can they give us some information about where the responsibility for indigenous health falls now, from a departmental point of view?

● (1715)

Ms. Marlisa Tiedemann (Committee Researcher): I haven't seen anything on the government website in terms of a specific announcement, but in media reports they did say the FNIHB, the first nations and Inuit health branch, has been transferred from Health Canada to the new ministry.

Mr. Don Davies: Okay.

The Chair: Can I have a show of hands for all those in favour of Mr. Davies' motion?

(Motion negatived)

The Chair: With that, I am going to conclude our meeting, unless there is other business.

Ms. Gladu.

Ms. Marilyn Gladu: Then for our next study, I would move that we go to the next topic on this list, which is home care.

The Chair: Would you like to move a motion?

Ms. Marilyn Gladu: I would like to move a motion that our next study be on home care, the next item on our list.

The Chair: Mr. Davies.

Mr. Don Davies: We should probably bring the motion up, because I think it was community care and home care, the issue of delivering more services into the community setting, and that transition from the acute care hospital to the community. I believe that motion was more than just home care. I don't know if we can pull up the motion for clarity in terms of what we're voting on.

The Chair: The motion was “To undertake a study on home care and palliative care and to report the findings to the House”.

Ms. Marilyn Gladu: That sounds marvellous. I so move.

The Chair: Is there any debate on this motion?

Dr. Eyolfson.

Mr. Doug Eyolfson: I move that the debate be adjourned.

(Motion agreed to)

The Chair: The meeting is ended.