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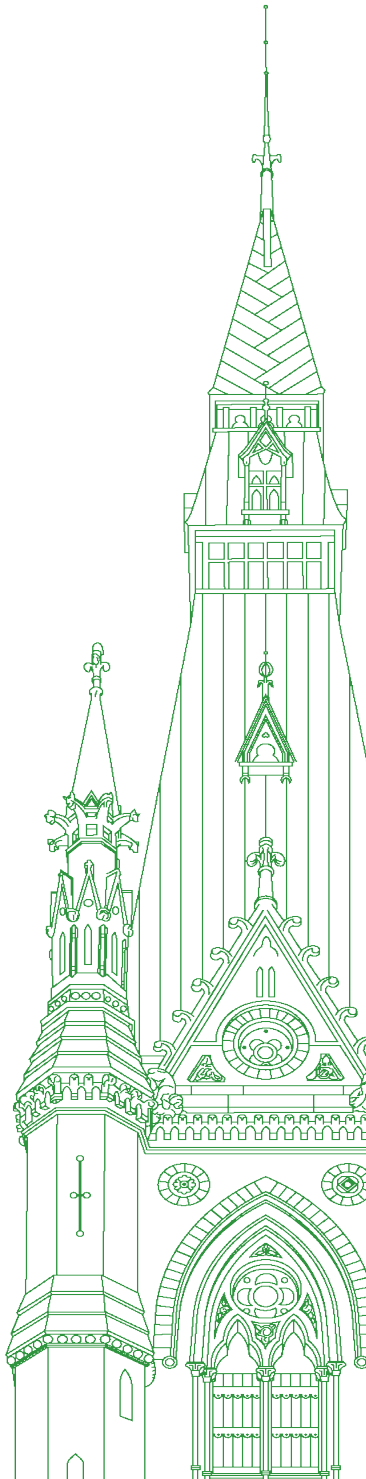

Chair: Mr. Ron McKinnon

Standing Committee on Health

Monday, November 23, 2020

● (1100)

[*English*]

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

Welcome to meeting number eight of the House of Commons Standing Committee on Health. The committee is meeting today to study the Patented Medicine Prices Review Board's guidelines.

I thank the witnesses for appearing today for the first hour, and we will do some planning for our COVID-19 and PMPRB studies in the second hour. The witnesses will come back for a second hour on Friday.

The witnesses we have here today are from the Patented Medicine Prices Review Board: Dr. Mitchell Levine, chairperson, and Mr. Douglas Clark, executive director.

Today's meeting is taking place in a hybrid format. I will start the meeting by providing you with some information following the motion that was adopted in the House on Wednesday, September 23, 2020.

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

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

To ensure an orderly meeting, I will outline a few rules to follow. For those participating virtually, members and witnesses may speak in the official language of their choice. Interpretation services are available for this meeting. You have the choice, at the bottom of your screen, of either "Floor", "English" or "French".

Before speaking, click on the microphone icon to activate your own mike. When you are done speaking, please put your mike on mute to minimize any interference.

As a reminder, all comments by members and witnesses should be addressed through the chair.

Should members need to request the floor outside their designated time for questions, they should activate their mike and state that they have a point of order.

If a member wishes to intervene on a point of order that has been raised by another member, they should use the raised hand function. This will signal to the chair your interest to speak and create a speakers list. In order to do so, you should click on "Participants" at the bottom of the screen. When the list pops up, you will see next to your name that you can click "raise hand".

When speaking, please speak slowly and clearly. Unless there are exceptional circumstances, the use of headsets with a boom microphone is mandatory for everyone participating remotely.

Should any technical challenges arise, please advise the chair. Please note that in that case we might need to suspend for a few minutes as we need to ensure that all members are able to participate fully.

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

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

Thank you.

We will now go to our witnesses. I will invite the Patented Medicine Prices Review Board to make a statement for 10 minutes.

Please go ahead.

Dr. Mitchell Levine (Chairperson, Patented Medicine Prices Review Board): Thank you very much.

Good morning.

My name is Mitchell Levine. I'm the chairperson of the Patented Medicine Prices Review Board, or PMPRB. I am also a practising physician and assistant dean and professor in the Faculty of Health Sciences and a faculty member of the Centre for Health Economics & Policy Analysis at McMaster University.

With me today is Doug Clark, the PMPRB's executive director. Mr. Clark will be familiar to some of you from his testimony in 2019 during his Standing Committee on Health appearance regarding the study of access to treatments for rare diseases and disorders in Canada.

Before I turn things over to Mr. Clark to walk us through the changes that have been made to our pricing regime and their impact, I thought it would be helpful to do a quick refresher on the PMPRB to provide a little background on the circumstances that have led to our issuing new guidelines last month.

As you know, the PMPRB was created in 1987 as the consumer protection pillar of a major set of reforms to the Patent Act which were designed to encourage greater investment in pharmaceutical R and D in Canada through stronger patent protection for pharmaceuticals.

The PMPRB is a quasi-judicial tribunal with a regulatory mandate to ensure the patentees do not abuse their patent rights by charging consumers excessive prices during the statutory monopoly period. Its creation arose out of the concern that stronger patent protection for medicines might cause prices to rise unacceptably and become unaffordable to consumers. The PMPRB is a creature of the Patent Act, which is the responsibility of the Minister of Innovation, Science and Economic Development, but given the nature of the products that we regulate, the provisions in the act that relate to us are the responsibility of the Minister of Health. While the PMPRB is part of the health portfolio, our role as an administrative tribunal with a quasi-judicial function means that we operate at arm's length from the minister and from other members of the federal health portfolio.

The PMPRB's regulatory framework is administered day to day by staff, public servants who monitor and investigate patented medicines that appear to be excessively priced. Staff apply the tests and thresholds specified in the PMPRB guidelines to identify potential cases of excessive pricing. When a price seems excessive, an investigation is then opened by the staff, and the patent team may be asked to submit a voluntary compliance undertaking, or VCU, which may include a written commitment to lower the price of the patented medicine and to pay back any excess revenue. In the absence of an acceptable VCU, an investigation may proceed to a public hearing before a panel composed of board members, like myself, who are part-time Governor in Council appointees. During such a hearing, the board panel acts as a neutral arbiter between the patentee and the staff. If the panel determines that the patented medicine was sold at an excessive price, it may issue a legally binding order requiring the patentee to reduce its price to a reasonable level and to repay any excess revenue that resulted from selling the patented medicine at an excessive price.

Since the establishment of the PMPRB over three decades ago, our operating environment has undergone significant change. Most notably, the nature of the products we regulate has changed dramatically. In the late 1980s and through the 1990s and into the early 2000s, the top-selling products in Canada were conventional small-molecule drugs for common ailments like high blood pressure or elevated cholesterol that would cost between a few hundred dollars to $1,000 a year per patient. In the early 2000s, the pharmaceutical industry began to shift its R and D focus to complex biological drugs that are often used to treat less common conditions and can cost several hundreds of thousands of dollars per year.

We have witnessed the upshot of that shift over the past decade, with the average annual cost of the top-selling patented drugs increasing by approximately 1,000% and the proportion of high-cost drugs—that is, drugs costing more than $10,000 per year—rising from 5% to 40% of overall pharmaceutical spending, while less than 1% of the population are using these medicines. By any measure, Canadians are paying a great amount of money for this new wave of high-cost patented medicines.

● (1105)

Of particular concern is that Canada pays the fourth-highest prices among the 31 OECD countries, 17% above the median price of those countries. Canada is the second highest in the OECD in terms of how much it spends on patented medicines as a proportion of total health care costs and in per capita spending. Only the U.S. is higher in both cases. From 2014 to 2018, growth in spending on patented medicines in Canada has doubled that of GDP, and it is over three times the growth of inflation.

As expensive drugs for rare diseases account for a rapidly increasing share of total spending, payers are becoming very concerned about sustainability. Not only are these drugs incredibly costly relative to the top-selling products of a few decades ago, but their market characteristics also shift the balance of power decidedly in the favour of patent-holding monopolists when negotiating a reimbursement price with public or private insurers.

This point was made rather emphatically by the pan-Canadian Pharmaceutical Alliance, pCPA, in its submission to this committee last year on access to treatments for rare disease.

It stated:

> The pCPA often negotiates under very challenging circumstances starting with an extremely high list price, severe untreated disease, no competing products, and high patient and care provider expectations to conclude negotiations quickly. As such, the pCPA remains very concerned that the prices achieved through negotiation remain largely unfair, excessive and not cost-effective and that pCPA needs collaborative federal support to manage.

As members of this committee well know, Canada is the only developed country with a public health care system that doesn't include price coverage for prescription drugs. The pCPA accounts for approximately 43% of total pharmaceutical expenses in Canada, with the remainder being taken up by private insurance and out-of-pocket payments. If the pCPA believes its power buying is woefully insufficient to secure a fair price from monopolist pharmaceutical companies for the types of drugs that are increasingly dominating the market, one can only imagine how the mixed bag of buyers who account for the remaining 57% of pharmaceutical expenditures in Canada can fare in their efforts to negotiate a price they can afford.

As a federal ceiling price regulator, the PMPRB exists to protect payers in precisely these circumstances, and thereby serves as a proxy for the monopsony power that Canada lacks because of the patchwork nature of pharmaceutical coverage in this country.

If one accepts the proposition that an unbridled free market is not in the public interest when it comes to patented medicines, then really the only question is, what rules should a regulator apply in seeking to protect consumers from excessive prices in today's pharmaceutical marketplace?

The PMPRB has been actively consulting stakeholders and the Canadian public on this all-consuming question for the better part of five years. This brings me to the last point I would like to make before Mr. Clark explains to you the rules that the government has ultimately landed upon, and their projected impact over the coming decade.

I understand that some stakeholders have taken issue with the transparency and authenticity of these consultations, describing them as a sham that largely took place behind closed doors. The truth is quite the opposite. Between Health Canada and the PMPRB, the government has produced more than a dozen policy documents over the past five years, and has twice travelled from coast to coast to consult with anyone who expressed even a passing interest in them.

In the past year alone, we have held multiple policy forums where attendees were encouraged to voice their views of concern and dialogue directly with government representatives. After the initial consultation process, the PMPRB published its first proposed draft of new guidelines in November 2019.

Since then, the PMPRB has attended over 60 meetings across Canada with more than 260 members of its stakeholder community. Every document that we have ever published or presented at any forum at any time throughout this process is available on our website. We have received more than 300 stakeholder submissions in response to the documents we've put out over that period.

● (1110)

During this period we published a revised set of draft guidelines in June 2020, which was followed by an additional consultation period. Then in October we published the final version of the revised guidelines. We have made substantive changes to our initial guidelines proposal as a result of that feedback. While these changes are too numerous to mention now, we would be happy to provide a comprehensive list to the committee if its members are interested in the details of those changes. More than 90% of the changes are favourable to industry.

It is a complex and contentious area for policy development by any government at any time, because it seeks to reconcile seemingly conflicting public policy objectives—namely, facilitating access to patented medicines at non-excessive prices while recognizing the legitimate interest of pharmaceutical patentees in maximizing the value of their intellectual property. Not surprisingly, the PMPRB's stakeholder community holds divergent and even diametrically opposing views on these reforms, with the industry on one side, the payers on the other side and patient groups scattered across the divide. Although consensus is not a realistic goal for us, we have made every effort through the consultation process to foster a productive, fair and transparent dialogue with our stakeholders, to listen carefully to their concerns and to have them reflected in the final guidelines document to the greatest degree possible

We believe the final product of our efforts represents an important step towards greater fairness in pricing, not only by bringing Canadian prices more in line with international comparators but also by introducing new pricing tests based on value for money and the health system's affordability.

While I recognize that our guidelines have given rise to a great deal of angst on the part of industry, I would ask the committee to consider how that could ever be avoided when the desired outcome of the policy is to lower prices and to reduce total expenditures on pharmaceuticals. To put the matter another way, what inferences might one draw about these reforms if they did not elicit such a reaction from industry? Nevertheless, a non-excessive price should be a fair price, and a fair price means a price that will permit the sustainability of both the health care system and the pharmaceutical industry.

Thank you very much for your time and attention.

● (1115)

The Chair: Thank you, Doctor.

Does Mr. Clark have a presentation as well?

Dr. Mitchell Levine: Yes, he does.

The Chair: You are at 12 minutes or so. Is it okay with the committee if we give Mr. Clark time to present?

Mr. Douglas Clark (Executive Director, Patented Medicine Prices Review Board): I'm in your hands.

It will take some time to go through this presentation. I had originally envisaged presenting it to you when we had two hours at our disposal. Now that it has been reduced to an hour, as I know committee members have an awful lot of questions, it might make more sense to just dive into them. I can refer you to slides in the presentation to the extent that they facilitate your understanding of my answer to your questions. It's really up to the committee.

The Chair: I understand that you're coming back on Friday as well. We have another hour scheduled.

Mr. Douglas Clark: Yes.

The Chair: Okay.

It's up to you. The committee has indicated that they're interested in hearing what you have to say.

Mr. Douglas Clark: Okay, sure.

The Chair: Thank you.

Go ahead.

Mr. Douglas Clark: I'll just refer you to the PowerPoint presentation that was sent to committee over the weekend. I'm going to zip right through this. I know that the committee has passed a motion to review and study our guidelines, but it's important to understand and to situate these guidelines in context.

They're actually non-binding and they sit atop—I'm on slide 2 of the presentation—a pyramid, if you will, of legal instruments that begins at the base with the Patent Act, which is obviously the responsibility of the Ministers of Industry and Health to the extent that our provisions are concerned and, ultimately, Parliament. It's in the act that the PMPRB is created and the excessive pricing factors are provided for, so I'll talk a bit more about those excessive pricing factors in a minute.

Then, above the Patent Act, we have the regulations, and they are the responsibility of the Minister of Health. They were recently amended. I'll be talking about that as well. It's in the regulations where patentees are directed to provide certain types of information and data to the PMPRB so that staff can administer the act and regulations on a day-to-day basis.

One of the factors in the act that the board is required to look to when trying to determine whether a price is excessive or not is the price of that same drug in other countries. The regulations also prescribe the list of countries that the PMPRB is to look to in making that comparison. Those are seven countries. I'll come back to that composition in a moment, because it has been amended. We call those the PMPRB7.

Then, at the very top, as I mentioned at the outset, are the guidelines. They don't have force of law, unlike the regulations and the legislation, but that's where the rubber hits the road. The act doesn't have a definition for what an excessive price is. It really doesn't offer a lot of specificity, nor do the regulations, so for a lot of the core administrative concepts, life is breathed into them in the guidelines, and that's where patentees turn to when they're trying to figure out how to comply on a day-to-day basis with the act and regulations.

As Dr. Levine mentioned—I'm on slide 3—we've been at this for quite some time. We published a strategic plan back in 2015 and identified some of the things in our environment, which Dr. Levine alluded to and that we feel have changed the nature of the game considerably. That was really when we put ourselves on a reform track and said that we needed to modernize and strengthen the regime if we were going to have the right tools to regulate the types of ceiling prices or types of products that were increasingly dominating the marketplace.

Shortly after we released our plan, we issued a discussion paper on guidelines modernization. It's important to understand that the guidelines are within the exclusive purview or authority of the board, so we wanted to get the ball rolling by engaging our stakeholders in a discussion on a document that we ourselves could amend independently and autonomously.

However, the ideas that were set out in that document were quickly picked up by the Minister of Health. Budget 2017, as some of you may know, earmarked additional funds for the PMPRB, CADTH and Health Canada to accelerate the market entry of patented drugs and to make them more affordable in Canada.

The types of changes we were talking about, and the guidelines, eventually got anchored into a more load-bearing document—the regulations—and the minister issued a white paper on regulatory reform. Ultimately, those proposed changes were published in the *Canada Gazette* in December 2017 and finally adopted in the *Canada Gazette*, part II, in August 2019.

Pretty much since that time we've been consulting on changes to our guidelines, for the better part of the past year. As Dr. Levine mentioned, we issued an initial draft for public consultation in November 2019, and then, based on the feedback we received, we revised that draft and issued a second one in June, and then made some additional changes to the version that is now final and was issued just last month.

I'm on slide 4 now. The changes to the guidelines are necessary to give effect to the changes, the amendments and the regulations.

● (1120)

What are those amendments? Basically, there are three types of amendments that we're talking about. First off, as I mentioned on the countries that we compare ourselves to currently, that list of countries, what we call the PMPRB-7, is being changed. The two most expensive countries are being removed from the list and countries with health systems and GDP per capita that are more in line with Canada are being added in. These countries also have prices that are more in line with the OECD median, if you will. The U.S. and Switzerland are out, and Australia, Belgium, Japan, Netherlands, Norway and Spain are in. That's the first change. The new list of countries we're calling the PMPRB11; there are 11 countries in it.

The second change is to add additional factors. I mentioned that section 85 of the Patent Act sets out the factors that the PMPRB is to consider when trying to make a determination as to whether a patented product is excessively priced in Canada. Those include the price of that same product in other countries, the price of other products in the same therapeutic class in Canada and in other countries and then the consumer price index.

However, section 85 also contemplates further factors being prescribed by regulation. For the first time in the PMPRB's history, the minister saw fit to introduce new factors by regulation through these amendments, these being primarily pharmacoeconomic value and market size. I suspect you'll have a number of questions on these new factors. I think I'll leave it to your questions to unpack them. They are complex and esoteric concepts, but I've become well versed in explaining them to people in layperson terms. I would be happy to do so in a moment.

As a result of these new factors, ceiling prices will be considerably lower in Canada. You've probably heard that concern expressed by industry and patient groups. In order for pharmaceutical patentees to be able to comply with those new lower ceilings that would result from the application of these new factors, it's important that the PMPRB have access to the true price of the product in the market.

Over the past two decades or so, prices in the pharmaceutical market have really gone underground, not just in Canada but also globally. Industry is increasingly negotiating confidential discounts and rebates with large institutional payers. Canada is no exception. No country knows what another country is truly paying for its patented pharmaceutical products. The irony in Canada is that the PMPRB is doubly handicapped in the sense that we don't know what other countries are paying and we also don't even know the real prices in Canada, because we don't have access to that true net price that takes into account the confidential rebate.

The third change in the regulations was to add a provision that requires patentees to provide us with those prices. However, as some of you may know, the regulations are being challenged before both the Quebec Superior Court and the Federal Court by the industry, two separate challenges. One of those challenges resulted in a decision from the Federal Court trial division earlier this year. It upheld the first two types of changes—the new countries, the new factors—but it did find that this third requirement that patentees provide us with this information was ultra vires of the enabling provisions of the act and therefore is of no force or effect. That decision is currently under appeal before the Federal Court of Appeal, but that has had consequences for how we are going to apply the new regime coming out of the gate in January of next year, 2021, when it comes into force.

It's important to understand that since inception, the PMPRB has taken the exact same approach to regulating all medicines that come under its jurisdiction. We look at them through the same lens. We apply the same tests. We only review the price substantively. We give a scientific and price review at introduction. We set the price, and that's it in terms of a substantive review of the appropriate price ceiling.

Going forward, however, in addition to changing our guidelines to implement these amended regulations, we're also taking a somewhat different approach, what we're calling a risk-based approach, to apply in our regulatory mandate. When new medicines come under our jurisdiction, we're going to apply screening criteria and divide them up into either category I medicines—medicines that we feel are at higher risk of excessive pricing—or category II medicines, which are medicines that we feel are at lower risk. You can see the screening criteria on slide 6.

● (1125)

With regard to the drug in question, its annual treatment cost is above 1.5 times GDP per capita, so it's about $90,000 annually. That will land it in category I. If its expected revenue in any of the first three years on the market is above $50 million annually, that will also land it in category I, in which case it will be subject to greater scrutiny under our new regulatory regime. I'll explain what I mean by that in a moment.

We expect that about 25% of new medicines will fall into category I and that the remainder will fall into category II. Although this represents a minority of the new medicines coming under our jurisdiction over the next decade, those medicines will account for the majority of sales of new medicines over the coming decade. The risk-based approach really scrutinizes a minority of drugs that will eventually account for the majority of sales.

The Chair: Sir, can I get you to wrap up after this slide?

Mr. Douglas Clark: Okay.

The Chair: Then we'll have time for one round of questions.

Mr. Douglas Clark: Okay.

I'm going to go straight to the impact; I think that's what people are really interested in. There's a lot of conflicting information out there about what the impact of these changes will be, ultimately, on prices, revenues and savings in the Canadian system.

There are three types of medicines, if you want to unpack the impact. First are all the existing drugs under our jurisdiction today—that is, everything that's patented and on the market today. As a result of these changes, their list prices, on average, will go down by about 5%, and that will result in about $4.6 billion in savings or less pharmaceutical spending over the next decade. That's for all existing medicines today. They will account for the lion's share of sales over the coming decade and result in about $4.6 billion less in pharmaceutical expenditures.

Then we have category I drugs. Their list prices will go down by about 8%. The corresponding savings to the system will be in the order of about $1.1 billion over the next decade.

Finally, we have category II medicines. Their list prices are expected to go down about 13%, and the corresponding savings to the system will be about $500 million.

Slide 11 puts this in context. It gives you a fictional example of a drug that currently has a price of $1,000 and how this would be impacted, either as an existing grandfathered drug or a category I or category II drug going forward. It gives you some context as to what to expect on a go-forward basis.

It's important to understand that for existing drugs, the ceiling price that we're going to apply is the highest international price of these new 11 countries. It's going to take quite some time before Canadian prices align with median and OECD prices or with median prices of new countries that we're comparing ourselves to. You can see on slide 12 that we're the second highest. It won't be until all these existing drugs have exhausted themselves and have been displaced by new medicines that have lower ceiling prices that we will see a reasonable alignment of Canadian prices with the OECD median.

I mentioned the global impact. If you add up all those numbers, it's about $6.2 billion over 10 years. That sounds like a lot, but when you consider, to put it in perspective, that we currently spend about $18 billion a year on patented drugs and that by 2030 we'll spend about $22 billion a year, you see it's not an insignificant sum, but neither is it an earth-shattering sum either. It's about 3.9% of total spending over the next 10 years.

With that, I'm happy to answer any questions that the committee members may have.

Thank you for your patience.

● (1130)

The Chair: Thank you very much.

I hope we will be able to ask you more questions on Friday. We will only have time for one round of questions today.

We will start with Mr. Kmiec. You have six minutes, please. Go ahead, sir.

Mr. Tom Kmiec (Calgary Shepard, CPC): Thank you, Mr. Chair.

My questions are for Mr. Clark.

Mr. Clark, I actually looked at all of your slides this morning; I read them over back and forth. I noticed that none of the slides talk about an analysis with regard to rare disease patients and patient access. Is there any reason for that?

Mr. Douglas Clark: We didn't try to parse it that finely.

I know that there is a lot of concern out there in the patient community about the impact that these changes will have on drugs for rare diseases.

One of the things that I didn't touch on in my presentation, because I didn't have time, is that one of the changes we made to the guidelines over the course of our consultations was to basically insulate these types of medications from the impact of the lower price ceilings that will result from the application of the new factors. Any product that's going to earn $12 million or less in revenue in Canada won't be impacted in any way, shape or form by the new factors; it will get the median international price—

Mr. Tom Kmiec: Mr. Clark, I'm sorry. I'm going to interrupt you.

How did you reach that $12-million cap?

There are a lot of drugs out there. I'm going to give you an example of cystic fibrosis. I know a lot of members are getting emails and phone calls, and I have a lot of constituents with cystic fibrosis.

Orkambi was refused in Canada by CADTH. I'm wondering if you have made any analysis on a drug like Trikafta or any of the other drugs for cystic fibrosis. Did they exceed $12 million for revenue in Canada? Patient access should be an important part here.

Mr. Douglas Clark: Some of them have.

Again, another aspect of the guidelines that I wasn't able to get into is the impact of that Federal Court decision that I mentioned. Going forward, until we have clarity from the Federal Court of Appeal and it reverses the decision at trial, the only price ceiling that these medications will be subject to is the median international price. I don't think it's unreasonable to expect pharmaceutical companies—some of the most profitable industry sectors in the global economy—to be able to bring drugs to Canada at a price that's more aligned with the international median. Canada is not alone—

Mr. Tom Kmiec: Mr. Clark, sorry, can I interrupt you?

I only have one round, so I have to make sure that it's totally worth it and I get the information out of you.

Mr. Douglas Clark: No problem. Absolutely.

Mr. Tom Kmiec: This year we've seen, I think, an almost 40% drop in applications. Part of it, I'm sure, is also the pandemic. I was looking at your 2018 annual report, and I have it right here. It shows there was a drop in sales, a drop in shares of patented medications. I don't see a 2019 report. Do you have the 2019 numbers, then? What do they look like?

Mr. Douglas Clark: Yes.

The 2019 report will come out soon. It usually comes out in the fall in the last few years. I don't know the exact timing off the top of my head. I don't have the number at my fingertips either. I can certainly undertake to get back to you on that.

In terms of the applications going down and the number of clinical trials going down, a lot of people have made that assertion, from industry predominantly. We take issue with those numbers. Our own analysis of the data doesn't support that. Clinical trials are going down in Canada. They're going down in all developed countries and actually at a less dramatic rate in Canada than in most other developed countries, as clinical trials move more and more towards developing emerging markets.

Mr. Tom Kmiec: Can I ask you, then, about those legal challenges that you mentioned, since I see also that Reuters reported that Ontario and Quebec shared that they have concerns about private concerns that they expressed. Now it's in the media about how these PMPRB regulatory changes are coming through. They're worried about pricing, that their rebates will be lower. You're squeezing the balloon on one side, and on the other side, the rebates won't be there.

Because there are these challenges at the Superior Court of Québec, don't you think it would be wise, perhaps, for the federal government to delay them for another six months in light of these legal challenges?

● (1135)

Mr. Douglas Clark: Well, it's really not for me to pronounce myself on the wisdom of the timing of those regulatory amendments.

As I explained, they are the responsibility of the Minister of Health. I know that the amendments were originally slated to come into force in July 2020 but were delayed an additional six months to January 2021. I do believe there are conversations happening around town. I think this is one of the industry asks—that given the nature of the ongoing pandemic, a further six-month delay be considered.

It's not my decision to make. I don't have authority in that area, so it's not really my place to answer that question.

Mr. Tom Kmiec: Thank you, Mr. Clark.

Maybe I'll just return to Trikafta, because the company has now been in application. I have a lot of constituents, as I think we all do, who want to see this drug approved and offered for public reimbursement in Canada. Has PMPRB looked at it already?

You said it was a $12-million cap for revenue. To me it sounds like—

Mr. Douglas Clark: It's not a cap.

Mr. Tom Kmiec: Is it not a cap?

Mr. Douglas Clark: Gosh, no. It's not a cap. It just means that if you're making $12 million or less on a particular drug, you're not subject to the new and more onerous, let's say, price ceiling. It's a mechanism to provide insulation from the application of the new regime. The new regime is not going to apply in that manner anyway for at least a couple of years, because of this Federal Court decision that I mentioned.

To answer your question specifically on Trikafta, no, we haven't looked at it in a formal way yet. We've had a number of discussions with the company. We've had open channels of communications with Cystic Fibrosis Canada throughout the past year, but until Trikafta is sold at non-zero prices in Canada—it's currently supplied under the special access program for free—or receives its notice of compliance from Health Canada, we won't look at it formally. That's how our regime functions.

Mr. Tom Kmiec: What about drug—

The Chair: Thank you, Mr. Kmiec.

Mr. Tom Kmiec: Thank you, Mr. Chair.

The Chair: We go now to Ms. Sidhu. Ms. Sidhu, please go ahead for six minutes.

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

Thank you to all the witnesses for being here with us.

As we know, Canada has among the highest drug cost in the world. Health Canada reports that the new PMPRB guidelines will save Canadians billions of dollars, which, of course, is a good thing for all Canadians.

My question is for Mr. Clark. How do Canadians' drug prices compare to other countries around the world? When can Canadians expect to see these changes?

Mr. Douglas Clark: One thing I should point out, and I did get into this a little bit in my presentation, is that when the regulatory amendments were published, they contained a cost-benefit analysis that projected about $8.9 billion in savings as a result of these changes, in net present value.

I did try to unpack the numbers a little bit for you on how we project the impact of the new regime with both the guidelines and regulations operating in tandem. It is quite a bit lower than that. It's more in the neighbourhood of $6.2 billion. That's probably an overestimate of the impact over the coming 10 years, because that looks at list prices and it doesn't take into account.... We look at list prices and we see how much they are going to come down as a result of these changes, and then we calculate how much less we are going to be spending on pharmaceuticals. However, the reality in the market is that list prices don't represent the true price in the market most of the time.

Let's say you have a drug with a list price of $100. As a result of these changes, the list price would come down 5%, to $95. If the true price in the market is $90—if the pCPA has negotiated a deal for $90—that won't have any real impact on pharmaceutical expenditures in Canada. That $6.2 billion is probably an overestimation of the impact by a considerable margin.

There is a significant gap between what we're projecting today versus what was projected in the cost-benefit analysis, the CBA, because of the impact of that Federal Court decision and our inability to apply new factors in a meaningful way.

To circle back to your original question, Dr. Levine mentioned this in his opening remarks. Canadian prices vacillate between third- and fourth-highest in the OECD, currently, for patented medicines.

Ms. Sonia Sidhu: Thank you.

One group we frequently hear from in regard to the cost of medicines are advocates for those with rare diseases whose drugs carry a higher price if they are not widely used.

As you are aware, the government is also considering a rare diseases strategy. Can you make any recommendations for this strategy? Can you explain how these new guidelines will bring down these prices and help people presently living with rare diseases?

● (1140)

Mr. Douglas Clark: Oh boy, that's a complex question. I will let Dr. Levine chime in if he wants to supplement my answer.

We hear a lot from advocates for patients for rare diseases' pharmacoeconomic value. This is a very esoteric topic, but it shouldn't have application in this space because there are unique features of these products that make them not amenable to that type of analysis. When I meet with my counterparts in other countries around the world, and with health technology authorities in particular who do this type of analysis on behalf of payers and governments worldwide, they take issue with that argument.

I will give you an example of the point I'm trying to make. The U.K. sets pharmacoeconomic value thresholds. If a drug costs more than a certain amount for one quality-adjusted life year, the U.K. health authority won't reimburse it unless the price comes down. There are varying thresholds that apply to different drugs. Rare disease drugs have a higher threshold than regular drugs.

At some point, people became very concerned that a lot of the new oncology drugs, for rare diseases in particular, weren't meeting these thresholds—even the more elevated thresholds. The U.K. decided to create a special fund just for cancer drugs and forgo the pharmacoeconomic value assessment for these drugs.

I think the fund started off with $1 billion. It was quickly exhausted. Authorities soon realized that health outcomes for cancer patients hadn't improved an iota over that period. In fact, they probably suffered a lot more side effects as a result of allowing medications on the market that didn't have good clinical data and weren't able to establish significant value in terms of their cost effectiveness.

I'm wary of putting these medications in their own little bucket. I'm very sympathetic to people who are concerned about the impact of these changes on rare disease medications, but that's one of the reasons we introduced that $12-million annual revenue insulatory mechanism that I alluded to earlier.

Dr. Levine has more experience day to day as a clinician dealing with these types of medications. Do you have something you want to add?

Dr. Mitchell Levine: The reason we don't want to parse things out at the moment is that as things are unfolding, the future of medicine is that everything is essentially going to become a rare disease.

We used to think that we'd treat all lung cancer the same way. Now, as we go through the biomolecular basis of cancer, you could end up with hundreds of different treatments for that lung cancer, which means that we now have small groups of patients who, in a sense, meet the criteria for a rare disease. If very few people have that kind of lung cancer in Canada, there's that specific treatment.

The future of all of medicine is really going to be very individualized and a “very rare disease per person” approach. We needed a robust approach to deal with all medicines, regardless of how many people are being treated with it, and to make sure that the health care system is going to be sustainable when we move to that environment. We are rapidly moving towards that environment.

The Chair: Thank you, Ms. Sidhu.

[*Translation*]

Mr. Thériault, you now have the floor for six minutes.

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

I also want to thank the witnesses for joining us.

The industry and several patient advocacy groups recognize the importance of modernizing the existing basket of comparator countries to ensure a more standardized and accurate comparison of different categories of drugs. However, there are still concerns about patient access to treatment.

The Collective Oncology Network for Exchange, Cancer Care Innovation, Treatment Access and Education has strong concerns about patient access to innovative cancer treatments. In my view, the most significant criticism is the following: “Moreover, considering only the price without taking into account the treatment's value in terms of the health of patients and their caregivers, and the resulting economic and social benefits, constitutes a false dichotomy.”

In its submission, the network noted that, at the Canadian Agency for Drugs and Technologies in Health, or CADTH, four factors were considered: clinical benefit, cost effectiveness, patient values, and feasibility of adoption. It acknowledged the need for more flexibility and pragmatism in the evaluation.

The national institute of excellence in health and social services, or INESSS, is another organization that takes these values into account in the establishment of prices.

The network noted a shortcoming in the analytical approach to the reform. It stated the following:

> This limited analysis does not take into account the overall value of these drugs to the health care system or the positive social and economic impact of having patients recover more quickly and resume their normal daily activities, including getting back to work. It also does not take into account the money saved in terms of care, long-term disability claims, drug claims and the use of the health care system. It overlooks the economic contributions made by individuals recovering from an illness when they resume their active lifestyle, their normal purchasing habits and their contributions to social programs.

Mr. Clark, what do you think about this?

● (1145)

Mr. Douglas Clark: Your question is quite substantial.

It would be an excellent idea to ask representatives of CADTH and INESSS to appear before the committee. I don't know whether this is on your agenda, but they should be answering these questions.

Mr. Luc Thériault: On that note, one criticism voiced by a number of stakeholders is that the new rules change the Patented Medicine Prices Review Board, or PMPRB, from an excessive price regulator to a price-setting regulator. I understand that your response brings us to this point. They claim that you're taking their place without having the jurisdiction to do so and without establishing parameters to help set a price that aligns better with a comprehensive vision. This is a basic criticism.

The collective network says that it would be necessary to hold further consultations; to carry out the implementation in more gradual stages, starting with the basket of existing comparator countries; to gradually introduce pharmaco-economic factors; and to create a multi-stakeholder evaluation and monitoring committee because the process must be more objective. According to the network, and this surprised me, it's important to maintain the confidentiality of the agreements, which the court seems to still be protecting.

What do you think about this? Would you be open to the idea?

Mr. Douglas Clark: Several of the measures that you just listed are part of our plan for the future. We agree with a number of these suggestions. The issue is that we're currently involved in two court challenges where the industry is making these types of arguments.

Mr. Luc Thériault: This isn't coming from the industry, but from the collective network, which is dedicated to protecting the rights of cancer patients.

Mr. Douglas Clark: I understand. However, the industry is making the arguments in the midst of these court challenges. This puts me in a bit of a delicate position to comment.

Mr. Luc Thériault: Okay.

The collective network says that 50% of the most common cancers, namely, skin, breast, lung and colorectal cancer, are involved in this.

There are six innovative drugs related to these cancers. When the network analyzed the first draft of your guidelines, it found that four of these six innovative and life-saving drugs wouldn't have been launched.

Are you aware of this?

● (1150)

Mr. Douglas Clark: I don't know which four drugs you're talking about, but—

Mr. Luc Thériault: I'm talking about pembrolizumab, atezolizumab, and trastuzumab—it's hard to pronounce and remember—

The Chair: Mr. Thériault, please let the witness finish his response.

Mr. Douglas Clark: A number of these drugs are already on the market in Canada. I don't know exactly why they claimed this. I can say that this analysis is based on data that's now outdated.

The thresholds that will be applied under the new guidelines are no longer the thresholds used as the basis for the calculations at the time. I think that they did this after the release of our—

Mr. Luc Thériault: According to your October 23 guidelines, there would still be two out of six today.

The Chair: Mr. Thériault, please let the witness finish.

Mr. Douglas Clark: I don't have the information in front of me. It's hard for me to provide an unequivocal response to your point.

I don't know whether Mr. Levine wants to add to my response.

[*English*]

Dr. Mitchell Levine: I don't really have anything to comment on specifically to the last point, but there was the concern that was earlier addressed that somehow the PMPRB was going to supplant the government drug program negotiations. Of course that's not the case. We're setting a ceiling and they can negotiate below that ceiling, but we have to remember that 57% of the market is not even part of those government-planned negotiations. We're there to protect against excessive pricing, especially in the 57% who don't have a common voice negotiating on their behalf.

[*Translation*]

The Chair: Thank you, gentlemen.

Thank you, Mr. Thériault.

[*English*]

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

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

Mr. Clark, if I understand your explanation of the purpose of these regulatory reforms, it's essentially to attempt to reduce drug prices in Canada and to increase transparency in the drug-pricing process. Would that be a fair statement?

Mr. Douglas Clark: If it's a forward-looking statement, part of it is fair. It's not that we're necessarily looking to reduce prices in Canada; it's just that we're looking to have mechanisms in place that ensure that prices are not excessive in Canada on a go-forward basis. The impact of that would be lower prices in some instances, but most of the regime is forward-looking.

In terms of transparency, I know it's a concern for many people that real prices internationally and domestically are not known outside the parties to the negotiations, the contractors who sign them. There's nothing about these changes that would lift the veil, so to speak, on those confidential prices. The PMPRB would have access to them, although we currently do not—which seems a bit absurd when you're an economic regulatory body that sets price ceilings on a particular industry—but we won't be broadcasting those confidential prices to the general public.

The implications of doing so would be dire. Industry would obviously be reticent about entering into those types of negotiations if they knew the Canadian price, the true net price, was going to be disclosed publicly with the ensuing domino effect that would have on negotiations internationally. That's not our intention.

With regard to our list price ceilings, what we're proposing eventually under this regime is to have two price ceilings: a public list price ceiling and a non-transparent confidential price ceiling that is known only to the patentee and the PMPRB. The patentee can choose to disclose that to the pCPA or to private insurers in the context of a negotiation. Nothing precludes them from doing so, but we would not be advertising that price. As a matter of fact, for precisely those reasons we've turned ourselves inside out over the course of various iterations of these guidelines to ensure that our processes do not lead to a situation whereby competitors or folks in other countries can easily come back from our price ceilings and come up with a rough estimate of what the ceiling price would be in Canada.

● (1155)

Mr. Don Davies: Okay.

The regulations are obviously not in force right now. I think it's fair to say that the main concern about these proposed regulations is the potential impact on access. We know there's a problem with access now because clearly we have patient groups all across this country who can't get access to the medication they want. Trikafta was mentioned as a famous example, and patients aren't getting access to that drug under the current regulations without these proposed changes to the PMPRB.

I'll put a thesis to you. In a system where we have finite resources—i.e., in Canada—we can only spend a certain amount of money every year on pharmaceutical products. Wouldn't controlling excessive costs help provide greater access to drugs than not?

Mr. Douglas Clark: That's our operating presumption. I know a lot of people feel strongly that there is a link between price and access. I would point out that notwithstanding the fact that Canada currently pays the third-or fourth-highest prices in the world, we are roughly 13th or 14th in terms of access. Even the industry's own studies show at best a very weak correlation between price and access. If you remove the U.S. from the equation and from many of those models that folks in industry put forward, there's hardly any correlation at all. You'd have to have a huge increase in price to get even a tiny improvement in access.

However, yes, ultimately the objective here is that if prices come down, and particularly the prices of these incredibly high-cost drugs—and not by a significant margin, mind you, and again the ultimate impact of this is $6.2 billion in the context of about $200 billion spent over the next 10 years—then presumably, if basic economic theory holds in this case, access would go up and utilization would go up. If prices go down, utilization goes up. Obviously you don't want prices to go down to a point where companies can't make a profit in Canada—

Mr. Don Davies: Do you have any concern, Mr. Clark, that it may happen here? I ask because it seems to be the concern of patient groups that if these measures go through, they will discourage or dissuade pharmaceutical companies from making their products available in Canada. What do you say to that concern?

Mr. Douglas Clark: Yes, I share that concern. I don't think that's going to be the impact. I think companies can afford to bring their products to Canada. I don't think the Canadian price has to be the highest in the world for companies to make a profit in the Canadian market. I don't understand that argument.

One of the things we're putting in place, now that we're close to the implementation date, is a comprehensive monitoring and evaluation plan. We will be looking at benchmarks today. Currently we're 13th in terms of access. We get about 50% of new substances that come to the market in any given year, notwithstanding that we have very high prices. We're going to be looking at the impact over time of these changes. Is access going down or going up? If it's going down dramatically, do we need to make adjustments?

Canada is not unique in struggling to find a socially acceptable price for products like Trikafta and other cystic fibrosis—

I'm sorry. I think I've answered your question. I don't want to take up too much time with my responses.

Mr. Don Davies: Just quickly, does the EU have similar regulations to what is being proposed here, and if so, what has been the impact on access there?

Mr. Douglas Clark: It's important to understand no two regimes are alike internationally. The thing that's unique about Canada, as Dr. Levine alluded to, is we don't have the monopsony power that most other developed countries have when they include prescription drug coverage as part of their universal health care system.

Every country that I'm aware of uses market size and pharmacoeconomic value to some extent in trying to figure out what price they think is socially acceptable for a product. They don't use it in the exact same way. Japan, the Netherlands and France use market size as a trigger for conducting pharmacoeconomic value assessments. Some countries, like the U.K., have specific thresholds for pharmacoeconomic value in place. We're going to have a ceiling price that's a function of pharmacoeconomic value. I'd say the distinction is one without that much of a difference. In either case, it's sort of the gateway to meaningful market penetration.

These new factors that we're adopting are based on best practices internationally, but adapted to a made-in-Canada context, as is necessary, given the unique characteristics of our regulatory regime.

● (1200)

The Chair: Thank you, Mr.—

Dr. Mitchell Levine: Could I also just add to the response?

The Chair: Sure, quickly.

Dr. Mitchell Levine: I would remind you that three-quarters of new drugs aren't even going to be in category I, as we estimate, which means that all we're asking for the other three-quarters is that they come in at a median price of countries just like us.

Why would Canada have to pay a higher price than the median of similar countries when obviously, if the pharmaceutical company can make a profit in these other countries, they can certainly make it here? In fact, Canadians purchase drugs at a higher frequency than a lot of other countries. We spend as much on pharmaceuticals as the U.K., and they have twice the population that we do, so Canada is a very viable market for the pharmaceutical industry to be successful.

The Chair: Thank you, everybody. I have to call an end to it there.

Thank you, Dr. Levine and Mr. Clark. We're looking forward to having you back again on Friday. I'm sorry for having to spread it out this way.

We have to do some planning now, so thank you for your time today.

Mr. Douglas Clark: Thank you very much for your interest.

Dr. Mitchell Levine: Thank you for your interest. See you Friday.

The Chair: The reason we had to split this up is we have to do some planning so that we know who to invite for next Monday. We need lead time to do that.

We have two studies we have to plan for. Certainly we have the other meetings of the PMPRB and we have meetings for the first part of the COVID-19 study.

Also, since we had originally planned to bring the law clerk in on the first meeting of the COVID-19 study, and we don't even have that organized and ready to go, we have an opportunity to bring the law clerk in on Friday for an hour. The current plan is that we bring the law clerk in for an hour on Friday and we will have the Patented Medicine Prices Review Board back for another hour on Friday. That's the current plan.

Could we agree on how to proceed with the PMPRB study? Before we rise for the Christmas break—not counting today, which is used up, and not counting Friday, which is also allocated—we have four more meetings to deal with. It would be good if we could get those meetings squared away so we know whom to invite and when so that we can have the clerk issue the invitations and make sure they have their headsets and make sure the technical issues are resolved.

Let us start with the Patented Medicine Prices Review Board.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, I have a point of order.

[*English*]

The Chair: Go ahead.

[*Translation*]

Mr. Luc Thériault: I want to move a motion that concerns the Standing Orders. I sent out the motion in English and French. Everyone received the notice of motion regarding the vote.

[*English*]

The Chair: Monsieur Thériault, when you get the floor, you certainly are entitled to move that motion, but I'm hopeful that we can get some motions, some decisions, made on some of these meetings before we get ourselves occupied with motions. Would that be acceptable to you?

[*Translation*]

Mr. Luc Thériault: No, I disagree.

I have a point of order. I want to move my motion in accordance with the practices governing the proceedings of Parliament. I raised my hand to speak earlier. I think that I was the first to do so.

[*English*]

The Chair: You are certainly first on the list. Go ahead.

Mr. Don Davies: Mr. Chair, I have a point of order. We're going to have to get control of how people get recognized.

With great respect to my colleague Mr. Thériault, he just seized the floor by interrupting you and starting to move a motion. You didn't recognize him. You were in the middle of speaking. It is not going to work if the ability to speak is determined by whoever hits their microphone and starts talking.

You were talking about the subject under discussion, which is the future business of this committee. Now, if Mr. Thériault has a point of order, then he can interrupt you and you can recognize him and he can state his point of order, but he can't interrupt you and seize the floor to move a motion. That has to be when you recognize people.

If Mr. Thériault is next, that's fine. When you are ready to recognize speakers, you may recognize him, but I think it's important.... I'm not picking on Mr. Thériault on this point. I think we've all maybe been guilty of this, but we're going to have to respect a fair process: We only interrupt and hit our microphones when we have a point of order. Otherwise, I think we have to respect your role as chair and wait for you to recognize people, or I don't see how we're going to have an orderly set of meetings.

● (1205)

The Chair: Thank you, Mr. Davies, I certainly appreciate your intervention. I agree with it.

I'm giving the floor to Mr. Thériault at this point because certainly he made a valid point. It would have been better to wait until I was finished doing the set-up, but we're not going to be able to move forward as long as this question about voting order is outstanding. I do appreciate your intervention, Mr. Davies.

Mr. Thériault, please go ahead.

[*Translation*]

Mr. Luc Thériault: I also want to thank Mr. Davies for his comments, Mr. Chair. I thought that you had finished and that you wanted to move forward with the analysis and discussion regarding the proceedings. If I interrupted you, I apologize.

I want to move the following motion:

> That, in accordance with the practices governing parliamentary committee proceedings, recorded divisions be conducted in alphabetical order of committee members and by party affiliation in the following order: Liberal Party, Conservative Party, Bloc Québécois and New Democratic Party.

[*English*]

The Chair: Thank you, Mr. Thériault.

Is there any discussion on this motion?

I see that Mr. Davies and Mr. Van Bynen have their hands up. Is that on this motion?

If you wouldn't mind, Mr. Davies, I will give you first up after we deal with this, followed by Mr. Van Bynen.

Is there anyone else who wishes to speak to this motion?

Monsieur d'Entremont, go ahead, please.

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

I think this is a reasonable request, because I think what happens is that as we go into any one of our votes or discussions, Mr. Thériault has to go first, not knowing, maybe, where government is going or fully what the decision is, or, even worse, his translation isn't complete before he has to make a decision on whether or not to support something. I think this is reasonable in that it is the practice of other committees that I have participated in at this point and of course in the House of Commons. I think this is a reasonable move forward that is being presented by Mr. Thériault.

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

We have Mr. Fisher next, please.

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

In response to what Mr. d'Entremont said, “not knowing maybe where government is going”, the way I read this, and with all due respect to Mr. Thériault and Mr. d'Entremont's comments, it was the purview of the chair to determine how to move forward with votes.

I'm content to let you make that decision, but as far as knowing which way the government goes, I don't see this as a huge problem. I want to make sure that we fully recognize the importance of bilingualism. If there's any way to do that to the fairness of the entire committee, we have to make sure that everything is done just perfectly to recognize the importance of bilingualism by this committee.

I will listen to the debate on this issue, but I don't know whether I agree with Mr. d'Entremont that someone should be able to see the direction of the government during the voting process. I will leave that to the rest of the debate.

The Chair: Mr. Maguire, please go ahead.

● (1210)

Mr. Larry Maguire (Brandon—Souris, CPC): On a point of order, Mr. Chair, Mr. Thériault tabled his motion. I don't think we have called for debate on it yet. He just wants to table it. I could be wrong, but I will leave it at that.

The Chair: He gave notice of motion last week, so he is able to move it. Maybe I'm mistaken, but I thought he did move it.

Mr. Thériault, you moved this motion, did you not?

[*Translation*]

Mr. Luc Thériault: Yes.

[*English*]

The Chair: Then we are engaged in the debate on this motion. Thank you for your intervention. Did you have more to say on this, Mr. Maguire?

Mr. Larry Maguire: I think it's very reasonable. All of the votes in the House start in the way that Mr. Thériault has presented his motion. It's normal, so I would support him on it.

The Chair: Is there any other debate on this motion?

(Motion agreed to: yeas 6; nays 5 [*See Minutes of Proceedings*])

The Chair: Very well. Thank you, Mr. Thériault. Congratulations. We will mend our ways and carry on as you describe.

Let us go back to the matter of the PMPRB.

Mr. Thériault, please go ahead.

[*Translation*]

Mr. Luc Thériault: Regarding the proceedings, we've received a significant number of briefs since Thursday. We had until Wednesday to send in our lists and the topics—

[*English*]

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

I'm sorry to interrupt again, but Mr. Thériault was first in line, and he used his place in the order to move his motion. I was next in line, as you already confirmed, and you confirmed that by stating you would come to me next when we returned to the order of business, which is determining our PMPRB order of business.

Again, with respect to Mr. Thériault—it's not his fault—I believe that I am next on the speaking list. You can't go back to the same person twice in a row. He can't be first twice.

[*Translation*]

Mr. Luc Thériault: Sorry, Mr. Chair, but I think that there's some confusion.

I raised my hand. I told you in my first comment earlier that I did so to speak about the proceedings. I thought that you had finished, so I did what I was supposed to do. I turned on my microphone and raised a point of order, but at the wrong time. However, I did raise my hand earlier.

[*English*]

The Chair: Thank you, Monsieur Thériault.

I believe that Mr. Davies is correct. I've kind of lost track of the hand raises on the participant panel. We have to figure out a better way of doing this. I believe that with your hand raise that was there, you dealt with your motion, so as I formerly agreed—and I apologize—I'll give Mr. Davies the floor.

Monsieur Thériault, if you wish to carry on with this point, you can raise your hand again. Thank you.

Go ahead, Mr. Davies.

● (1215)

Mr. Don Davies: Thank you, Mr. Chair, and thank you, Mr. Thériault.

I'm very pleased the committee is finally getting to work on business. I think all of us are feeling some sense of relief and satisfaction that we are getting witnesses before our committee to do the work that we are supposed to do. I think I speak for all of us, and certainly for myself, when I say that it feels good to be doing that. Really, we need to continue the good work we did last meeting, making progress in working together to determine an orderly calendar of business in front of us.

As you pointed out very helpfully, Mr. Chair, we basically have four meeting after this week. This meeting and I think Friday are essentially allocated. We really have four meetings before the seasonal break in December. I think we can even look beyond that. I would suggest that with those four meetings, we allocate at least the first three to the COVID study. In the fourth meeting we can come back to the PMPRB study and pick that up. I say that for the following reasons.

We haven't heard from a single witness on COVID this fall. I think Canadians would be very surprised to know, given that we're in the middle of a raging crisis across this country, that their health committee at the national level is not meeting and discussing what is clearly the number one health priority facing Canadians. People are dying every day.

Two, this isn't just any old motion. This motion came from the House of Commons. We were directed, by a majority vote in the House, to study this matter.

Three, we have submitted our topics. We had all submitted our priority topics by Wednesday of last week. We have topics ready to go. I think that gives the analysts a chance for us to submit witnesses and then schedule those witnesses starting next week and the week after.

I would point out that given our start on the PMPRB study today—we've had half a meeting today and we have another half-meeting on Friday—by the end of this week we will have had the equivalent of one meeting on PMPRB. I don't want to read Mr. Thériault's mind, but he started to say something important, I think, which is that we have received a number of submissions on PMPRB. I have just started to wade through them. That's why I would like a chance to actually read those submissions and digest them to help me focus my questioning on PMPRB. If we proceed with COVID next week and have the first two meetings on COVID and then maybe the following meeting on Monday on COVID, that leaves us with our final meeting on Friday. It gives us two weeks to do justice to those submissions and determine who the witnesses will be and how we want to home in on that topic.

We also just heard from Mr. Clark and Mr. Levine on the PMPRB study. I think we're all getting a sense of where the essence of the dispute is, but there is no question that there has been extensive consultation. Patient groups want their voices heard, and I think that's important. Patient groups and patients have to have their voices heard at this committee, but it's not correct to say that they have not been consulted or that they have not had an opportunity to make their views known to the government. This is a process that's been going on since 2015. It was either Mr. Levine or Mr. Clark who detailed the process that has happened so far, with the plan in 2015, and then a discussion paper, and then a white paper, and then consultations over the last year, and then more consultations since the guidelines have been published.

That's not to minimize the importance of having those voices heard. It's meant to help put it into perspective that this is not a situation of groups who want to comment on PMPRB not having an opportunity to do that. They have. That's just a fact.

● (1220)

What people have not had a chance to do is to comment on the second wave of COVID that is ravaging our country right now. I think we as the health committee need to follow the directions of the House and get to work on the first topic that has been provided by the Liberal Party. We'll have to determine how many meetings we want to allocate to that.

My final point is that there is no emergency on PMPRB. These changes are going to come into force in January, but nothing our committee is going to do is intended to stop them from coming into force. That is not the purpose of our committee. We are not rushing to do a quick study of PMPRB so that we can stop the implementation of the PMPRB changes slated for January. Instead we need to have a considered, thoughtful approach to understand these changes and to understand how they're going to operate, because I think we're going to have to follow them closely for the next several years to determine how they are acting and to ensure that they don't have the unintended consequences, which many people fear, of restricting access to life-saving drugs. None of us wants that to be the case. We want to make sure all patients get access to the drugs they want. That's what I'm going to suggest.

I'm also going to suggest that we have until Wednesday, and I will put that in the form of a motion if necessary. I think today we should allow the Liberals to name the topic they want to study. Then by Wednesday we can submit our witnesses. The House has already told us that there will be equal witnesses, so each party has to come up with one witness for next Monday, one witness for the following Friday and one witness for the Monday after that. That gives the analysts some time to start scheduling these witnesses.

I want to stop and say for a moment that we have not been fair to our analysts. We all know, sitting on committees, that it's difficult for the analysts to contact these witnesses and get them arranged and scheduled. We need to give them acceptable lead time to do this. By choosing the next four meetings after next week, we give the analysts the ability to move these witnesses around. Some might not be able to come on the Monday—maybe it's the Friday—and this gives the analysts some flexibility with the witnesses over those three meetings to make sure we can get the witnesses the parties want, if not necessarily on the day in question.

I think that's another really functional reason why we need to deal with that. Also, it will give us a change. Therefore. I would say by Wednesday or maybe by Friday, we should submit the names of the witnesses we want for the PMPRB study when we pick it up two Fridays from this Friday.

My final point will be this, and if need be, I will put it into a motion as well. I think it's very important that all witnesses who appear before this committee on the PMPRB study declare any potential conflicts of interest. I'm going to ask the analysts to provide a standard document that is very commonplace in the medical and scientific profession.

Often we have heard doctors and other people—researchers—who appear before our committee make a brief 10-second statement at the beginning of their testimony to declare whether they have any conflicts or potential conflicts, including whether they're receiving money from any particular group. That may be important for us in weighing their testimony.

We know that the pharmaceutical industry is very strongly against the PMPRB changes, and we know—we just heard testimony, and it stands to reason—that one of their main concerns is about the economic impact the changes are going to have on them. We also know that many groups in this country receive funding, sometimes not transparently, from the pharmaceutical industry. I think we need to consider that as we are weighing testimony.

It doesn't necessarily mean that the opinions of anybody receiving money aren't as valid, but knowing about that will help us to objectively weigh the evidence we're going to hear. In fact, I would probably argue that a basic conflict screen should be a standard affair for every witness who appears before our committee on any subject. It would probably be a good practice, and I'm happy to do that. I don't want to single out this study or this particular.... We do know that this is absolutely a real issue with respect to the PMPRB changes.

If you want, here is the motion.

● (1225)

I move that we have three meetings starting next Monday, the first three on our COVID study and the fourth on PMPRB. We will proceed with the first order of business as determined by the Liberal Party. We will then determine how many meetings we will allocate to that first topic proposed by the Liberal Party. We will submit our witnesses for the COVID study by the close of business this Wednesday and we will submit our witnesses for the PMPRB study. Again, it will be one per party for the PMPRB study meeting two weeks from this Friday. Finally, all witnesses who appear before this committee on the PMPRB study will declare any potential conflicts of interest and fill out a standard document as may be provided by the analyst to them.

Thank you.

The Chair: Thank you for your intervention. It's very comprehensive, absolutely. I think it's very helpful.

Really, what I want to achieve today is to know who our witnesses are going to be for Monday, certainly, and Friday. If we can go beyond that, awesome.

You have a motion on the floor. The debate now is on that motion.

Mr. Thériault, if you've spoken already and your hand is still up from before, please take it down. If you wish to speak again on this motion, I think we have—

[*Translation*]

Mr. Luc Thériault: I have a point of order, Mr. Chair.

I was a good sport earlier. I accepted the fact that you interpreted things that way. That said, I don't think that all issues regarding the Standing Orders require us to raise our hands. I raised my hand before everyone else because I wanted to exercise my right to speak about the organization of the proceedings. I was a good sport about letting Mr. Davies speak. Concerning the organization of the proceedings, you asked me to put my hand down if I didn't want to say anything about the comment. However, I left my hand up because I wanted to speak without being last to do so.

I urge you to reconsider your interpretation. I've been a good sport, but I won't be taken advantage of. I had my right to speak from the start. However, to ensure cohesion within the group, I gave it to Mr. Davies. His statements show that he has already decided that there won't by any meeting on the PMPRB and that this won't be an issue at all. This isn't how I see things, Mr. Chair. I urge you to consider this now.

[*English*]

The Chair: Thank you, Mr. Thériault.

There is a little confusion with the speakers list from the participants panel. Some of the hands are up from previously, from whatever other previous business we were talking about.

At the moment, Mr. Davies has moved a motion, and the motion is on the floor. Following Mr. Davies is Mr. Van Bynen, who is followed by Mr. d'Entremont.

They were proposing to speak on whatever the business was. If they wish to carry on in response, well, they have the floor.

Mr. Van Bynen, please go ahead.

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

I agree with what's being proposed and I want to thank Mr. Davies for putting forward some progressive thoughts in getting on with the business. I think that's really critical. My hand was also raised to follow Mr. Davies before the motion was introduced on a separate discussion.

I think we should go forward on the basis that is being proposed. I truly appreciate how we are approaching this, and I want to thank Mr. Davies. It's quite apparent that his experience as a parliamentarian is showing.

I would support what's being proposed.

● (1230)

The Chair: Thank you, Mr. Van Bynen.

I would encourage everyone to keep their interventions short. We want to reach a conclusion here within the next half-hour so we can go forward and know what to do next week.

Go ahead, Monsieur d'Entremont.

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

My question revolves around how much work there will be per topic and whether that should be included in the motion itself.

I know we've all submitted a pretty expansive list of possible discussion points for our study over the next number of months. Knowing that we only have those four meetings between now and Christmastime and that one of them is being taken away for PMPRB, are we going to be doing two Liberals and maybe one Conservative, and then coming back with a Bloc after that?

I'm wondering if that should be included within this motion. I mention it more for discussion. I feel that we have a lot to discuss and a lot to do when it comes to access to rapid testing and all the other topics that are before us. I'm wondering if that should be included in there.

The Chair: Last week, we all submitted our lists of priorities. The first one on the list for the Liberals was mental health, so that will be the first PMPRB study. We have to determine, with respect to that study, how many meetings we want to have.

My understanding of the motion is that we would do all of that study, and then it would be followed by the Conservative study, followed by...and so forth. I think that was already clarified.

We could go ahead now with Monsieur Thériault. I think he is next.

Go ahead, Monsieur Thériault.

[*Translation*]

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

Contrary to what Mr. Davies was saying, we don't need to provide a witness list again for either the PMPRB study or the COVID-19 study. The deadline was Wednesday at 6 p.m. All these lists have already been submitted with our priorities, as requested in Mr. Davies' motion, last time, on the organization of the proceedings.

However, the issue here is that Mr. Davies' motion—which is, once again, a motion about the organization—changes the purpose of the motion that we adopted on the PMPRB study. I'll read it again, because I think that some people don't remember it.

The motion moves the following:

> That, pursuant to Standing Order 108(2), the Committee undertake a study on the Patented Medicine Prices Review Board (PMPRB) Guidelines issued on October 23, 2020; that, as part of this study, the Committee invite experts and pharmaceutical industry representatives, as well as civil society organizations or associations (representing patients), to appear; that the Committee hold a minimum of four (4) meetings; that this study be conducted in parallel with the Committee's study on COVID-19; that additional meetings be added to the Committee's schedule if the Committee deems it necessary; that the Committee issue a request for written briefs and for requests to appear by the end of the week with a submission deadline of November 6, 2020; that the Committee report its findings and recommendations to the House; and that the government provide a response to these results within 30 days.

I'll go through the points one by one to remind you of the motion's purpose. The 30-day period was related to the date of January 1. Ms. Rempel Garner introduced the idea of a simultaneous study because we didn't want to go beyond January 1.

We can't say that we have time to discuss this because the motion had an urgent nature. That's why we adopted it in this manner.

Why did we set November 6 as the date for the submission of briefs? This deadline was very short. We needed time to debate the motion and make our recommendations before January 1. That was the goal.

However, at one point, issues related to the organization of rooms and logistics made it difficult for us to find times to meet. However, we spent at least three meetings on COVID-19 not discussing the substance of the issue, but trying to agree on the organization of the proceedings. These meetings could have already been used to address the matter.

I'm speaking out, not for the pharmaceutical companies that have a legal department to represent them, but for patients, sick people, individuals with rare diseases and cancer patients who want access to the best drugs available and who are worried right now. I'm fighting for them.

We can say that this matter isn't urgent and that we can move this once the guidelines have been implemented. However, I'll say that this wasn't the purpose of the motion. I moved the motion. We introduced things in the motion. I believe, Mr. Chair—

● (1235)

[*English*]

The Chair: Mr. Thériault—

[*Translation*]

Mr. Luc Thériault: Mr. Chair, I have the floor. You cannot cut me off like that.

[*English*]

The Chair: I'm asking.... I need to comment here—

[*Translation*]

Mr. Luc Thériault: Mr. Chair, you did not say we had five minutes to speak. I have the floor. Plenty has been said by my colleagues. Mr. Davies spoke for a very long time.

I hope I can continue to talk.

[*English*]

The Chair: I just want to remind you that we are speaking on Mr. Davies' motion, not on a general thing. I want to remind you of that—

[*Translation*]

Mr. Luc Thériault: Mr. Chair, I am talking about the motion.

Mr. Davies' motion is based on a false premise. He actually believes that we have time and that we could go beyond January 1 to discuss the PMPRB. His motion is based on the idea that we will use only one meeting for that at the end of this session. But we are neck deep in briefs.

I have read all the briefs we have received since Thursday. If I had a half an hour to put questions to people, I could have done so. I did what I had to do. So I don't need time to read the briefs. I made it my duty to read them, since I asked those people to submit them by November 6.

I made a point of reading all of them before I met with people who claim to be acting for the good of Quebeckers and Canadians by establishing those guidelines. The fact that a process has taken five years—and this is the fallacy of time—does not mean everything has been done for things to be carried out properly. If that were the case, we would not still be here talking about it. There are issues related to this, and it would be in our interest to change our view of things.

Furthermore, it is currently considered urgent for the committee to submit a report on the study of this pandemic's second wave, as if it was up to us to make decisions on its management. The committee makes no decisions on that. The report it will produce will follow the government's decisions. How can we continue our work on COVID-19? That is one of the reasons I wanted to hold back my support for the Conservatives' motion until the issue of the report and the work we have done on the study of the first wave was included in this motion.

But how can we continue our work if we do not hold at least one meeting to deal with this report and with what has been implemented since the first wave? The analysts, about whom Mr. Davies expressed concerns, have been working tirelessly. Yet, we're behaving as if that work has in no way informed our questions on the assessment of the second wave or given them relevance.

What cannot wait today are patients who are concerned about the implementation of those guidelines preventing them from accessing medicines. It is certain that pharmaceutical companies will be the ones to decide whether to do business in Canada. That won't happen if they decide to pull out because of the ongoing competition across the planet. As I said earlier, the cost of drugs is not the only issue. It won't be once that has taken place that it will be time for us to return to the topic. Lives are at stake, and people on the front lines are managing the COVID-19 crisis. Those people are not waiting for the committee's advice to make their decisions. The committee is analyzing decisions that will be made to determine whether things will be done correctly when a third wave, a fourth wave or the next crisis hits.

What is urgent is for us to produce a report to identify the points of convergence among industry, patients and government, which wants to reduce the price of drugs. There is no issue on that side. However, some organizations—such as INESSS, in Quebec—are already setting drug prices and have considerably more comprehensive parameters than the PMPRB does. Those people have provided no analysis of the direct impact on patients, the network or the business.

So I will move a subamendment to Mr. Davies' amendment. I want us to set aside three meetings for the study on the PMPRB and one last study on COVID-19, or two meetings on the PMPRB study, another meeting on the COVID-19 study and another one on the PMPRB. I propose that we hold four meetings. We could use one for the study on COVID-19, but we have already wasted three of them even though dealing with this issue was urgent. We spent time on hardware issues and bickered over details. During that time, concerned people have been calling the clerk every day to find out when we will focus on the PMPRB. Patients are victims of COVID-19. Of course, the impact is collateral.

● (1240)

Those patients don't want to be collateral victims of COVID-19 or of a study that does not require waiting for January 1 to be carried out. We would do the same thing that is currently happening.

My mind on the PMPRB is not made up. If Mr. Davies' mind is made up, that's his problem, not mine. I want to be able to make a free and informed decision, and that is why we have to hear the voices of the most concerned people, and not only briefs read by experts.

I propose that we hold two meetings on the PMPRB, one meeting on COVID-19, and one last meeting on the PMPRB. That is my subamendment.

[*English*]

The Chair: Thank you, Monsieur Thériault.

We have a subamendment on the floor—sorry, no; it's an amendment.

Mr. Kelloway, do you wish to speak to the amendment?

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Mr. Chair, through you to MP Davies, thank you for your motion. I appreciate it immensely. I think it puts a lot of framework to what we need to do to get working. I think all MPs and our staff look forward to getting to work.

On a point of clarification, you mentioned three meetings. Is that three meetings in total, or three meetings for the remainder of the year, with the additional one for the COVID study, which would be four in total?

The Chair: We will go to Mr. Fisher.

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

I am not speaking specifically to this subamendment. I do want to support Mr. Davies' motion, so all things considered, I probably shouldn't speak to Mr. Davies's motion if you're asking for us to speak to the subamendment.

However, I certainly see a lot of value in what Mr. Davies has proposed as a way forward.

The Chair: Thank you, Mr. Fisher.

Now we have Mr. Van Bynen.

Mr. Tony Van Bynen: Mr. Chair, my hand is up to speak to the priorities we'd like to bring forward as the study, but it doesn't speak directly to Mr. Davies' motion.

The Chair: Mr. Barlow, please go ahead.

Mr. John Barlow (Foothills, CPC): Thank you, Mr. Chair.

I want to speak to Mr. Davies' motion. I do not wish to comment on Mr. Thériault's amendment, so please leave my hand up for when we're done with the amendment.

The Chair: Mr. Davies, please go ahead.

Mr. Don Davies: I have a couple of clarifications to what Mr. Thériault said.

He read the motion on the PMPRB. I'm not sure that was the motion that was ultimately passed, because Ms. Rempel Garner made an amendment to that motion that we passed. I specifically recall that it was that we wanted to get the submissions in by a certain date so we could then determine who the appropriate witnesses would be to call before the committee, which hasn't yet happened.

I'm sorry, but there's no other way to say this: He's completely wrong when he says that the study was to be completed by January 1. That simply is not in the motion. Those words are not there. If he had wanted this study to be completed by January 1, he could have said that in his motion and we could have passed it, but we did not.

I want to be clear: The motion does call for at least four meetings—

● (1245)

[*Translation*]

Mr. Luc Thériault: I have a point of order, Mr. Chair.

It cannot be said that this was not part of the motion's intent.

[*English*]

The Chair: Mr. Thériault, speak on a point of order only, please.

[*Translation*]

Mr. Luc Thériault: We can check the blues, Mr. Chair. I justified the 30-day time frame repeatedly by saying that it must be done before January 1 because that is the deadline. I talked about January 1 a number of times. People who have followed our work could tell you so. That is why, Mr. Chair—

[*English*]

The Chair: Mr. Thériault, this is debate at this point.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, we cannot distort a motion's meaning as it suits us. I did read the amended motion.

[*English*]

The Chair: Mr. Thériault, this is debate.

We will go back to Mr. Fisher. Please go ahead.

Mr. Don Davies: I'm sorry; I think I had the floor.

The Chair: I apologize; I'm losing track of my mind here.

Mr. Davies, please go ahead.

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

However Mr. Thériault wants to clarify it, the bottom line is that it sounds like we're in agreement. There is nothing that ever said that the PMPRB study has to be done by January 1. I want to also state that the motion does say that we have to hold at least four meetings, and I believe it even provides for our choosing to have supplementary meetings if we wish to as well.

What I'm talking about is having two meetings of the PMPRB study to be completed before we break for the seasonal break in December. That will be the one we have this week, and then one more, and then three on COVID.

I don't want Mr. Thériault—and if it's my error, that's fine—to consider that I'm suggesting that we do not have the remaining meetings on PMPRB when we come back in the new year, which we can do. What I am suggesting is that when we come back in January or February, we schedule the remaining two meetings on PMPRB and maybe even consider having more, if that's the will of the committee.

I would finally just point out that what was curious about the PMPRB motion was that it spoke to conducting that study in parallel with the COVID study. We did that was because, as we all know, it's the normal course of action for committees to usually deal with one study at a time, but we wanted to have two going at the same time. Of course we have very different, unique circumstances in terms of scheduling committee time in this COVID environment.

The COVID study is going to be going on for months. We have just submitted 16 different topics, and we're going to deal with the very first one next week. Obviously the COVID study will continue in January, February, March and April. We honour the PMPRB motion by having four meetings conducted in parallel with the COVID study. Nothing says we do that first.

I'm going to conclude by saying this: I agree that the PMPRB study is important. What I'm saying is that the COVID crisis must take priority right now for the reasons I indicated before, and we can move the PMPRB study in parallel in due course as we study COVID.

If we don't get to work on the COVID crisis very quickly.... Maybe Mr. Thériault and I disagree on this, but I say that Canadians want us to get to work on the COVID crisis right now and start dealing with the very serious, imminent and pressing health and life challenges that we are dealing with right now as we also move forward on the PMPRB study.

Thank you, Mr. Chair.

The Chair: Thank you, Mr. Davies.

Mr. Clerk, perhaps you could guide me as to who is next.

● (1250)

The Clerk of the Committee (Mr. Jean-François Pagé): I think it's Mr. Thériault.

The Chair: Go ahead, Monsieur Thériault.

[*Translation*]

You have the floor.

Mr. Luc Thériault: Mr. Chair, this has already been said, and I repeat it.

The sentence saying that the study should be carried out in parallel with the committee's study on COVID-19 was added to the motion because we had to consider two emergencies, which is fairly rare. That is why it was included. Otherwise, it would not have been.

Everyone knows this very well. Even the government representatives here, and Mr. Fisher, who attended a forum on the Trikafta drug, are well aware of this.

January 1 has been brought up several times. I even insisted on this twice, following comments made by Mr. Davies, who was trying to explain it. Absolutely nothing he is doing today surprises me.

However, if it's not down to the emergency issue related to January 1 and the implementation of guidelines, give me another reason why it is being added to a motion that this study must be carried out in parallel with the COVID-19 study.

Earlier, Mr. Davies was talking about one meeting plus three—so one at the end, just before we resume after the holidays again. If you want, we can always hold eight meetings after January 1. What will that lead to? People will realize that nothing will change by January 1. The government's current position is to accept the date of January 1, see what will happen and adjust next year.

Mr. Chair, put yourself in the shoes of someone who is waiting for access to a drug that will save their life. That is what we are talking about today. Saying that we can take the time we need to carry out this study seems inappropriate and insulting for patients that have a great deal of hope for that drug. The clerk could surely attest to this. I'm convinced that people are eager to testify and that they are only waiting for the opportunity. What Mr. Davies' motion is saying to them is that they will be entitled to one meeting. We will have only one meeting, which means a maximum of eight witnesses, before the holidays. Are you really serious?

I am speaking to the Liberal government's representatives around this table. Are you really serious? Many innovative medicines are coming on the market. Are you seriously ready to look rare disease and cancer patients lacking access to two of the six drugs in the eye and to tell them there is no emergency?

Mr. Chair, I will stand by my position and will not accept that, as I'm the one proposing the motion. We can always say that January 1 is not a set date. We don't need to do that because it corresponds to the implementation of the guidelines. However, a 30-day time frame, for instance, was provided in the motion.

I would like us to get back to common sense and intellectual integrity, and to recognize the true intent of this motion. That must be recognized.

If I have understood correctly, people don't even want to discuss my subamendment. That speaks volumes. People watching us with great hope in terms of the work we could do before Christmas on the PMPRB will be able to pass judgment on everyone here.

I will be able to look in the mirror because I am not distorting the motions that have been passed. If we were to look at the blues to consider the entire argument, we would see that what I am presenting has been voted on. I have presented the same thing I am talking to you about today.

● (1255)

[*English*]

The Chair: Thank you, Mr. Thériault.

Mr. Barlow, please go ahead.

Mr. John Barlow: Thank you, Mr. Chair.

Again, I'm speaking on Mr. Davies' motion, Mr. Chair. Are we done with Mr. Thériault's amendment?

The Chair: Not until the debate on the amendment is done. If you—

Mr. John Barlow: I will wait until we talk about Mr. Davies' motion. When we have the vote on Mr. Thériault's amendment, I will speak afterwards.

The Chair: Okay. Thank you.

Is there anyone who wishes to speak further on Mr. Thériault's amendment?

Seeing none, Mr. Clerk, will you please conduct the vote?

(Amendment negatived: nays 6; yeas 1 [*See Minutes of Proceedings*])

The Chair: Thank you, Mr. Clerk. The amendment is defeated.

We now go back to Mr. Davies' motion, the main motion. The debate continues on that.

Mr. Barlow, go ahead, please.

Mr. John Barlow: Thank very much, Mr. Chair. I appreciate your patience with my hand raised there.

I have a comment on Mr. Davies motion, and maybe Mr. Davies can correct me when he has a chance to intervene as well.

On his motion for the three meetings that we're going to have on COVID, he doesn't discern how many are going to be for the Liberal topic, and so on. I know that in the motion we've approved, there will be up to four meetings per issue. My concern would be with this, and I look to Mr. Davies to maybe clarify in his motion.

The Liberals' first priority is mental health, which I think all of us here would agree is extremely important. It's something that we all want to address. Certainly, mental health issues and the opioid crisis and things like that are reaching numbers never seen before. However, my concern is that I would like to see us have at least one meeting before we rise in December on a vaccine distribution, which is the Conservatives' number one topic.

The reason I raise this point, Mr. Chair, is we could very well have a vaccine of some sort ready to be distributed in Canada by the end of January or early February when we return. We haven't had a chance to even discuss potential vaccines that are being assessed and any sort of distribution plan. To put that in context, the United States has Operation Warp Speed. They have already started an assessment in co-operation with the military, the CDC and the health department to ensure that when a vaccine is ready for distribution, there is a strong, solid distribution strategy in place to make sure that every American gets access to that vaccine.

In contrast, as far as we know, Canada has no such distribution plan in place in partnership with the provinces and territories. It may or may not with the Canadian military. I think if we are going to have a vaccine ready for distribution, we haven't had any insight as parliamentarians, and certainly on the health committee, on questions such as what that distribution strategy looks like, how it will be distributed, who will distribute it, infrastructure on storage and transportation, the role of the provinces and territories and which provinces get what. We don't know if remote and rural communities and first nations communities will have access to an amenable number and whether it will be based on per capita or what. We don't have any answers to any of those questions. I think as a committee and as the health committee, this is a critical issue right now that we need to address.

I know Mr. Van Bynen is a strong champion for the mental health issue. I think all of us on here would agree that it is important. My colleague Todd Doherty, with the 988 helpline, has been pushing on this very hard as well. I think it's something we should include as part of that discussion, but I don't think there's any question that when we talk about COVID, we have to prioritize this. We have to triage the issues that are coming through. I completely understand that for the Liberals, mental health is number one, but I would say that the number one top-of-mind issue for Canadians is to know when a vaccine is going to be ready, how many doses we are going to have and how it is going to be distributed.

That is the Conservatives' number one priority. I would like to see us at least address that topic with one meeting prior to rising at Christmas, as we likely won't have a chance to come back to talk about it until February, when that vaccine may be ready and some process may be in place.

To Mr. Davies, I don't think you specified in your motion how many meetings of those three would be for a specific topic, but I would like to see two meetings on mental health and at least one on vaccine distribution before Christmas.

Thanks very much, Mr. Chair.

● (1300)

The Chair: Thank you, Mr. Barlow.

Ms. Sidhu, please go ahead.

Ms. Sonia Sidhu: Mr. Chair, first of all, can we confirm if we're all good with four meetings on the topic of mental health? Three meetings would be before Christmas, and one would be after that.

Can we ask the analysts when they would prefer to receive witness lists for the Monday meeting? Then we can start work.

The Chair: Sure. I will ask the analysts if they want to speak up to answer that point of information.

If we are to get witnesses for Monday, in what time frame do you need to get those lists?

Ms. Karin Phillips (Committee Researcher): I think I might actually pass it over to the clerk. I think he needs them Wednesday. I'll let him speak to the exact time.

The Clerk: My only concern is time. We need to do some testing in advance. We need to send headsets in advance. If you send your witness list by the end of Wednesday, I'm afraid it will be too tight for Monday. It would be great if I could get those names before that. If not, I'll do my best, obviously, but it would be a bit tight for Monday.

I'll do whatever the committee decides.

The Chair: Thank you, Mr. Clerk.

Ms. Sidhu, were you looking to amend the motion regarding the number of witnesses for the mental health study?

Ms. Sonia Sidhu: Sure.

Mr. Chair, can we clarify that it's four meetings?

The Chair: I guess that was what I was trying to say. Are you moving to amend Mr. Davies' motion to specify four meetings on mental health?

Ms. Sonia Sidhu: Sure, if everyone agrees. Yes, Mr. Chair, you can amend.

The Chair: We have an amendment by Ms. Sidhu on the floor, which is to specify that under the regime proposed by Mr. Davies, there will be four meetings on mental health.

Is there any discussion on Ms. Sidhu's amendment?

At the top of my list here I have Mr. Fisher.

Mr. Darren Fisher: I was on the list again to talk to Mr. Davies' original motion, but I actually think that makes sense. This is a topic that is massive, this pandemic within the pandemic. I'm happy to support four meetings if that is something Mr. Davies feels like adding to his motion.

The Chair: It's actually not up to Mr. Davies right now. It's an amendment by Ms. Sidhu, so we support it or we don't.

Dr. Powlowski, please go ahead.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I have to say I'm somewhat agnostic about the procedure in terms of which meetings we have first. I certainly understand what Mr. Thériault is saying about the PMPRB and the—

The Chair: I'm sorry, but we're running short on time. Can I get you to speak on Ms. Sidhu's amendment and whether it's four meetings or—

Mr. Marcus Powlowski: With all due respect, Mr. Chair, I am speaking on this as to whether we do four on mental health now or whether we do one with vaccines.

I generally agree with Mr. Barlow on the idea that vaccines are the number one issue that we're facing as a country right now. It will drastically change our lives when a large number of people are vaccinated, but we haven't gotten there yet. How are we going to get there? There are very important policy decisions to make on that subject.

I've listened to everyone else talk at length about various things, so I'm going to talk a little bit.

I don't really mind too much in terms of which order we do things. I think the problem here is that we're trying to do two really important things at once. There are several really important topics that we have to deal with. Certainly mental health is one of them. Vaccines are another one, and the Patented Medicine Prices Review Board. They're all important topics.

I don't really have any specific preference on which we do first, other than to say the problem seems to be that we just don't have enough meetings to cover everything.

That's all I want to say.

● (1305)

The Chair: Thank you, Dr. Powlowski.

Mr. Van Bynen, go ahead.

Mr. Tony Van Bynen: I wanted to clarify that four meetings are important. Last week the list of the top four topics for study for each party was submitted, and it's no surprise to anyone here that the impacts of COVID-19 on the mental health of Canadians is at the top of our list.

I want to thank my colleagues for their support in prioritizing this important topic. Today I'm seeking the support of my colleagues to have no less than four meetings on mental health. In the motion I introduced earlier this fall asking for a mental health study, I outlined a number of key areas for the committee to focus on, and having four meetings on mental health will allow us to cover these topics without rushing through them or missing any of them.

I know it's been a while since we've had a chance to read the motion, so I'd like to briefly refresh our memories.

The first area was understand the impacts, including the gendered impacts of COVID-19 on mental health and the well-being of Canadians.

The second was to analyze the impacts on indigenous peoples, racialized Canadians and vulnerable populations in an effort to identify and address the support gaps.

The third was to study the availability of mental health promotion programs and supports for those experiencing new pandemic stress-related issues, the anxiety that those issues produce and how we're going to be able to respond.

Next was to study the effectiveness and availability of virtual mental health services, and also to analyze how the Government of Canada can assist the provinces and the territories in alleviating potential new demands on their health care systems that would result in an increase in depression, psychological distress and substance abuse, as well as PTSD and domestic violence.

Mr. Chair, I believe it was—and I can't speak for Mr. Davies—the intention to attribute the three meetings to the current year, and it was my understanding that the fourth meeting would be next year.

I do want to emphasize how important it is, given what we're trying to cover, to have four meetings allocated to the mental health study.

The Chair: Thank you, Mr. Van Bynen.

[*Translation*]

Mr. d'Entremont, go ahead.

[*English*]

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

Quite honestly, I understand the importance of the mental health review and that we have to spend time on it, but Mr. Barlow lined up the importance of the vaccines that are coming. Every day there seems to be a new vaccine brought forward. Today a different kind of vaccine may become available from Oxford University. There's a lot of information that we need to understand on that side of things.

We're not saying that we don't do four meetings on mental health, but maybe we could do a couple now, do one on the vaccines, and then come back and finish the other two, dispersing PMPRB in there as well.

I know we're trying to do an awful lot at the same time, but that's the complicated landscape we find ourselves in today. I hope we can do the first two on mental health, then head off into a meeting on vaccines, maybe one on PMPRB, and then in January we could come back and pick up the mental health side of things again.

● (1310)

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

[*Translation*]

Mr. Thériault, go ahead.

Mr. Luc Thériault: Mr. Chair, this is getting a bit complicated.

First, according to Mr. Davies' motion, we would have three meetings for one study and one meeting for the other study by the holidays.

Second, Ms. Sidhu proposed four meetings on our priorities. The Liberals' priority is mental health. The themes we were to submit had to be related to mental health. The motion passed by the House could include other topics that have actually been rejected by the Liberals. They could have proposed mental health, since they just did that.

My understanding of Ms. Sidhu's motion is that the Liberal Party wants to set aside four meetings for mental health. That won't be done by Christmas. That will be done as part of the study and motion passed by the House on COVID-19.

It is pointless to move a subamendment to Mr. Davies' amendment, as his amendment strictly concerns organizing our work until Christmas. Why does this subamendment need to be moved when what is proposed by Mr. Davies does not currently go beyond Christmas?

I am struggling to understand why we are receiving this subamendment when Mr. Davies' amendment concerns the organization of the work we will do until Christmas. Does that mean Ms. Sidhu absolutely wants four meetings on mental health by Christmas? That is what the subamendment means if you accept it, Mr. Chair.

Ms. Sidhu did not specify why she moved her subamendment. I would like our true intent to be clarified.

Mr. Davies' amendment concerns the organization of work from now until Christmas. He talked about three meetings for one study and another meeting for the other study. Earlier, he said two meetings to look good because we are in fact having a meeting on the PMPRB today. If we count them, we have had a number of meetings on COVID-19 and half a meeting on the PMPRB. We have not had a two-hour meeting today. I would not take today's meeting into account.

Mr. Chair, can you clarify what we are talking about?

Why have you accepted Ms. Sidhu's motion, which concerns the work after the period mentioned in Mr. Davies' motion?

[*English*]

The Chair: Thank you, Mr. Thériault.

The motion is in order. Although she said in her remarks that she intended three meetings before Christmas and then one after, she basically wants it understood that there will be four meetings in total on mental health within that study.

Mr. Davies, go ahead.

Mr. Don Davies: Thank you.

I would like to thank Mr. Barlow and Mr. Kelloway for their thoughtful questions. I think Mr. Thériault is correct that there's a little bit of complexity here, but I think it can all come together.

The reason Ms. Sidhu's motion makes sense is that my motion is simply trying to deal with the remaining meetings we have before Christmas—and, by the way, what else is there to deal with? I think I can say without offending anybody that we've wasted a lot of time in the last couple of months. What I'm trying to do is get an orderly system of business so that we can get down to hearing witnesses both on the PMPRB study and on COVID. That requires us to determine what our remaining four meetings in the next two weeks are going to be.

The reason that Ms. Sidhu's motion is entirely in order is that if you go back to the motion we passed setting up the COVID study, we said that once we determine the order of issues, then it would be Liberal, Conservative, Bloc and NDP, in that order. We left it open to the committee to vote by majority as to how many meetings would be allocated to each topic.

Now we know that the Liberals want to proceed with mental health. That's established. We know we have three meetings on COVID before Christmas, according to my motion, if it passes. The question before this committee is how we are going to use those three meetings. The Liberals have said mental health, so now we have to determine whether we will have one, two or three meetings on mental health.

It's entirely in order and it is entirely sensible, because if the Liberals said they want to study mental health but we only want one meeting on it, then we would schedule that for the second meeting next week, and then we would have two more meetings on COVID, at which time we would proceed to the Conservatives' topic. Then we would take their first priority and have a discussion about how many meetings the Conservatives would like on that topic, ranging from one to four. Of course, we can have more by, I think I said, unanimous consent. The range of one to four meetings was to ensure that every party would get at least one meeting devoted to their topic, but no more than four.

I hope that we can proceed to the vote on this motion now, because otherwise, if we don't pass this today, despite everybody's pronouncements about how important these issues are to them, we're not going to be able to move ahead with any of them with the remaining four meetings we have—not PMPRB, not COVID. I would like to move forward on both of them.

I'm agnostic on the number of meetings. I do think all of us agree on mental health being an important issue. The issue of vaccines was the NDP's number one topic. I don't know if we've distributed the topic choices, but my number one pick on the COVID study was vaccines, so I empathize with Mr. d'Entremont's comments on that.

The reality is that we're not going to be able to get to everything or do justice to the subjects. Let's honour the motion we passed. We said we would go in order. The Liberals have identified their issue. We just have to determine how many meetings we want allocated to mental health. They want four. That's fine with me. When we come back after the holiday season, we will finish off that fourth meeting and then we will proceed to the Conservatives' next choice. Hopefully, before we break for the holidays, we'll determine how many meetings are appropriate for the Conservatives' next choice as well. That gives the analysts January to schedule those witnesses and for us to get our witness lists in.

Please, let's get down to business and start getting witnesses before this committee and do the work we're supposed to be doing here.

● (1315)

The Chair: Thank you, Mr. Davies.

We go to Mr. Thériault now.

[*Translation*]

Go ahead, Mr. Thériault.

Mr. Luc Thériault: Mr. Chair, I thought it was clear, but the further it went, the less clear it became.

I am acting in good faith, but you said earlier that Ms. Sidhu mentioned she wanted to split the four meetings as follows: three for one study and one for the other. In the blues, the Liberal Party said they wanted four meetings on mental health as part of the COVID-19 study by the holidays. We are here talking about the part concerning getting the study done by the holidays. Mr. Davies' motion concerns the breakdown of meetings and the organization of work until Christmas. He said earlier in his presentation that he wanted three meetings to be set aside for COVID-19 and one for the PMPRB. Once again, that's from the blues. How can that be compatible? So Mr. Davies thinks that the first three meetings could all focus on mental health. If the answer is yes, there is some consistency. If it is not, I don't understand Ms. Sidhu's amendment.

[*English*]

The Chair: Thank you, Monsieur Thériault. Ms. Sidhu's motion is that in general we want four meetings on mental health. That fits into Mr. Davies' motion, which means that three of those meetings on mental health would happen before Christmas and one would happen after. That is perfectly consistent with Mr. Davies' motion, but it is important to clarify how many meetings we have on a particular subject so that we know how to allocate witnesses.

We have now Monsieur d'Entremont.

Mr. Chris d'Entremont: Thanks a lot.

I'm still trying to—

[*Translation*]

Mr. Luc Thériault: Hold on now.

Mr. Chair, you just explained it to me, but I want to understand. This means that, if we were to vote for Ms. Sidhu's subamendment, the three meetings on COVID-19 would focus on mental health. Is that correct?

● (1320)

[*English*]

The Chair: That is correct.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, I would like the clerk to reread Mr. Davies' amendment, please.

The Clerk: That would be hard, because I don't have it in writing. I made some quick notes, but I don't have the exact wording. Perhaps Mr. Davies could reread it.

[*English*]

Mr. Don Davies: I'm sorry; I delivered it verbally. I don't have it written down. It's in the record. Is there a particular question about it?

I'll go over the basics on it again. Starting next week, we have four remaining meetings. The first three are devoted to the COVID study. The fourth meeting is on PMPRB. The parties will have until the end of Wednesday of this week to get their witnesses in on the COVID study. Of course, that presumes that we choose what the topic is, which will be mental health. We have until Friday of this week to get our witnesses in on the PMPRB meeting, which will be held two weeks from Friday, and there will be an equal number of witnesses, one from each party. I talked about having a conflict of interest declaration and screen by the analysts being required by all witnesses on the PMPRB study.

I think that was the nub of it. I'll defer to my motion that I moved if there is anything missing, but those are basically the elements of it.

The Chair: Thank you, Mr. Davies.

We'll go back to Monsieur D'Entremont, *s'il vous plaît*.

Mr. Chris d'Entremont: Thanks a lot.

Again, I don't want to discount the issue of mental health. We all have the phone calls in our riding offices. We're all talking to people who are having a tough go of the lockdowns that continue to happen in our respective provinces. Today, of course, the bubble has been burst; Newfoundland and P.E.I. have left the Atlantic bubble or the maritime bubble. It will be causing a whole bunch of other problems.

I think what people really need to understand is the issue of vaccines and how vaccines will be becoming available to us. Under this current run, we're going to be bumping the issue of vaccines until February, at this point, by any look of it, because we're going to be taking that break over Christmas. We don't come back until the second or third week of January. Vaccines, as Mr. Davies alluded to or said, are their number one concern as well.

I'm just wondering if there is a way to break it up so that we can at least get one kick at the can before February rolls around and we haven't had any look at this issue at all. I mean, everything has been changing. Things could go backwards—

Mr. Darren Fisher: On a point of order, Mr. Chair, we're not on Mr. Barlow's subamendment. That's been settled. We're on Sonia's, right?

Mr. Chris d'Entremont: No, we're on Mr. Davies' right now.

Mr. Darren Fisher: No, I think we're on Sonia's.

Mr. Chris d'Entremont: I'm trying to understand Sonia's, if you don't mind, Mr. Fisher, for just a few moments.

The Chair: Let me clarify.

Thank you for your point of order.

We are talking about Ms. Sidhu's amendment to Mr. Davies' motion.

Please go ahead.

Mr. Chris d'Entremont: All right.

My question revolves in and around why we're bringing this forward now and why we're pushing off the issue of vaccines to February. That's effectively what this motion ends up doing. We can't discuss probably the most important issue before Canadians today, which is vaccines and rapid testing and all that stuff, so that we can get out of the current situation we're in today. I just don't understand why the Liberals continue to want to push this off beyond a reasonable amount of time.

Unfortunately, Mr. Davies, I appreciate your trying to fill in the blanks, but I think you fell into the Liberals' trap here of trying to rag the puck as long as they possibly can so that they can't possibly discuss vaccines within a reasonable amount of time.

Again, I am not saying mental health is not important. We do need to talk about it. I am hoping we can talk about it for a couple of meetings and talk about vaccines and do the couple of meetings when we come back from our break. Don't interpret our vote against this as our being against mental health, please, because that seems to be where things tend to go in these meetings, but, gosh, we have a lot to try to cover here. To get it all blocked up by one is just irresponsible, I believe.

● (1325)

Ms. Sonia Sidhu: I have a point of order, Mr. Chair.

I just want—

The Chair: Excuse me.

Thank you, Mr. d'Entremont.

Go ahead, Ms. Sidhu.

Ms. Sonia Sidhu: I want to clarify that my amendment, the mental health topic, had a COVID study consisting of four meetings in total, with the final meeting to be held upon the committee's return in January.

I do agree with Mr. Davies' point. Let's go. We need the work done.

The Chair: Thanks for your point of order. Let's not get back into debate.

Yes, your amendment was for four meetings on mental health. Mr. Davies' motion is that three meetings on that study would happen before Christmas and one would happen after, and that there would be one meeting before Christmas on the PMPRB.

Mr. Thériault, please go ahead.

[*Translation*]

Mr. Luc Thériault: Things are becoming a little clearer now. Committee members cannot do through the back door what they cannot do through the front door.

We have spent a number of meetings on the motion relating to the COVID-19 study, which had to be proposed in the House of Commons. The Liberal Party tried to make us conduct a study on mental health. Mental health is one of my priorities, but there was a debate, and the House made a decision. We got our marching orders to work on the COVID-19 study, and the priority leading up to Christmas was not supposed to be mental health.

In that sense, I agree with Mr. d'Entremont. When the Bloc Québécois sent its list of witnesses and topics Wednesday of last week, we tried to address what would not be covered by the other parties, to avoid overlap and ensure relevant issues would be studied.

What this subamendment would do is have the committee meet three times on mental health and once on the PMPRB before Christmas. I can't support that, because I agree with Mr. Barlow, Mr. Powlowski, Mr. d'Entremont and Mr. Davies.

If we are going to spend only one meeting on COVID-19 before Christmas, it should focus on vaccines. Unfortunately, the Liberal Party is going through the back door to delay the COVID-19 study.

Mr. Van Bynen does not deserve that. What he is trying to do is commendable. I am as interested as he is in examining the issue. I am going to have to vote against the subamendment, not because I am anti a mental health study, but because it has taken us a long time to get to where we are today. We can't turn back the clock and do things through the back door. If we do, we will never see this through. We will never get anywhere if members keep trying to put a spoke in the committee's wheel.

[*English*]

The Chair: Thank you, Mr. Thériault.

Is there any further discussion on Ms. Sidhu's amendment?

Ms. Sidhu's amendment is to add to Mr. Davies' motion the understanding that the committee will deal with four meetings on the mental health aspects of COVID-19, in keeping with our previously adopted motion on the order of studies.

Seeing no further interventions, I will ask the clerk to please conduct the vote on Ms. Sidhu's amendment.

(Amendment agreed to: yeas 6; nays 5 [*See Minutes of Proceedings*])

The Chair: Thank you, Mr. Clerk. Ms. Sidhu's amendment passes. Is there any further discussion on Mr. Davies' motion as amended?

Seeing none, I will ask the clerk to—

● (1330)

[*Translation*]

Mr. Luc Thériault: Mr. Chair, does that put an end to Mr. Barlow's subamendment?

I thought Mr. Barlow had proposed a subamendment to Mr. Davies' amendment. Am I wrong?

[*English*]

The Chair: No, there is no subamendment.

[*Translation*]

Mr. Luc Thériault: All right. It was simply Mr. Barlow's wish to have the committee study vaccine distribution as soon as possible before Christmas.

Mr. Chair, that means we are considering Mr. Davies' motion, as amended by Ms. Sidhu, to have the committee hold three meetings on mental health and one meeting on the PMPRB before Christmas. Is that right?

[*English*]

The Chair: That is correct.

[*Translation*]

Mr. Luc Thériault: In that case, Mr. Chair, given what I said earlier about committee members' priorities, I clearly disagree on what we should be focusing on before Christmas. That is especially true since the committee would be putting mental health before the distribution of vaccines and spending just one meeting on the PMPRB, if I understand correctly.

I will definitely be voting against the motion.

[*English*]

The Chair: Thank you, Mr. Thériault.

Go ahead, Mr. Maguire.

Mr. Larry Maguire: Thank you, Mr. Chair.

Yes, I can see a lot of issues here. People want to have debates on the issues we have talked about here today. I have no problem with the three meetings on COVID and the one on the PMPRB, but I would ask our colleague, Don Davies from the NDP, to consider using one of those meetings for vaccines. If that was a friendly opportunity for him to do that, I think it would be fine.

We have no problem with four meetings for the mental health study. We could probably use four for vaccines as well. We know that we can't get them all in now. Many of them would be held in January and February, when we come back after the Christmas break.

I wonder if the committee would look at that idea without making it a formal amendment to his motion. I think it's a very good motion in regard to having three meetings on COVID and one on the PMPRB. I wonder if there would be some consensus to be able to use one of those meetings for vaccines.

Thank you.

The Chair: Thank you, Mr. Maguire.

I should point out that this is relitigating the motion that we decided last week, I believe unanimously, on how to proceed with this study. Is there any further discussion on this motion as amended?

Mr. Barlow, please go ahead.

Mr. John Barlow: Thank you, Mr. Chair.

Mr. Maguire took a bit of my thunder. I'm not sure if Ms. Sidhu is maybe taking advantage of semantics here, but I just can't let this go.

If Canadians had a better understanding of vaccines and the distribution of those vaccines, that would certainly help relieve their mental health and some of their anxiety. Ms. Sidhu's motion was to have four meetings on mental health, which I support, but I don't think the motion stipulated that the next four meetings concurrently have to be on mental health.

I would put forward an amendment to Mr. Davies' motion that of the three meetings we have on COVID prior to Christmas, one of those meetings be on vaccines and on vaccine distribution. I think that is a critical issue. It would help address people's mental health. Maybe we could even massage it into the mental health study. I would move an an amendment to Mr. Davies's motion to add that one of those three meetings on COVID prior to Christmas be on vaccines. We would still keep those four meetings on mental health, but we would just stick one in there.

● (1335)

The Chair: Thank you, Mr. Barlow.

Mr. Barlow has an amendment on the floor, which is that one of the three meetings in the remaining time before Christmas be devoted to the vaccines.

Mr. Davies, please go ahead on Mr. Barlow's amendment.

Mr. Don Davies: First of all, I think all of the issues that are being talked about and raised are important. I think one thing we have to resist as a committee is to get involved in politics about which one is more important and that if we vote in favour of studying this or that, it means we don't care about the other one. That's just not the case.

I can think of 10 different extremely important issues on COVID. Vaccines are one, treatment is another, mental health is another, and long-term care, where we've had 80% of the deaths.... My colleague Ms. Sidhu has been a champion on that. That's extremely important.

There is PMPRB reform to all those patients who are waiting for life-saving drugs. That's critically important. I'm already seeing on Twitter and other places the idea that if we push with one or the other, it means we don't care. We all care about all of those issues.

The fact remains we have four meetings in front of us. That's what we have. Surely as a committee we're going to have to start making those little compromises to get going, because if we don't get these meetings done, nobody's talking about anything before Christmas.

The truth is that we passed a motion last week that established a fair order of how we were going to proceed. It's not perfect, but it's a compromise. It allows each party to take their position in turn. The Liberals have gone first, and I think that's as it should be, because they are the government and they have the most members. If you have to determine who goes first, that's the fairest way to determine it.

We then left it to this committee, once each party identifies its topic, to determine how many meetings we as a committee feel ought to be addressed to that topic. I'm happy with what Mr. Barlow said. As I've already pointed out, for my part, I would proceed with vaccines, but in fairness to the Liberals, they are entitled to select their first topic, and that's mental health. They have decided that they would like four meetings for that, and we've passed that. That's not what I would have done, but that's what they've done, and I suppose they'll have to defend that decision politically as well if they want to.

Mr. Barlow's point, I think, is a fair one, which is that they don't have to be consecutive. I think it's understood in the motion we passed last week that we go in turn, so each party picks their issue and we deal with that issue. All we have to do is set the appropriate number of meetings.

I think it would really be up to the Liberals whether they were willing to split up their four meetings. I think if we're most faithful to the intent of the motion we passed last week, we would deal with each topic in turn as we determine the number of meetings for each topic.

Let's face it: Vaccines are going to be a critically important issue in January, February and March as well. While I would love to have some focus on them in one meeting, one meeting in December is not going to do sufficient justice to any of these important issues, including vaccines. I do note that we directed a lot of questions to the minister on Friday about that, and I know we have a session in the House of Commons this Thursday. I believe we have a committee of the whole with the health minister there, so there will be a chance to focus on those issues there as well.

Look, it's not perfect, but it gets the ball rolling. I just think we should get the ball rolling for these four meetings. We're not going to be able to deal with all the important issues that we need to before the holiday season, for sure, but let's get started on it. It doesn't mean that the issues coming afterward are any less important, because they're not.

The Chair: Thank you, Mr. Davies.

We have Mr. Thériault now.

[*Translation*]

Mr. Luc Thériault: The motion calling on committee members to submit a list of topics and witnesses by Wednesday of last week was based on the fact that each party was supposed to put forward at least one topic and its witnesses. According to Mr. Maguire and Mr. Barlow, we have three meetings on COVID-19 and one on the PMPRB right now. Two parties have already stated that the vaccine issue was a priority in the lists they sent to the clerk. It could be the subject of a single meeting.

The Liberal Party decided that the study would focus on mental health. One meeting could be held on that topic. It seems to me that, in accordance with the rotation set out in the motion Mr. Davies put forward the other day, the Bloc Québécois should get one meeting for one of its topics. That way, everyone would get what they want. The committee would meet three times on COVID-19 in connection with each party's priorities.

I would like the committee to spend a meeting on the importance of health transfers, which the pandemic brought to the fore. That would be perfectly in line with the work plan Mr. Davies proposed last week. That would determine the topic for each of the three COVID-19 meetings, the fourth being set aside for the PMPRB. I imagine there would be consensus on that.

● (1340)

[*English*]

The Chair: Thank you, Mr. Thériault.

Is there any further discussion on this amendment?

Seeing none, I will ask the clerk to conduct the vote.

Mr. Darren Fisher: Is this on the main motion now?

The Chair: No, this is on the amendment, which is to slot another vaccine meeting into one of those three COVID-19 meetings.

Are we all clear on the amendment?

Mr. Tom Kmiec: Mr. Chair, could we get clarity on exactly what the amendment is? I know people have been just saying things at committee. It's in the record; I understand that. Could we just be clear on what we're voting on right now? I know it's an amendment, but I would like the wording of it.

The Chair: We have Mr. Davies' motion as amended by Ms. Sidhu, which allows for four meetings on the mental health aspect of the COVID-19 study. According to Mr. Davies' motion, that would.... According to the meeting we had last week and the process motion, the order of study is determined already. Mr. Barlow's motion was to modify that to make one of the meetings on COVID-19 that we're having before Christmas on vaccines.

Is that clear?

All right.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, that means the committee will meet once on vaccines, twice on mental health and once on the PMPRB?

[*English*]

The Chair: That is what Mr. Barlow's amendment would achieve.

Is there any further discussion on Mr. Barlow's amendment?

Seeing none, I will ask the clerk to conduct the vote.

(Amendment negatived: nays 6; yeas 5 [*See Minutes of Proceedings*])

The Chair: Thank you, Mr. Clerk.

Mr. Barlow's amendment is defeated, so we will go back to Mr. Davies' motion as amended by Ms. Sidhu.

Is there any further discussion on this motion as amended?

Monsieur Thériault, go ahead.

● (1345)

[*Translation*]

Mr. Luc Thériault: Mr. Chair, I want to make sure I understand what's happening.

I gather from the votes and the parties' voting positions that three meetings will focus on mental health and one will focus on the PMPRB before Christmas. Is that correct?

[*English*]

The Chair: That is correct.

Mr. Luc Thériault: That is correct. Okay.

[*Translation*]

Mr. Chair, a moment ago, Mr. Davies was calling for consensus and co-operation. He talked about the importance of getting the ball rolling.

Mr. Barlow is proposing a subamendment on an issue that the population as a whole seems to care a lot about. The first thing we see happening is that the government is realizing its desire to make mental health the main priority of the Standing Committee on Health before Christmas. However, we, the opposition members, spent opposition day trying to make sure that the COVID-19 study would cover a series of issues. Mental health is one we could have added to the list, but today, the government is successfully imposing mental health as a topic of study before Christmas through a work planning motion.

I have nothing against mental health, but people are wondering why the committee is not getting anywhere. Because we keep being tripped up at every turn, because the government keeps putting a spoke in our wheel at every junction. There is no genuine willingness to co-operate. The government is going to study what it wants to study. The meetings that were derailed were used by both sides to stonewall.

All of this is being duly noted. Today, I hope the folks who thought we were going to make progress on the PMPRB issue are not questioning our intention as lawmakers. These kinds of political games are unacceptable. I don't understand Mr. Davies' position or the way he is voting. Although he can vote how he likes, he should walk the talk, as the saying goes, and he isn't doing that right now.

I was sure there was support for the study on vaccines, which is one of the NDP's priorities. Nevertheless, we find ourselves conducting a study on mental health before Christmas—and that comes as quite a surprise. I am having a lot of trouble understanding how we work on this committee and what each member's real intentions are.

Perhaps Mr. Davies still means to condemn the fact that the government is focusing on mental health instead of vaccines. He did make that point earlier, but he voted with the government, so I'm totally confused. Consequently, I'm going to abstain from the next vote.

[*English*]

The Chair: Thank you, Mr. Thériault.

Mr. d'Entremont, go ahead, please.

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

Definitely, I have the same sentiments that my colleague Mr. Thériault has. We always sit in these meetings and we all say that we should find ways to get along, and yet when we make reasonable suggestions, it seems that the government tries to avoid them.

Mr. Chair, we don't have any answers on vaccines, and even though we got to ask a few questions about vaccines on Friday, we still don't have the answers we need to understand how people are going to be getting the vaccines, when the vaccines might become available, or how they are going to be transported from place to place to place.

I thought that in this new era, when Mr. Davies got going, we were actually going to find a way to manage the next few meetings so that everyone could be on the same page. Unfortunately, we're finding that is not the case. We're finding that since they were not able to get their way the last time around when Mr. Van Bynen tried to run the motion on mental health to try to take up the time of this committee and was turned down because of the motion in the House of Commons, here we are again today, with their taking up the four meetings consecutively, except for the PMPRB meeting that is going to be stuck in the middle.

I find it unfortunate that we cannot get along when it comes to the number one issue that comes before us, which is for us to have a vaccine and to be comfortable with how it's going to transported across the country and how people are going to be able to get it. That will alleviate the anxiety that most Canadians have—not all Canadians, but a good chunk of them—because they are worried about the vaccine.

The example is really good here in the bubble, and I know that a number of my colleagues on this call—

● (1350)

Ms. Sonia Sidhu: I have a point of order, Mr. Chair.

Is this comment on the main motion?

Mr. Chris d'Entremont: This is on the main motion. Thank you very much.

The Chair: Thank you.

Mr. Chris d'Entremont: I love the interruptions in the middle. The frustrating part is that people are anxious. We've already had two provinces drop out of the bubble because of the anxiety those provinces have about the number of cases we now have in Halifax and in New Brunswick, so there is the challenge that we have.

We have the opportunity over the next few hours, the next few days, to be able to go back and discuss this, to have a better presentation on vaccines, to be able to talk about these things, and yet here we go. We've found a way to—

I see Mr. Davies' hand is up. Maybe he can explain a little bit more what his intention really was, but unfortunately we seem to have gotten railroaded by the Liberals on this committee.

The Chair: Thank you, Monsieur d'Entremont.

Mr. Maguire, please go ahead.

Mr. Larry Maguire: Thank you, Mr. Chair.

I have to agree. I thought we were operating in the spirit of co-operation and moving rather well there for a while. We have three meetings on COVID and one on the PMPRB. We know the work schedule here for the next while. I don't think it was too much at all to ask for one meeting on vaccines, and I don't want to put all the pressure on Mr. Davies either. There are Liberals on this committee who know that the vaccine is a big issue. They said so today, and I appreciate that.

Back home in Manitoba, I can tell you, where we have the highest per capita COVID cases in the country on a per 100,000 basis, vaccines are the big issue.

Now, not everybody is going to want the vaccine when it does come; don't get me wrong. For those who do, though, this is a big issue. How to spread those around, how to deal with the people who are in long-term care homes and how to deal with the workers in those homes I think is a huge issue.

People would be able to be a lot more relaxed over the Christmas holidays if we actually had a discussion about vaccines, how they are going to be distributed and where the priorities would be in these areas. A lot of these people are seniors. A lot of the people who are dying are in their eighties and nineties. Many are in their seventies, and some are much younger. We could really still help ourselves here by being accountable to people in Canada by dealing with vaccines as the number one issue, and it will help everyone's mental health—

Mr. Tony Van Bynen: I have a point of order, Mr. Chair.

The Chair: Go ahead, Mr. Van Bynen.

Mr. Tony Van Bynen: I believe the discussion of vaccines has been had and the vote taken.

Mr. Larry Maguire: Mr. Chair, I'm speaking to the main motion, and I think that's a fair assessment of where we need to be. The Liberals could still just say that we'll have one meeting on vaccines, or even even half a meeting on vaccines. They're not even willing to do that.

We all know how important mental health is. My colleagues have stated that, and everyone on the committee agrees. I agree with Mr. Davies when he says that just because you vote for something or against something doesn't mean they aren't all important. They all are important, but I think you have to go back to the number one issue on people's minds in Canada today, and it certainly is vaccines. It's about how they can help with everyone's control of their mental health by providing more understanding to the general public in regard to the priorities for making vaccines available to people, whether that priority is in the long-term care areas or whether it's with the workers in those facilities and our hospitals.

I'll leave it at that. I just hope that our Liberal colleagues will be able to accommodate one of those. Thank you.

● (1355)

The Chair: Thank you, Mr. Maguire.

Mr. Davies, please go ahead.

Mr. Don Davies: I only have one point to make, and that is, to the extent that there have been some minor aspersions about people's motivations, I think all of us are on the same page here. Look, I drafted the motion last week. Where did I put the NDP? Last. I'm going to be getting my issue maybe in March or April.

What I would say is this: Vaccines are important. As I said, it's my number one pick. If I were picking first, that's the one that I would go with, but we passed a motion giving the Liberals first choice and the Conservatives second. I assume the Conservatives will choose vaccines as their second pick.

Having one meeting on vaccines in December can't begin to plumb the depths of the issue of vaccines. Yes, it would be helpful, but vaccines are going to be incredibly important in January and February as well.

I agree with the Conservatives. It would be nice, if the Liberals saw fit, to have two of the four meetings and then one on vaccines. That would be helpful and it would be collaborative, but they're not required to do that. They're entitled to go first. They're entitled to pick their issue. They chose mental health. The question is, how many meetings do we want to allocate to that? I could go either way. There were sensible arguments made all around, but I'm warning us all again that if we don't make a vote on this right now, nobody's talking about anything next week. We will render meaningless all the profound commitments to all of these important issues if we don't pass this motion now.

There are many other vehicles to discuss issues. I think it is a very wise move on the Conservatives' part to have a debate in the House in committee of the whole with the health minister. That's an excellent venue in which to bring up vaccines, as well as in question period and other things.

Let's not make perfection the enemy of the good here. Let's proceed on this, and we can come back. I'll go on the record right now to tell you that I'll be supporting the Conservatives in having four meetings on vaccines when we return in January. Let nobody here think that vaccines aren't going to be a ferociously hot issue in terms of health care in January and February, because they will be. I don't think we're losing very much by getting this thing moving now.

I urge my colleagues: Let's just pass this motion, please.

The Chair: Thank you, Mr. Davies.

We have Mr. Thériault.

[*Translation*]

Mr. Thériault, you may go ahead.

Mr. Luc Thériault: Mr. Chair, the motion Mr. Davies successfully put forward last week established a rotation among the parties and topics. That rotation was agreed upon.

If we look at the remainder of the committee's meetings leading up to the holidays, it's clear that the rotation is not being respected. That is not at all in keeping with the motion that was adopted. If we hold a meeting on vaccines before Christmas, it doesn't mean that we won't hold more meetings on the issue after Christmas.

I repeat, what I find odd is that we started going adrift and wasting time right when the government members did not want us to move forward with the COVID-19 study. They tried to introduce topics that prevented the committee from dealing with the subject. Today, after spending a number of meetings on work planning and discussing proposals, we are in the same boat we were in five, six or seven meetings ago.

It's absurd that we let the government use a work planning motion to impose a decision on an issue that was the focus of an opposition day in the House. When must we bring forward a motion in the House that does not pass muster, that cannot be settled in committee? When the committee is at an impasse.

We sought direction from the House, and that direction was amended by a motion on the scheduling of committee business. Now, here we are confronted with the Liberal government's initial intention not to discuss hot topics related to COVID-19.

I just wanted to say this. No one is pulling the wool over our eyes. We are more than capable of seeing the alliance between the government and the NDP.

● (1400)

[*English*]

Mr. Don Davies: I have a point of order, Mr. Chair. Those kinds of comments are unhelpful, and frankly, they're beneath the honourable member from Quebec. I would remind him that if we don't pass this motion, all of his vaunted comments about the PMPRB will not happen as well, and we won't be getting to that study either if we don't pass this motion.

I resent any implication that anybody is motivated by anything other then the best interests of the committee. I would ask him to retract such an offensive comment.

The Chair: Thank you, Mr. Davies.

Mr. Thériault, did you want to say anything to Mr. Davies?

[*Translation*]

Mr. Luc Thériault: Although the member found the comment offensive, it was not meant to offend, Mr. Chair.

I think Mr. Davies has to take ownership of his voting position, plain and simple. By voting how he is, by siding with the government, he is supporting an effort that cast the committee adrift for seven meetings. I appreciate that his intentions are good, but this is the first time I have ever heard him say the government has precedence over us and that we must accept it because the government holds the majority in a minority Parliament. The voters in Canada and Quebec were the ones who decided that it would be a minority government.

This is the first time I have heard him say such a thing since we have been in Parliament together. I have a really hard time accepting that a minority government can throw the committee off course for seven meetings and impose its will. That is Mr. Davies' contention. I have the utmost respect for him, but as members, we must take ownership of how we vote. He doesn't want to be lumped together with the government, but his actions speak louder than his intentions.

I do not hear many Liberals jumping into the discussion. I imagine they are waiting until it's time to vote because they know they have the majority and don't need to make their case.

That is what I wanted to say. I did not at all mean to offend Mr. Davies.

[*English*]

The Chair: Mr. Thériault, I recognized you to respond to Mr. Davies. Did you wish to make a further intervention? Your hand has gone down.

Is there anyone who wishes to speak to Mr. Davies' motion as amended by Ms. Sidhu?

Seeing none, I will ask the clerk to conduct the vote.

(Motion as amended agreed to: yeas 10; nays 0 [*See Minutes of Proceedings*])

The Chair: Thank you all.

I will ask the clerk to distribute to all members the text we just agreed to, as well as the other motions upon which we're operating at this point regarding this study.

As per this motion, you are asked to get your lists of witnesses for the study on the mental health aspects of COVID-19 in by Wednesday and for the PMPRB in by Friday. On that basis, we will put together an appropriate panel.

Note that the House motion allows us one witness per one-hour panel and two witnesses per two-hour panel, so depending on the number of witnesses, we will decide what the panels are going to look like.

The meeting is adjourned.