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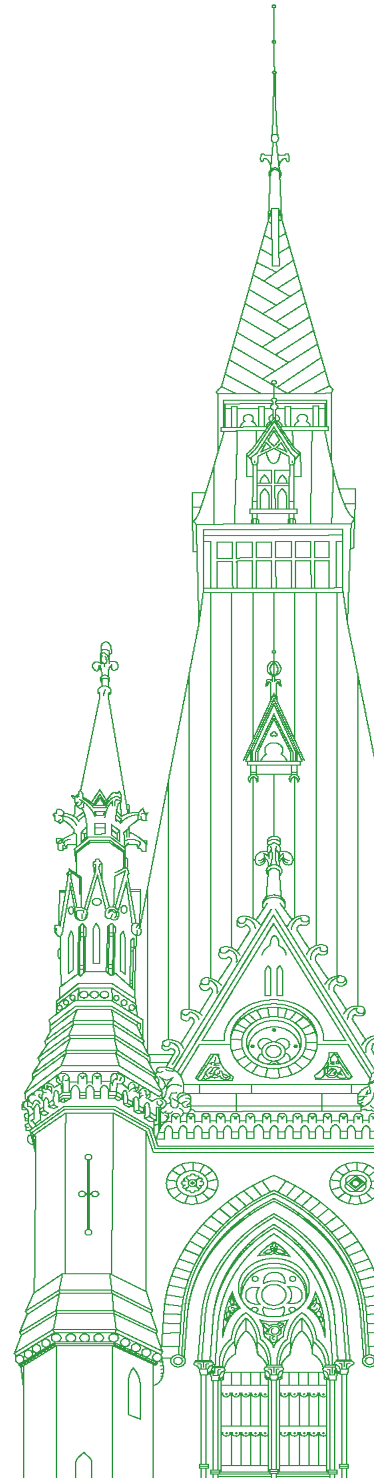

Chair: Mr. Sean Casey

Standing Committee on Health

Thursday, May 23, 2024

● (1535)

[*English*]

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

Welcome to meeting number 116 of the House of Commons Standing Committee on Health.

Before we begin, I'd like to ask all members to consult the cards on the table for guidelines on preventing audio feedback incidents.

Please take note of the following preventive measures that are in place to protect the health and safety of all participants, including the interpreters: Please use only the black approved earpiece. The former grey earpieces must no longer be used. Please keep your earpiece away from all microphones at all times. When you're not using your earpiece, place it face down on the sticker on the table for this purpose. Thank you for your co-operation.

Pursuant to the order of reference adopted by the House of Commons last night, the committee is commencing its study of Bill C-64, an act respecting pharmacare.

As was indicated in the memo that was sent out this morning, I'd like to remind members that amendments to Bill C-64 must be submitted to the clerk of the committee by 4 p.m. Eastern Time tomorrow, Friday, May 24, 2024.

It's important for members to note that pursuant to the order adopted by the House yesterday, the 4 p.m. deadline to submit amendments is firm. This means that any amendments submitted to the clerk after the deadline and any amendments moved from the floor during clause-by-clause consideration of the bill will not be considered by the committee.

Colleagues, we also have a budget for the study of Bill C-64 that I propose to present to you after we hear from all the witnesses this evening.

Without further ado, I'd like to now welcome our first panel of witnesses.

We have with us the Honourable Mark Holland, Minister of Health. He's accompanied by officials from the Department of Health. They are Michelle Boudreau, associate assistant deputy minister, strategic policy branch, and Daniel MacDonald, director general, office of pharmaceutical management strategies, strategic policy branch.

Minister Holland will be with us for an hour, and the officials will stay on until five o'clock.

Without further ado, welcome to the committee, Minister. You can now go ahead with your opening statement for the next five minutes.

The Honourable Mark Holland (Minister of Health): Thank you so much, Mr. Chair.

It's such a pleasure to be here with the committee.

[*Translation*]

I am extremely grateful for the work the committee is doing on this important issue. It is essential that Canadians have access to the medication they need. It's a fundamental aspect of our health care system.

First of all, I'd like to thank the member for Vancouver Kingsway for his work.

[*English*]

I think it's an excellent example of how, when we work together as parliamentarians and seek solutions to the difficult issues that are in front of us, we can find solutions.

I want to also thank the now-health critic, the member for New Westminster—Burnaby and the House leader. Both as a House leader and as a health minister, I've had a chance to work with him in his different roles. I thank him for his work.

Of course, within our own caucus, I want to thank the member for Brampton South, who has really been extraordinary in her advocacy.

Of course, there are so many that I could use the full five minutes. However, I'm going to focus today on drugs. We could talk about all the things we're doing on health, but let's talk specifically about medication.

There are 1.1 million Canadians who aren't insured and about one in five who are under-insured. In a very practical sense, that means they don't have access to the medicine they need.

Today in question period, Mr. Chair, we were talking about your home province of P.E.I. and the difference it makes for the folks—for islanders—to be able to afford their medication and how critical that is, not just as a function of affordability but also as a matter of dignity and a matter of prevention.

Let's just take diabetes in the first example. Some folks ask, “Why diabetes?” This is so fundamental to stopping so many other chronic diseases and illnesses.

Do you know that about 70% of chronic diseases and illnesses are preventable? We're taking historic action to deal with the crisis in primary care and to make sure people have access to the doctors and nurses they need.

Making sure we're upstream so that somebody doesn't get sick in the first place is so critically important. When somebody has access to the diabetes medication they need, what does that mean? It means they don't wind up with heart disease or a stroke. They don't wind up with the loss of a limb, or dying. That's fundamentally important as a matter of social justice.

It also is fundamentally important as a matter of savings. We know that about 25% of folks with diabetes right now are saying that cost is a major factor for them in sticking to a regime of taking the medication they need.

You can focus on problems and critiques or you can focus on solutions. That's what this bill does. It says we'll work with provinces and territories on creating a baseline. When we're looking at that formulary, that's a minimum, not a maximum. Let's be very clear that everything we're doing here is additive. It's working with provinces. Nobody is going to lose coverage. This is all about expanding coverage and making sure that patients have choice and that they get the medication they need.

Let's talk about sexual health as well for a second.

We need to have a conversation in this country around sexual and reproductive health, to be able to say that every woman in every part of this country has the ability to choose the reproductive medicines they need to take control of their reproductive and sexual health and futures. To me, that is fundamental. I hope it sparks a general conversation about sexual health in this country and about sex being something that is affirming and makes you grow stronger, not something that's used as a tool for shame and pain and hurt.

As I look at this plan, as I was saying today in the House, there are people who say that it's too much to hope for: Don't hope for dental care. Don't hope for pharmacare. Just give up. Go away.

Well, they said that about dental care, and yesterday at noon we crossed the point of 100,000 seniors getting dental care. To put that in perspective, I was in Vanier talking to a denturist about a patient who for 41 years had the same set of dentures. Next week she'll be getting a new pair of dentures for the first time. That means she won't be crushing food in her mouth with plastic plates. She will be afforded the dignity of teeth in her mouth. This is real stuff that we're doing.

There are people right now waiting for the contraceptives they need for their sexual and reproductive health. They're waiting for the diabetes medication they need. I was talking to Sarah in a diabetes clinic here about what that will mean for people avoiding illness, and about not seeing patients who are reusing syringes and getting blood-borne diseases because they don't have access.

This opens the door for us to negotiate with provinces to make sure that everybody gets that coverage. It will have a huge impact in terms of dignity, social justice, prevention and cost avoidance. I am exceptionally excited to talk about it today.

Thank you, Mr. Chair.

● (1540)

The Chair: Thank you, Minister.

We'll now begin the rounds of questions, starting with the Conservatives for six minutes.

Go ahead, Dr. Ellis.

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

Thanks, Minister, for being here.

You talked about access to primary care. Can you tell the committee how many Canadians do not have access to primary care?

Hon. Mark Holland: It's high. It's of course regionally dependent, but far too many Canadians don't have access. That's why we're working on these agreements.

Mr. Stephen Ellis: Just across the country, Minister, how many Canadians don't have access to primary care? You know the number.

Hon. Mark Holland: Well, it varies. Sometimes it's difficult to know, actually, because the circumstances are too opaque. We're missing a lot of the data we need in health to be able to give precise numbers. There are best guesses, but the number is too high. I've seen a lot of numbers all over the map.

Mr. Stephen Ellis: Clearly, Minister, you're too afraid to say the number, because under your watch it continues to increase. Is that not true?

Hon. Mark Holland: Well, no, actually. In the last 10 months, we've made huge progress. On my watch as health minister, we've signed 26 agreements, moving forward with $200 billion in funding. I think you wouldn't find an association or an organization that represents nurses, doctors or personal support workers that isn't saying that we're making tremendous progress, and have, over the last year.

Mr. Stephen Ellis: It's interesting, though, Minister. You've refused to give a number, but now you're telling Canadians that you've made progress. If you can't even count the number of people, how can you tell that you've made progress?

Hon. Mark Holland: One thing we did in the agreement that I think is critically important is to put common indicators across the country and prioritize health data so that we don't have that level of an opaque nature to our health system. We have provincial and territorial governments, and I think it's essential that we have common indicators so that we can have clear and concise answers to these questions. That was one of the things we built into that.

Mr. Stephen Ellis: Let's go back to the question. Let's just give a number. How many Canadians do not have access to primary care? Let's just have a number: How many million; how many—

Hon. Mark Holland: It's too many. We don't know the number.

Mr. Stephen Ellis: No, no, that's not a number. “Too many” is not a number.

● (1545)

Hon. Mark Holland: Well, we don't know the number. I've tried to explain that we can't—

Mr. Stephen Ellis: Everybody knows the number, Minister, except you.

Hon. Mark Holland: Well, if you know the number, say it. Where does it come from? Can you cite the source?

Mr. Stephen Ellis: Thanks very much.

Maybe I will try one of your associates here.

Mr. MacDonald, do you know how many Canadians don't have access to primary care?

Mr. Daniel MacDonald (Director General, Office of Pharmaceuticals Management Strategies, Strategic Policy Branch, Department of Health): Per the minister's comments, that information is being collected pursuant to the agreements that have been signed.

Mr. Stephen Ellis: Here we are. We have....

Madame Boudreau, could I ask you the same question? How many Canadians don't have access to primary care?

Ms. Michelle Boudreau (Associate Assistant Deputy Minister, Strategic Policy Branch, Department of Health): Thank you for your question.

Mr. Chair, I wouldn't be able to add anything further.

Mr. Stephen Ellis: What you're telling me is that we have three officials, including the Minister of Health, who have no idea how many Canadians don't have access to primary care. Wow. This is going to go a long way to helping Canadians, then.

How about this, Minister? Why is semaglutide not on your list of medications?

Hon. Mark Holland: What we did was create a base. One of the things we do when we're negotiating with provinces is we say, “This is just a floor” to make sure that we do have a floor for those who are uninsured or under-insured. We're absolutely open to the committee's comments and to negotiations with provinces in order to be additive.

I would say that the list you see is an absolute minimum. I would expect that there will be no final list that doesn't include more. If there are things you think should be on that list, I am quite interested in having that conversation. Hopefully, it would mean you support the legislation.

Mr. Stephen Ellis: I don't think we need to worry about that, because it's bad legislation and it's bad for Canadians.

Can you tell Canadians how long it takes in Canada, in general, from first launch of a medication to public reimbursement?

Hon. Mark Holland: Again, it varies by province.

I will take it back. I hope you won't just summarily reject the idea of helping people who are uninsured to get medicine.

Mr. Stephen Ellis: Minister, I don't think that was my question, sir.

Hon. Mark Holland: I would ask you this: What is your plan, sir, if not this plan? There are 1.1 million uninsured Canadians.

Mr. Stephen Ellis: Excuse me, sir, I believe it's my question to—

Hon. Mark Holland: Could you tell us what your plan is to insure those folks and make sure that people who don't have medication have medication? What is your plan, sir?

Mr. Stephen Ellis: Do you know what, Minister? You'll have your chance to ask me questions at some point when you're sitting in the opposition.

Can you tell all Canadians the number of days from global first launch to public reimbursement in Canada?

Hon. Mark Holland: Again, it depends on the medication and the jurisdiction.

I would put it back to you. If you are going to vote against something, my proposition would be that you have to explain what you're going to do in its place. If you have all of these folks who have no insurance or medication, it's a pretty simple question to ask back: What are you going to do in its place? If you say you have no answer, I would ask you why you are voting against this.

Mr. Stephen Ellis: No, I didn't say I didn't have an answer. You're the person who has given me.... I have asked you two questions now on simple numbers, questions to which you do not know the answer, nor do your officials.

Here's a third question, a simple number. Let's try another one. It's on the percentage of new medications available by OECD country.

There were 460 new medicines launched from 2012 to the end of 2021. How many are approved in Canada? What is the percentage? Just give the percentage.

Hon. Mark Holland: I will be straight with you: What is your purpose? What are you trying to ask?

I understand you're trying to play a “gotcha” game here, instead of.... I'm trying to talk about people who don't have medicine, and you seem to be lost in some kind of weird partisan thing you're doing.

Mr. Stephen Ellis: Oh, no, no. Let's—

Hon. Mark Holland: Do you have a plan for people to get medicine, or do you not? Is this an attempt to obfuscate the point that you don't have a plan?

Mr. Stephen Ellis: If you want to talk about the wacko things you're trying to do, we can talk about those. What I'm asking are simple questions on behalf of Canadians.

Hon. Mark Holland: I'm curious. What's your point? Do you have a point?

Mr. Stephen Ellis: I have lots of points.

Let's start with the first point: You have no idea what you're talking about.

The second point is this: Canadians wait the longest time in OECD countries for approval of medications, which you clearly have no clue about. We're back to that again, sadly. The last time you were here, you had no clue and you remain clueless, obviously.

The percentage of new medications available in Canada is 44% of 460 medications. What that means is this: Despite the fact that you want to go out and announce things that are untrue and not even happening, the system you have—the regulatory system that you, sir, have control over—is failing Canadians. You had an opportunity to change that. You have chosen not to. You have chosen to attempt to keep yourself in power with your costly NDP coalition partners by creating something that already exists at provincial levels—

The Chair: That's your time. If you want an answer—

Mr. Stephen Ellis: Thank you very much, Chair. I think we have already provided the answer.

The Chair: Hopefully, somebody else will allot you some of their time to respond. I think that would be the fair thing to do.

Mr. Naqvi, go ahead for six minutes, please.

Mr. Yasir Naqvi (Ottawa Centre, Lib.): Thank you, Chair.

Welcome, Minister.

I think the behaviour we just saw from Mr. Ellis is shameful. We're really trying to have a thoughtful conversation about a very important piece of legislation that is going to make an incredible impact on the lives of Canadians. You don't have to agree with everything. The idea behind a committee meeting is to have an analytical discussion as to how we can improve a piece of legislation, not get into the political, rhetorical diatribes that we saw.

I'm personally very excited to see this piece of legislation. I spent time working at the provincial level in the parliament in Ontario, where we brought in pharmacare legislation, a program called OHIP+. I was very disappointed when I saw the Conservative government of Doug Ford gut that legislation, denying so many Ontarians access to important life-saving medication, so I'm thrilled that at the federal level we are coming in with the national pharmacare plan.

I'm interested, Minister, in learning about the details. I know that this is a thoughtful piece of legislation. Can you share with us, if this legislation passes, the next steps in terms of engaging the provinces, the territories and indigenous peoples in rolling out this particular program? Also, I'm interested in the work that you are doing pursuant to this legislation, if passed, to ensure that all Canadians get access to diabetes medication and contraceptives.

● (1550)

Hon. Mark Holland: I think, in the first order—and this is why I was pushing back—that we have a very serious problem, and that problem is that a huge number of Canadians don't have drug coverage.

If we're discussing how we address that problem, I'm totally open to different ideas. I think this process is indicative of that. We had two different parties with two different ideas try to come together and find common ground. If other parties have other ideas, then I think it's important to talk about them.

Frankly, if they have no idea and they just think people should continue to be uninsured, then yes, I'm going to point that out. I think that's important to highlight, and I don't think it is appropriate to try to obfuscate behind some kind of weird strategy.

What I will say in terms of the next steps, because this is critically important, is that we've already started those steps. There have been very productive conversations with every province and every territory. They have really set aside partisanship to ask, in each province and each jurisdiction, how we can work with that jurisdiction of authority to augment and make better what they have.

We have provinces that are leaders, so let's acknowledge Quebec, B.C., Nova Scotia, and Manitoba particularly, which are really taking leadership in this area. We want to see that go even further to be able to work with leaders and to be able to expand our circle of action.

What's exciting about that is that it's an example of governments of all political stripes recognizing that diabetes and contraceptives are not something that we should be crossing swords over or trying to score political points on, that it's really how we get the medicine to people who need it and how we talk about solutions. It could be quite frustrating when I'm talking to provinces about solutions to be curtailed from that.

Then I would add an additional measure. Obviously, to really finalize those conversations, we need the House to adopt this so that we can finish those conversations, but then I would turn to the non-insured health benefit. You were asking, very importantly, about indigenous peoples, and I think that this is an important opportunity, in conjunction with what we're doing with the non-insured health benefit, to consider its efficacy and make sure that everybody has access to the medicine that they need. That's an iterative process, and it has to be taken a step at a time.

Mr. Yasir Naqvi: In terms of next steps, you are working toward what you foresee as bilateral agreements, and I'm assuming that they would provide for the delivery and payment of those medications.

For example, if I'm a Canadian who's uninsured and I don't have access to these medications, can I walk up to my local pharmacy and use my provincial health card to get access to, let's say, diabetes medication, if I need it?

Hon. Mark Holland: I think that's a fair characterization. We have to work it out for each province, but the idea is that you would have choice.

Somebody who has existing coverage can continue to use that coverage. For somebody who doesn't have coverage or is under-insured, this would give them a path towards coverage.

There are a lot of folks who are under-insured. Somebody may only have 70% coverage for their medicine, as an example, and can't afford the 30% copayment. That means they're not getting the medicine they need, which means they don't adhere to a regime of taking that medication, which means they wind up with a chronic disease, which means they end up in our hospital system, which costs us an enormous amount of money.

It's more than social justice. It's critical that those people have access to a choice. That is what this measure is going to do. It's going to open up a choice about whether you want to use your existing insurance or go with the single-payer universal system.

● (1555)

Mr. Yasir Naqvi: Talk to me a bit about choice. It's important, because there are a few out there who are trying to relay the point that somehow this is going to get rid of the private insurance someone may have and that this will be the only option to get their diabetes medication or their contraceptives.

Can you assure Canadians about what that choice looks like and how, if they choose to maintain their private insurance, they can do so?

Hon. Mark Holland: Yes, that's 100% right.

It's incredibly important that we don't allow misinformation to fill this space. This is about adding folks, expanding coverage and making sure that folks who are under-insured or who need access to insurance can get it and get the medication they need. It can be delivered through a single-payer model.

The Chair: Thank you, Minister.

[*Translation*]

Mr. Blanchette-Joncas now has the floor, for six minutes.

Mr. Maxime Blanchette-Joncas (Rimouski-Neigette—Témiscouata—Les Basques, BQ): Thank you very much, Mr. Chair.

I'd like to welcome the minister, who has joined us today.

Minister, the Bloc Québécois is in favour of the principle of helping sick people and the most vulnerable among us to obtain health care and benefit from a pharmacare program. Of course, you know the Bloc Québécois' position and that of the Quebec government, which are similar.

Minister, here is my first question: Have you had a discussion with the Quebec Minister of Health, Christian Dubé? If so, what did he tell you, in concrete terms?

Hon. Mark Holland: You're absolutely right, it is essential that we work in co-operation with the Government of Quebec. It has accomplished a great deal in the area of access to medicines for all Quebeckers. Our intention is to work directly with the Government of Quebec to increase what the provincial system provides. We don't intend to create another system; the idea is really to increase what the current system offers.

Mr. Maxime Blanchette-Joncas: Minister, what specific request did Quebec's health minister, Christian Dubé, have for you?

Hon. Mark Holland: We have to make sure that jurisdiction is respected. Indeed, we must respect Quebec's jurisdiction in the process. Consideration should be given to how the Government of Canada can work with the Government of Quebec to improve services for treating diabetes and contraceptives for women. There are needs, and it is possible to work in a spirit of collaboration while fully respecting jurisdictions.

Mr. Maxime Blanchette-Joncas: We understand each other.

Just so I'm clear, Minister, I'm going to quote what Quebec's health minister, Christian Dubé, said: “We have no problem adding this money to the pharmacare program. But there cannot be strings attached. It is not up to them to decide on the best drug coverage for Quebeckers.”

Minister, when you talk about respect, are you also talking about respecting the Quebec government's decision not to have a new pharmacare program imposed? Quebec has had its own program for 30 years now.

Hon. Mark Holland: We have no intention of encroaching on jurisdictions. For us, it's really about looking at how we can ensure that every person can obtain the medication they need, or the devices they need, as in the case of diabetes. It's not just a matter of medication; it's also about making sure that people have access to the devices and tools they need. There are a lot of needs. Our goal is to make sure that all needs are met.

Mr. Maxime Blanchette-Joncas: Yes, we agree on the needs. Now we have to talk about the way things get done.

Do you agree that Quebec should have the right to opt out of this pharmacare program, with full compensation and no strings attached?

● (1600)

Hon. Mark Holland: When I spoke with Minister Dubé, there was no problem.

The same was true with the bilateral agreements. There really was a spirit of co-operation.

Mr. Maxime Blanchette-Joncas: Let me rephrase the question, Minister, and the answer should be yes or no.

Do you agree that Quebec should have the right to opt out of your new pharmacare program, with full compensation?

Hon. Mark Holland: To me, it's—

Mr. Maxime Blanchette-Joncas: Minister, is it yes or is it no?

Hon. Mark Holland: Let me explain. You use the expression “strings attached.” I don't see it as a matter of imposing conditions, but as a matter of common purpose. We have to find the common goal.

Certainly, we have federal objectives. They are stated in the bill. However, I'm seeking—

Mr. Maxime Blanchette-Joncas: Okay. The answer is no, Minister.

Hon. Mark Holland: —common goals.

Your use of the term “strings attached” is the reason I'm avoiding that.

Mr. Maxime Blanchette-Joncas: You're mostly avoiding answering questions, as you just did again. That demonstrates a lack of respect for Quebec's wishes and, of course, for the request made by the Government of Quebec.

So your decision has been noted, and warm words and negotiations will no doubt follow.

I'll continue, Minister. You must understand that the Government of Quebec's own pharmacare program has already been in place for 30 years—yes, 30 years. You know that you copied the Quebec model for the child-care system. So what we are requesting today is legitimate. We already have a model. We simply want to get our money and manage our own program, which, I repeat, has been around for 30 years.

Quebeckers already have a program and are paying for it. They don't want to pay twice by also paying the federal government for its new program.

So the question we are asking you is this: do you agree that Quebeckers, who already have a program, should be able to get money from the federal government, to which they already pay taxes, and that these funds should be set aside by Ottawa with no strings attached to enhance the existing Quebec program?

That's the question.

Hon. Mark Holland: When it comes to federal money and the federal government's goals, it is essential to have a discussion to find common goals. This isn't about jurisdiction at all. In the case of this bill, given our responsibilities and the fact that the funds are federal, this is about finding common goals.

I think we're saying the same thing. This is not a problem when I discuss it with Minister Dubé.

Mr. Maxime Blanchette-Joncas: That's perfect.

The only thing I want you to understand is that the Government of Quebec already has its own program and that Quebeckers pay for it. If Quebeckers pay for a new federal program and that money is not returned to them, they will pay twice. That's the only thing we're asking you to understand and respect.

Hon. Mark Holland: Please understand that there is no federal program for that. We will work directly with provinces and territories to use the existing systems to provide people with medication.

So it's impossible with the Government of Quebec. The Government of Quebec is truly a partner in this process and it's important to find common goals.

The Chair: Thank you, Minister.

Thank you, Mr. Blanchette-Joncas. Your time is up.

[*English*]

Mr. Julian, you have six minutes, please.

Mr. Peter Julian (New Westminster—Burnaby, NDP): Thank you very much, Mr. Chair.

I want to underscore the important historic nature of this hearing today. It was 60 years ago that Tommy Douglas, the first leader of the NDP and the father of Canadian medicare, helped to push through the House—in a minority Parliament—universal health care. Now we're back, 60 years later.

Tommy Douglas's intention was always to move from universal health care to universal pharmacare, because the reality is that every other developed country that has universal health care also has universal pharmacare, so this is a historic hearing.

I certainly want to thank the many organizations that have brought this into being: the Canadian Health Coalition, the Canadian Labour Congress, the Canadian Federation of Nurses Unions, the Council of Canadians and so many other groups that have been pushing for years for this start of universal pharmacare. It's a historic day.

I want to thank you, Mr. Chair, for giving us adequate notice. We've known about this motion of instruction to the House for weeks, of course. We knew because of your memo last week that we had a week and a half to prepare for today's hearing and to prepare amendments. I appreciate the minister being here.

I do note that my Conservative colleagues have not asked a question on the legislation yet. I hope they took the week and a half you gave them to read the legislation.

Mr. Chair, I would like, through you, to ask the Minister of Health the following questions about some of the clauses of the bill.

First off, clause 8 talks about a national formulary. How do you see this developing as a national formulary that is required—once we pass this bill, as you know—to be put into place one year from now?

● (1605)

Hon. Mark Holland: Thank you very much.

Of course, the national formulary is one of the reasons that this bill.... We've also announced the establishment of a Canadian drug agency and put dollars forward to that so that the national formulary can be developed independently by subject matter experts to list that national formulary. I agree that it's critically important.

I was remiss in my opening statements. I think I spent a minute and a half saying thank yous, but you're right that this has been advocated by so many different organizations and groups. You're correct to acknowledge that. I want to acknowledge that omission.

Mr. Peter Julian: I want to move on to clause 9, which talks about the national bulk purchasing strategy.

As you know, Minister, we've seen countries like New Zealand using bulk purchasing, and bulk purchasing can reduce the cost of pharmaceutical products and medications that Canadians depend on by up to 90%.

You have that timeline of a one-year anniversary. How do you see that strategy being developed to meet that one-year deadline? Have you done studies internally to know what the difference would be in terms of the cost of medications to Canadians?

Hon. Mark Holland: We know that the action we've taken so far has saved about $300 million a year. We have coordinated bulk purchasing. That doesn't include private purchasing, but we have coordinated a lot of national purchasing through working with provinces and territories. That saved about $300 million a year. It's a significant amount of money. It's made our drugs much more competitive—so much so that we had the crisis with the United States looking to import our drugs.

However, we have more work to do. The exact quantum of how much we can save is difficult to say. There have been a lot of different estimates, but I can say that it is significant. When I talked to private insurers, they acknowledged that the ability to move to one common bulk purchasing program has the opportunity to save consumers an enormous amount of money.

Mr. Peter Julian: It makes you wonder how anybody could oppose lower costs and having more medication available.

Finally, I wanted to ask you to comment on clause 11, which is the committee of experts. Again, the deadlines are very tight—one year. That's why I think we've had so many people and so many organizations across the country urging us to move on this. This bill has been, unfortunately, blocked in the House for months, but now we're finally moving forward, which is wonderful.

With that one-year timeframe, the deadline is tight. How do you perceive the committee of experts reporting back to you and to the House of Commons?

Hon. Mark Holland: Yes, the need is urgent. The blocking of the bill is problematic, because people desperately need these medications. It's important that we act expeditiously.

With respect to the committee of experts, the intention would be to immediately name the folks who would populate that committee and for it to be able to report back so that we can get clear and concise information around costs and options on the path forward.

While this work we're doing now is essential in the areas of diabetes and contraceptives, we know there's a lot more work to be done. That committee, I think, is going to be very important in instructing costs and process in the way forward.

Mr. Peter Julian: For my final question for this round, a constituent from Burnaby, B.C., Amber, is paying $1,000 a month for diabetes medication that keeps her alive and in good health. What does this bill mean for people who, like Amber, don't have insurance and struggle to pay for their diabetes medication? What would it mean if this bill continued to be blocked and she didn't have access to the solutions that are provided for in the bill?

Hon. Mark Holland: To be very direct, you see it in going to diabetes clinics where patients like Amber are forced into choices of paying for their rent, their groceries or their medicine. Often, medicine is what drops.

What is so tragic is that same clinic will see the person return much later with an improperly managed condition, like diabetes, in a terrible state, or they wind up with a terrible chronic disease or illness.

Seeing something like that for Amber, something that is entirely preventable, I don't think we want to live in that kind of country. Raina, a 12-year-old, was at the announcement of this. She's an advocate and a kid who has diabetes, and she said to me that no one in this country should not not be able to afford their medicine. Sometimes when somebody is young, they can put something so clearly. I find it hard to disagree with Raina or with Amber that they deserve to be able to get their medication.

● (1610)

The Chair: Thank you, Minister.

Hon. Mark Holland: If the answer is “No, not this”, then it's a fair question for Amber or Raina to say, “Well, then what?”

The Chair: Thank you, Minister. That's all the time for this round.

Next up is Ms. Goodridge for five minutes, please.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair.

Thank you to the minister for being here.

Is there anything in this legislation that will prevent employers from cancelling or downgrading existing insurance plans?

Hon. Mark Holland: There's nothing that would change that. I was a head of the Heart and Stroke Foundation, so I negotiated private insurance plans. I can tell you that insurance companies very much want to continue their businesses. The fact that under-insured and uninsured people are now going to have the ability to get the medicine they need represents no threat to insurance companies. I think that—

Mrs. Laila Goodridge: I didn't ask about insurance companies. I asked about employers.

Hon. Mark Holland: But that gets to it. I mean, if you're an employer.... As I said, I would negotiate the health benefits for employees. Obviously, health benefits for employees include much more than just diabetes, drugs and contraceptives.

Mrs. Laila Goodridge: I understand. I'm asking if there—

Hon. Mark Holland: To drop your plan because a portion of medicine.... It's just not logical, right? No company would do that.

Mrs. Laila Goodridge: All right.

If this is a single-payer program, is anyone going to lose coverage from existing plans?

Hon. Mark Holland: The objective here.... No, we're making sure that people have choice about where they will go. For example, if you have somebody with 70% coverage and they can go to a public plan with 100% coverage, I imagine that they would make that choice. However, if they prefer their private plan, they would continue to use their plan.

Mrs. Laila Goodridge: Then can you assure us that no one will lose coverage based on this legislation?

Hon. Mark Holland: I can assure you, yes, that —

Mrs. Laila Goodridge: Thank you.

What consultations did you do specifically with Minister Adriana LaGrange in advance of putting forward this bill?

Hon. Mark Holland: I had conversations with all ministers, including Adriana. Obviously, there's a lot to settle. We know that we're talking here about just diabetes, drugs and contraceptives, but there have been positive conversations.

Mrs. Laila Goodridge: She has stated that you did not consult with her before putting forward this bill.

Hon. Mark Holland: She and I have talked many times—

Mrs. Laila Goodridge: Did you do it before putting forward this bill, on this bill?

Hon. Mark Holland: Yes, but I mean.... I want to be careful, Mr. Chair, if I could be precise, because I don't want to mis-characterize it. Obviously, before the introduction of the bill, those conversations had to be at a very high level. In fairness to her, they were not detailed conversations, because of course I would have been precluded from having those. However, we had conversations before and after generally about it, yes.

Mrs. Laila Goodridge: What about with Everett Hindley, the minister from Saskatchewan?

Hon. Mark Holland: It would be the same thing.

Obviously, before a bill exists, I can't share something of that nature. That would be violating and disrespecting Parliament, but at a very high level, for sure, there were conversations with Everett in Saskatchewan and elsewhere about the general concept and that I would come back to him with more details.

Mrs. Laila Goodridge: Minister Hindley is saying that you also didn't have specific conversations with him in advance of this bill.

My question becomes.... If you didn't have conversations with the two ministers from Alberta and Saskatchewan, and we know Quebec has shared some concerns regarding provincial jurisdiction, and we've had Saskatchewan, Alberta and Quebec all state that they want to opt out of this program, why did you not just put your ego down and work with the provincial governments and their existing plans to provide the coverage for those gaps?

Hon. Mark Holland: That's precisely what we're going to do—

Mrs. Laila Goodridge: That's not what this bill is. That's not what this bill does—

Hon. Mark Holland: Mr. Chair, if I could be afforded the opportunity....

There were a lot of people who said that we wouldn't get an aging with dignity agreement or a working together agreement with Alberta or Saskatchewan, but of course, we did.

I can say that on this subject, we've had very productive conversations around the needs in those provinces. I couldn't go into the level of detail of what would be in the bill because that would have violated parliamentary privilege, but afterwards, we've had very constructive—

Mrs. Laila Goodridge: Do you have deals with these provinces? Do you have a deal with Alberta, Saskatchewan, Quebec...?

Hon. Mark Holland: We do. There are 26 deals across the country.

Yes, we have deals with every single province and every single territory on health care. They were negotiated collaboratively, and I'm very confident that we'll get the deal on pharmacare as well.

Mrs. Laila Goodridge: With regard to pharmacare, do you have deals with the provinces on pharmacare?

Hon. Mark Holland: That would violate Parliament. Parliament needs to adopt this legislation before I can do that. I would be negotiating with no parliamentary authority, and I'm not allowed to do that.

Mrs. Laila Goodridge: Will your committee of experts have representatives from provinces and territories?

Hon. Mark Holland: I'm open to your feedback, so if you—

Mrs. Laila Goodridge: Can you commit to having—

● (1615)

Hon. Mark Holland: On the committee of experts, I think it's exceptionally important that we have people who understand the current context, and obviously consultations with provinces and territories will be a critical part of their process.

Mrs. Laila Goodridge: Minister, I want to bring forward an amendment to ensure that there are representatives named by every single province and territory across the country to make sure that their voices are heard when it comes to the committee of experts. Will you allow the Liberal-NDP members on this committee to support that amendment, yes or no?

Hon. Mark Holland: I don't think any more consultation than federal-provincial consultation is—

Mrs. Laila Goodridge: You won't support that amendment.

Hon. Mark Holland: No, and I'll tell you why. That's an extraordinary number of people for an unnecessary outcome. In negotiating with the provinces, I talk—

Mrs. Laila Goodridge: You don't think negotiating with provinces is a good idea.

Hon. Mark Holland: I do that every day.

I mean, there's not a province or territory that I'm not speaking to on a daily basis, and that will continue. I've been to every province and every territory—at least twice with the provinces, and once in the case of the territories—and I'm talking every day with them, so that consultation is an ongoing process—

Mrs. Laila Goodridge: I think that is exceptionally condescending to provinces that have their own jurisdiction on this—

The Chair: Thank you, Minister.

Thank you, Ms. Goodridge. That's your time.

We go to Ms. Sidhu, please, for five minutes.

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

Thank you, Minister and your team, for being here with us.

The discussion is very important. It's historic legislation that aims to increase equitable access to contraceptives and diabetes medication.

Minister, as you know, important progress has been made in our country with the national framework to fight diabetes. As we discuss Bill C-64, can you update this committee on the progress in implementing the national framework for diabetes as well?

Hon. Mark Holland: Thank you so much, Madam Sidhu, and I thank you for your advocacy, not only for this bill but against diabetes generally.

The framework is so important, and this is actually part of the framework. One thing the framework identified was access to medication, so this is a really important step forward, along with other actions we're taking, such as establishing the Canadian drug agency and running a pilot in the chair's home province of P.E.I. to help folks there.

There have been a series of actions. The framework really laid out the path, and this is demonstrative of our being serious about that framework.

Ms. Sonia Sidhu: Over the past few years, this government has put together several national programs to support the needs of vulnerable Canadians, including seniors. Many low-income senior citizens now have access to adequate dental care and to diabetes medication, and pharmacare is going to be transformative. We all know that.

How can these initiatives combined impact quality of life, including for seniors? They impact all Canadians, and we know that, but particularly seniors.

Hon. Mark Holland: In a very practical sense, I'll bring up dental care, because I just mentioned yesterday at noon that we surpassed 100,000 seniors, which in three weeks is pretty outstanding.

When you go and meet with a senior.... I think of Raphael. Yesterday, when I was in Toronto, I had an opportunity to talk with Raphael about what this meant. He could go in to get that care and he wasn't going to wind up sick. When I was in New Brunswick last week, I talked to dentists, who said, “Do you know what? I know the people who don't have access to dental care, and I know I'm going to see them in an emergency room, and I'm going to have to come in on a Saturday and not get paid and worry about whether or not they're going to lose their life because they didn't have access to care.”

It's the same thing for diabetes, and what we're making real with dental care we need to make real with diabetes medication and with contraceptives. It's about getting practical results and being upstream, which is not only about social justice: As I said, this is a huge opportunity to save money and avoid strain on our health system.

Ms. Sonia Sidhu: Thank you.

Minister, access to the latest technology is essential in managing diabetes. How does this legislation and other measures proposed by this government improve access to technology and devices such as pumps, lancets and glucose monitoring devices?

Hon. Mark Holland: It's a really great point, because when we're talking about medication, we also have to think about the monitoring strips, pumps and syringes. As I mentioned, it's tragic, but people are reusing syringes and getting blood-borne diseases because they don't have the money for new syringes. To me, that's not the kind of country we want to be in, so having a device fund to make sure that people have access to the devices they need is really critical as well. That will be an important part of the conversation that we have with provinces.

On the technology question, that's a bigger answer. However, building common indicators, upgrading interoperability, focusing on health data—the health data charter that we signed in Charlottetown—and a whole bunch of other actions in health data are absolutely critical to make sure that we have a modern health system.

Ms. Sonia Sidhu: Mr. Chair, do I have time for one more question?

The Chair: You have one minute.

Ms. Sonia Sidhu: Okay. Thank you.

Minister, we know that one Canadian out of four with diabetes has reported that they stopped following their treatment plans due to the cost. Could you explain how dangerous it is for Canadians living with diabetes to not have access to medication? What are the serious consequences? Is it costing them everything, including, sometimes, even their lives? Can you comment on that?

● (1620)

Hon. Mark Holland: I can tell you that I was head of Heart and Stroke's Ontario mission and I was head of their national program for children and youth. I can't tell you how many patients whose heart disease and strokes are the result of improperly treated diabetes or how many patients are winding up in hospitals with blindness or amputation or are dying because they don't have the medication they need and aren't adhering to it.

This is very serious, and it's why, when we're having this conversation, it's so important to talk about solutions. I really haven't met people out there in the country who don't want to see us fix this, so I think having a solutions-based conversation is extremely important.

We have a really great solution here. I hope Parliament adopts it. I haven't heard another solution.

The Chair: Thank you, Minister.

Thank you, Ms. Sidhu.

[*Translation*]

Mr. Blanchette-Joncas, you have two and half minutes.

Mr. Maxime Blanchette-Joncas: Thank you, Mr. Chair.

Minister, we're going to tell the truth today. It's been 30 years since Quebeckers developed the expertise to administer their own pharmacare program, without federal assistance. We didn't ask you for a single cent and we've never needed your expertise. What's more, you don't have that expertise, since you don't currently have a pharmacare program. I recognize that you have good intentions and that it's a good idea. That's great. We're in agreement there.

Currently, 45% of the population of Quebec is covered under a public drug plan, while the remaining 55% of Quebeckers are covered under a private plan.

Minister, what can the federal government do better than the Quebec government, which has 30 years of experience?

Hon. Mark Holland: Give me the opportunity to negotiate with the province of Quebec to identify common goals and add to what the Quebec program is providing. It's entirely possible and that's my goal.

I understand what you're saying. However, the program will be managed by the Quebec government and can exist only on a co-operative basis. Any other situation wouldn't be possible.

Mr. Maxime Blanchette-Joncas: All right. We want to manage the program, but we also want the right to withdraw with full compensation. That's what Quebec is asking for.

Minister, do you know where to find the best pharmacare program in Canada? Quebec. We have 30 years of experience.

Tell me concretely what the federal government can do and what the Quebec government can't do under its own program.

Hon. Mark Holland: We can learn many things from the province of Quebec. I'm greatly inspired by what it has accomplished. I think that, by working together, we can improve the situation not only in Quebec but across the country.

Mr. Maxime Blanchette-Joncas: Name one thing that the federal government can do that Quebec can't.

Hon. Mark Holland: First, it's a matter of money.

Second, it's about co-operation. We can always obtain better results by working together.

Quebeckers are concerned about their health, and not about areas of jurisdiction. It's my responsibility to work with the provinces to improve the quality of health care across the country, including in Quebec.

Mr. Maxime Blanchette-Joncas: Minister, if you want to improve health care in Quebec, transfer Quebec the amounts needed to fund that care and respect your agreement topay 50% of health care costs. Once you have done that, you can come and teach us things, all right?

Hon. Mark Holland: All right. I'll respect the principle and we'll work together.

The Chair: Thank you, Minister.

[*English*]

Mr. Julian, please go ahead for two and a half minutes.

[*Translation*]

Mr. Peter Julian: I'm pleased to have the opportunity to speak now, Mr. Chair, because I have an announcement to make. My Bloc Québécois colleague seems to be suggesting the opposite of what nine major organizations in Quebec stated just a few hours ago. These organizations include the Union des consommateurs, the Centrale des syndicats démocratiques, the Coalition solidarité santé, the Confédération des syndicats nationaux, the Fédération interprofessionnelle de la santé du Québec, the Fédération des travailleurs et travailleuses du Québec, the Table des regroupements provinciaux d'organismes communautaires et bénévoles, to name just a few.

These organizations, which represent over two million Quebeckers, are saying that they applaud Bill C-64 introduced by the federal government: “Never have we been so close to establishing truly public and universal pharmacare. Quebec's hybrid public-private program is creating an unsustainable two-tiered system that must be corrected.”

In the brief they submitted today, these organizations point out that the current Quebec pharmacare program is far from guaranteeing everyone reasonable and equitable access to medication, as set out under Quebec's Act respecting prescription drug insurance. These organizations are saying that Bill C-64 puts in place a framework leading to the creation of universal and public pharmacare. They stated the following: "We're calling on the federal government not to give in to the provinces and territories that are demanding the right to opt out unconditionally and with full financial compensation."

Minister, given that this large coalition representing a significant proportion of the population of Quebec is saying that it supports Bill C-64, should Quebec members of Parliament listen to it?

● (1625)

Hon. Mark Holland: I would simply say yes. That seems logical. When people are willing to work together, anything is possible. When people are looking for a fight or problems, it's easy to find them.

Those organizations aren't the only voices we need to listen to. Quebeckers just want us to improve the quality of health care, and this is proof of that.

Mr. Peter Julian: Of course, that's because nearly 15% of the population of Quebec isn't covered by the current plan. The reality is that public-private plans are often far more expensive. We know that. They turn a profit but they don't cover everyone. So—

The Chair: Thank you, Mr. Julian. Your time—

Mr. Peter Julian: —what are your comments on that?

The Chair: Please give a brief answer.

Hon. Mark Holland: I have nothing to add, Mr. Chair.

The Chair: All right. Thank you.

[*English*]

I think Dr. Ellis and Mr. Steinley are going to split the next turn.

Mr. Stephen Ellis: That's correct, sir.

The Chair: Dr. Ellis, you have the floor.

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

Interestingly enough, this legislation talks about a universal single-payer system. Can you explain that a bit, and not in your usual ongoing fashion that you like to do? Can you simply explain to Canadians what that might mean?

Hon. Mark Holland: Sure. It means that somebody is going to be able to get the drugs that they need without having to pay.

Mr. Stephen Ellis: That's great. That's interesting.

My colleague talked a bit about somebody who had pre-existing coverage through their employer. Why would employers continue to offer their employees a program if this is going to exist?

Hon. Mark Holland: Employers offer much more coverage than we're contemplating here. This is a very tiny sliver of what employers offer.

I can tell you from negotiating these things that there is not the opportunity to go à la carte. If you try to pull out a tiny fraction, you're not going to save very much. You're going to show your employees that you're not serious about them.

What I've seen from the insurance industry is that they are very anxious to maintain their coverage and their business—

Mr. Stephen Ellis: Thanks very much, Minister—

Hon. Mark Holland: What I've seen from employers is they're anxious to make sure that their employees continue to get coverage—

Mr. Stephen Ellis: I think you've answered the question I've asked.

Again, you have to go on and on. Maybe you could just try answering the question instead of doing your political grandstanding.

That said, what you've now said is that what you've created is a very basic, inferior program on behalf of Canadians. I find that absolutely interesting.

Built into this bill, you talked about the creation of the Canadian drug agency, which I understand should have been stood up around May 1. It is in your purview as the Minister of Health, so I'll give you kudos on that.

Given that you could have actually created an agency that has significant oversight.... Maybe you don't realize it should have oversight, because the approvals that are done through the process, including Health Canada, the PMPRB, the new CDA, pCPA, etc., are some of the worst in the country, or maybe not the worst, and you could have actually changed that with this legislation, but you chose not to, can you tell Canadians why they're going to be left out in the cold waiting for new medications?

Hon. Mark Holland: They're only going to be left out in the cold waiting for new medications if you're successful in stopping them from getting their medication, in the first order. In the second order, Health Canada is known around the world not only for the rapidity with which we approve applications, but the quality.

Canadians should feel very proud not of me but of our health officials. Every day they do extraordinary work to make sure that the products, medications and food that Canadians consume are safe. I think that to cast any shadow on that would not only be not connected to fact, but—

Mr. Stephen Ellis: Thanks very much, Minister.

I think that what I asked about was the Canadian drug agency and why you didn't put some oversight into this bill with respect to the Canadian drug agency.

It's not my plan to stop Canadians from getting drugs; you are the one who will be responsible for having some oversight of the CDA, which you do not have.

Why do you choose not to do that on behalf of Canadians?

● (1630)

Hon. Mark Holland: I would say that through our existing mechanisms, we have very strong oversight. We are recognized as being one of the best regulators in the world. When people look to approvals done by Health Canada, they know that this is a gold standard that other countries look up to.

I am extremely proud of the people who work in our public service every day to do that.

Mr. Stephen Ellis: Minister, do you think it's okay that of the 460 medications that were brought forward from 2012 to 2021, Canadians would have access to only 44% of those? Do you think that's okay?

Hon. Mark Holland: I think that we have to be—

Mr. Stephen Ellis: It's a simple yes or no, Minister. Is that okay or not?

Hon. Mark Holland: I don't get to dictate your questions; you don't get to dictate my answers—

Mr. Stephen Ellis: The answer is a simple yes or no.

Is it okay, yes or no?

Hon. Mark Holland: The answer is that when we approve medications, ensuring they're safe and ensuring that people aren't hurt—

Mr. Stephen Ellis: No, Minister. Is it okay that Canadians have access to only 44%, yes or no?

Hon. Mark Holland: Making sure that they don't injure people's health is a hallmark of Canada's drug approval system that I am deeply proud of.

Mr. Stephen Ellis: Again, you talk about people grandstanding and all you choose to do is continue to talk, which is quite impressive—

Hon. Mark Holland: I don't know; you don't seem to want to let me answer.

Mr. Peter Julian: I have a point of order.

The Chair: Mr. Julian, go ahead on a point of order.

Mr. Peter Julian: I think the tradition around this table has been that when you ask a question, you wait for the answer. I would appreciate it if we could get the answer.

The Chair: Dr. Ellis, Mr. Julian" is correct, but there have been violations by both the person posing the question and the person answering the questions throughout this round, quite frankly.

There is about a minute left in your turn, Dr. Ellis, if you want to share with Mr. Steinley or if you'd like to carry on.

Mr. Stephen Ellis: That's correct, Chair. The rest of the time is for Mr. Steinley.

Mr. Warren Steinley (Regina—Lewvan, CPC): Thank you, Minister Holland.

Did the Minister of Health from Saskatchewan ever ask for dental care or pharmacare from your government?

Hon. Mark Holland: I think they've asked a lot of questions about how we can work together on dental care. Those questions have been productive.

I expressed to both jurisdictions that if they wanted to operate those programs provincially, as long as they were at the same cost and the same quality, I would be open to that.

Mr. Warren Steinley: Mr. Minister, I have from their health minister that they have never asked the feds for dental care or pharmacare. Is he not telling me the truth or are you not telling me the truth?

Hon. Mark Holland: You can ask him whether or not he wants dental care. Dental care for nine million Canadians is coming.

Mr. Warren Steinley: No. I said, did he ever ask for it?

Hon. Mark Holland: I can tell you that I've had very good conversations with Everett. I have an enormous amount of respect for him. He and I have sat down and talked.

It's about how we can work collaboratively. He has never said to me that he doesn't want dental care for the people in Saskatchewan. If he said that to you, that's not—

Mr. Warren Steinley: He said that he never asked for it.

I have one more quick question.

Do you know how much coverage we have in Saskatchewan right now when it comes to diabetes programs and the seniors' drug program?

Hon. Mark Holland: I think Saskatchewan has done a good job. They have a good program.

Mr. Warren Steinley: Can you tell me what it is?

Hon. Mark Holland: There are still a lot of gaps and there are a lot of things we can do together. Everett and I have talked about those gaps and about how we can improve them to make sure that everybody has care and isn't under-represented.

Mr. Warren Steinley: Can you tell me what ages are covered in Saskatchewan by—

Hon. Mark Holland: I would commend Saskatchewan for the work they've done. I do agree that Everett has done a good job as the health minister.

The Chair: Thank you, Minister.

The last round of questions for you this evening will come from Dr. Hanley, please, for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you.

I'll add my welcome for seeing you here today, Minister, and thanks to the officials for being here.

My first question is along the same lines as some of my colleagues around the table, perhaps with a little different flavour.

I think Canadians—people in my jurisdiction in the Yukon, for example—have a large number of public employees covered by insurance plans, as well as by some of the larger private employers. They are very interested in the integrity of those programs continuing.

Also, it has been pointed out that in subclause 6(1), there is the authorization for the minister to enter into an agreement to make payments to the province or territory "to increase any existing public pharmacare coverage—and to provide universal, single-payer, first-dollar coverage" for the specific areas of contraception and diabetes.

Is there a vision, ultimately, of a universal single-payer system? A single-payer system is frequently used in advocacy and in various reports recommending that we ultimately move towards universally accessible pharmacare.

Maybe you can tell me about your vision for a single-payer system and how that is compatible with the existing system that many benefit from with third party coverage.

● (1635)

Hon. Mark Holland: Thank you very much, Mr. Hanley, and I thank you for your advocacy and work in public health prior to this job and during it.

In the first order, what we've said is that this is a bit of a pilot. We have an opportunity to see a single-payer universal system out of an academic construct and out in the real world.

In P.E.I., we have another model, which is a fill-in-the-gaps model, and we have now a committee that's going to be able to look at it and examine the costs and the future path for a single-payer universal system. We're going to be able to compare that and then be able to make informed decisions about the path forward. What I've said is that the conversation needs to be informed by data and real-world results and action.

If I could, I'll take a moment to talk about, for example, why providing contraceptives is such a logical place to start with a single-payer universal plan. You could have somebody in an abusive relationship with a partner who has insurance, and they have to go through their partner in order to get the contraception they need, or you could have a 16-year-old who wants access to contraception but doesn't have parents who would support them in getting access to that contraception.

This is, I think, a very logical place, when you're talking about that experiment, and also because of the number of under-insured folks with diabetes.

Mr. Brendan Hanley: Thanks.

On your latter point, you and I actually just had a discussion with one of the family doctors from Yukon who is an expert in reproductive health care and also a passionate advocate for access to reproductive health care. You said in your opening remarks that Bill C-47 really provides an opportunity for us to talk more about sexual health, about access to sexual health and reproductive health care. Maybe I'll give you a little more space to talk about how important this topic is.

Hon. Mark Holland: Thank you so much for that.

When I go to AIDS clinics, just as an example, they have a huge problem getting people to come in and get tested and have conversations, because of the stigma. AIDS is an entirely manageable condition. It's a chronic condition. It doesn't have to be a death sentence. We want people to get care.

On even a more granular basis, how many kids.... We look at teen suicide around sexual identity issues, and shame has led to terrible outcomes. I can say that the lack of conversations around sex in my own household was incredibly damaging. When sexual violence was visited upon my family—and we didn't talk about sex in our household—that was incredibly damaging and left me very confused about sex.

Having a broader conversation in this country about sex and sexuality, and sexual health and sexual autonomy, is critically important, and I hope it's part of the conversation that we'll have as we're talking about contraceptives.

Mr. Brendan Hanley: Thank you.

If I can, I'll quickly squeeze in a third question.

You talked about your previous role with the Heart and Stroke Foundation, and you did I think some really excellent work there. The Heart and Stroke Foundation, in their briefing note, pointed out that almost one in 10 people in Canada are visiting an emergency room due to a worsening health issue because they are not able to afford their prescriptions.

Bill C-47, I think, is going to try to help address this gap. Can you comment very quickly on that?

Hon. Mark Holland: You're 100% right.

I would encourage every member of the committee to go and talk to a nurse or a doctor—or, frankly, a dentist—about what happens when you don't do prevention right.

It is the most heartbreaking thing in the world to watch somebody you love get sick or die. The only thing that is more heartbreaking is when it was preventable and never should have happened. We are too great a country. Our values are, I think, that we shouldn't allow that to happen in this country—that if we can prevent it, we should prevent it. That's what this bill will do. That's what we need to negotiate with the provinces.

The Chair: Thank you, Minister.

We've gone a bit over the time that you had committed for us. We're grateful to you for showing up right off the hop on this study. Regardless of political views, the passion that you bring to your work is evident. Thank you for that.

Minister, you're welcome to stay, but you're free to go.

We still have about 25 minutes with officials. I'm not going to suspend, because I'm sure we have questions for them.

Thanks again, Minister.

Colleagues, I know that we're facing an imminent emergency with the lack of coffee. We've made the folks aware of that impending emergency and trust that it will be rectified fairly soon.

We're going to continue now with rounds of questions. We're back to the Conservatives for five minutes.

Dr. Ellis, go ahead, please.

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

Interestingly enough, as you know, we had some probing questions with respect to drug approvals in Canada, and, as I said previously, the minister specifically had an opportunity here with respect to this legislation because it does talk about standing up the new Canadian drug agency, and there certainly was an opportunity to have some safeguards around the Canadian drug agency and drug approvals in Canada.

Perhaps now I could ask the officials about the drug approval process in Canada, because, quite frankly, we've already established that Canadians don't have access to primary care. I think everybody out there watching knows clearly that it's hard to get a prescription if you don't have access to a physician to write you one, which, again, this government has failed to address. They've made it clear historically that they would provide 7,500 new doctors, nurses and nurse practitioners to Canada, even though we're missing about 30,000 family doctors.

That being said, one thing that's going to plague Canadians in the not so distant future and is plaguing them now—I spoke about this previously—is the number of days from global first launch to public reimbursement.

There were 460 new medicines launched from 2012 to the end of 2021. My colleague from the NDP referenced New Zealand as a beacon. Interestingly enough, in this particular study, New Zealand had the longest time for approval, at 1398 days.

Could the officials tell me who had the second-longest time for approval of medications in this group of countries? Anybody?

● (1640)

Ms. Michelle Boudreau: I can't tell you that, but I'm happy to speak a little bit more about any questions that you have around the data and the time it takes in Canada—

Mr. Stephen Ellis: That's excellent. I appreciate that, but Canada is the second worst, at 1301 days, for getting new drugs approved.

Are you aware, Madame Boudreau, that we are having difficulties getting new drugs approved in this country?

Ms. Michelle Boudreau: What I can say is that there are a couple of different pathways for drugs to be approved in Canada through our health products and food branch.

There is a faster pathway that is about 180 days, and on average, with the ones that do not proceed via that pathway, it's approximately 300 days. We also have an aligned review process between what happens at Health Canada and what happens at CADTH in health technology to try to speed up access for patients as well.

Mr. Stephen Ellis: I'm sorry. Are you disputing the data that I have here? What you're suggesting is that the pathways you're talking about provide approval in 300 days. Is that what you said?

Ms. Michelle Boudreau: Sir, I'm not disputing it. I think you were perhaps speaking about the pathway as a whole, between launch and patient access, or access to a prescription.

I was speaking about your latter comment, which is the amount of time it takes for approval of a new drug submission, for example, by Health Canada.

Mr. Stephen Ellis: Then are you familiar with that data, but you're not familiar with the data that I'm referencing?

Ms. Michelle Boudreau: No. I'm sorry. I'm not. I could ask my colleague if he is, if you'd like.

Mr. Stephen Ellis: No, that's okay.

Am I clear then to say that you don't think there's a problem for Canadians in accessing new medications in Canada? It's a long process.

Ms. Michelle Boudreau: No, I think what I would say is.... I would refer back to my earlier comments that we do have different pathways for Health Canada to approve the product.

Mr. Stephen Ellis: Thanks, Madame Boudreau. I heard that part.

Do we or do we not have a problem with the length of time it takes for getting a new drug approved in this country?

Ms. Michelle Boudreau: I referred earlier to the 300 days, and that in fact is fairly close to what happens in the U.S. and quite close to what happens in the EU.

Mr. Stephen Ellis: Yes. I don't think that's what I asked, though. Do we have a problem, or do we not?

Ms. Michelle Boudreau: I'm sorry, Mr. Chair. I don't know that I can add anything further to my previous answers.

Mr. Stephen Ellis: Okay, fair enough.

I'll say, on behalf of Canadians, that there was an opportunity here to change the Canadian drug agency and to have oversight, but the officials and the Minister of Health, in spite of the fact that all Canadians know it takes an excessively long time, as referenced by the data in the study, don't think that's a problem. Perhaps that's why we have a problem.

The other part that I'll return to is new drug launches in Canada.

It appears from the evidence here in front of me that new drugs are not being launched in Canada as frequently as in other countries. Do you think that's true?

Ms. Michelle Boudreau: You are, I guess, looking at some data that I don't have in front of me, so I can't comment on that, but I would like to come back for a moment and speak about the Canadian drug agency and clarify for the committee that the legislation does not set out the CDA and does not propose a particular mandate or establish the CDA. It speaks to the types of functions that the CDA will do, and it also speaks to a couple of specific functions.

If you'll permit me to conclude, the CDA is not being contemplated to be an agency that would review drugs—

Mr. Stephen Ellis: Absolutely. I totally agree with that. The difficulty is that the Canadian drug agency could have been mandated to have better numbers, and you've chosen not to allow that to happen, or at least the minister has.

The Chair: Thank you, Dr. Ellis.

We'll go to Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Our committee is tasked with reviewing this legislation. We're going to go through it line by line. With that in mind, I read the legislation, and I have what may seem like some mundane questions.

There's one provision here, and I don't understand what you mean by it. Perhaps you can explain it to me.

Let me start off by saying that I've been a long-time doctor. I also have a few law degrees, including one in health law. I worked for WHO, writing health law, and I was part of drafting some pharmaceutical legislation. I've now been in Parliament for five years. If there's anyone who should be able to read things and understand them, I would have thought I'd be one, but I don't understand this bit on principles.

The minister is to consider a bunch of principles when they're consulting with the provinces and territories on implementing national universal pharmacare. It says that one of those principles is to "provide universal coverage of pharmaceutical products across Canada."

I don't see, within that wording, a clear indication of what that means. Universal coverage means that every person will receive pharmacare and pharmaceutical products from the government. Which pharmaceutical products are included? Is it all pharmaceutical products?

It seems very vague to me, almost to the extent that it nullifies any meaning at all. What do you mean by that statement?

It says—and it's rather weird wording—"The Minister is to consider". Usually it's "shall" or "will" consider, but here it's "is to consider". What are they supposed to be considering here? What is the goal of that?

● (1645)

Ms. Michelle Boudreau: The section sets out principles, as you've set out. Very much as is stated there, in moving towards the implementation of national universal pharmacare, you've heard the minister refer to this as a first phase. You've heard the minister also refer to the other section of the bill that speaks to contraceptives and diabetes as part of that first phase.

This sets up the framework generally for the broader discussions that will take place in a step-by-step manner to create the national universal pharmacare program.

"Universal" has the meaning that I think most people would consider it has, which is that everyone—every resident of Canada, everyone who's living here—would have access to a pharmacare program.

Mr. Marcus Powlowski: The term "pharmaceutical products" isn't defined, so which pharmaceutical products does it refer to? Is it all pharmaceutical products? Is it products on an essential drug list?

What does "universal coverage" mean? We've already talked about how this isn't meant to replace pharmaceutical coverage in a pharmaceutical plan provided by an employer. This isn't intended to replace that, but if you say, "provide universal coverage", it would seem to me to imply that all of us are going to be provided with a pharmacare program, but that doesn't seem to be the intent.

Why put this in? Again, I'm a little mystified by the intent of this section.

Ms. Michelle Boudreau: If it's helpful, I would refer you to the definition of a pharmaceutical product, which is set out in clause 2 of the legislation, and reads as:

> ...means a prescription drug or related product that is funded, in whole or in part, through a pharmacare agreement to which the Government of Canada is a party.

Mr. Marcus Powlowski: I'm not sure if that helps me a lot, but let me go on to clause 6, which talks about first-dollar coverage.

I understand that perhaps in the industry there's a recognized definition of first-dollar coverage. Again, you would think I'd be someone familiar with such a term, but I don't know what it is. What is first-dollar coverage?

Ms. Michelle Boudreau: You're correct that there is, if I can use the phrase, a bit of a term of art within the insurance policy business. "First dollar" means that as soon as an insurable event occurs—in this case, having a prescription filled—the insurance would apply: That is, the coverage would apply before any other payments.

In other words, the person coming to the pharmacy is not paying a copay or something first. It's the insurance coverage that would pay that full charge.

The Chair: Thank you, Ms. Boudreau.

Thank you, Dr. Powlowski.

[*Translation*]

Mr. Blanchette-Joncas, you have the floor for two and a half minutes.

Mr. Maxime Blanchette-Joncas: Thank you, Mr. Chair.

My questions are for Ms. Boudreau.

Ms. Boudreau, you're an associate assistant deputy minister at the strategic policy branch of the Department of Health. When it comes to strategy, we typically know what people want and what people have.

I'd like to confirm that your department received the motion unanimously passed by the National Assembly on June 14, 2019. In other words, it was supported by all parties representing the people of Quebec. In that motion, the National Assembly of Quebec wanted to “reaffirm that Quebec has had its own general prescription insurance plan”, “indicate to the federal government that Quebec refuses to adhere to a pan-Canadian pharmacare plan” and “ask the Government of Quebec to maintain its prescription drug insurance plan and that it demand full and unconditional financial compensation from the federal government if a proposal for a pan-Canadian pharmacare plan is officially tabled.”

Ms. Boudreau, did officials at your department provide you with this motion?

● (1650)

Ms. Michelle Boudreau: Yes. I'm aware of that letter or motion.

Mr. Maxime Blanchette-Joncas: All right.

For you, strategically speaking, does a unanimous decision by a parliament have democratic value?

Ms. Michelle Boudreau: Sorry, but I'm not sure I understand your question.

Mr. Maxime Blanchette-Joncas: I'll repeat it. Does a motion unanimously passed by a parliament have democratic value?

Ms. Michelle Boudreau: I lack the necessary expertise to answer that question. You're in a better position to answer it than I am.

Mr. Maxime Blanchette-Joncas: Let me put this in context, Ms. Boudreau.

If the Canadian Parliament were to unanimously pass a motion, your department would take it into account. True or false?

Ms. Michelle Boudreau: True, but if I may, I would like to repeat what the minister said. In a context—

Mr. Maxime Blanchette-Joncas: That's all right. That answers my question, Ms. Boudreau. Thank you. You understand the democratic importance of a unanimously adopted motion. I hope that the people representing a political party with the word “democratic” in its name are also taking note.

Ms. Boudreau, I'll continue with my questions for you.

Are you familiar with the pan-Canadian Pharmaceutical Alliance?

Ms. Michelle Boudreau: Yes.

Mr. Maxime Blanchette-Joncas: Thank you.

This organization carries out negotiations, regarding medication in particular, to obtain the best prices through a bulk purchasing process. Is that correct?

Ms. Michelle Boudreau: Yes.

Mr. Maxime Blanchette-Joncas: Under the current pharmacare framework—

The Chair: Sorry to interrupt you, Mr. Blanchette-Joncas, but you're out of time. Two and a half minutes go by quickly.

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

Mr. Peter Julian: Thank you.

I'd just like to make sure that you received the statement issued a few hours ago by nine Quebec labour and community groups calling for the adoption of Bill C-64. Did you receive it? If not, I can provide it to you. The Union des consommateurs, the Centrale des syndicats démocratiques and the Confédération des syndicats nationaux, to name a few, were very clear. There's a consensus in Quebec in favour of the bill.

[*English*]

I come back to the issue of the approval process of Health Canada. I think my Conservative colleague cut you off, but it's important for members of the committee to understand. Is it a 300-day period for approval, through Health Canada, from the application date to availability for consumers? I just want to understand what you were saying.

Ms. Michelle Boudreau: I'm going to ask my colleague to fill in a little, but just to be clear, yes, what I was referring to is the period during which Health Canada will review a drug for authorization in Canada and when it will conclude that review.

Then what I was trying to refer to as well is that there are other processes that typically take place before a product will be available at, say, a pharmacy. That includes a review, which we call the health technology assessment, by CADTH—or INESSS in Quebec—and then there will be perhaps some negotiation on pricing.

However, my colleague can fill in those other steps as well, if the chair permits.

Mr. Daniel MacDonald: In terms of the data that Michelle was referring to, it's the Health Canada regulatory standard of 300 calendar days service, and that is met over 99% of the time. As Michelle mentioned, there are expedited routes in there as well.

Further on the detail of the rest of the drug approval process, there is the health technology assessment approval process. I will be referring to the report by the Conference Board of Canada, “Access and Time to Patient”. That's the data I'll be referencing. It's a January 2024 product. It identifies that the time to review a product following a notice of compliance from Health Canada through the former CADTH is 246 days. That's 2022 data. The average time spent for products that were waiting to be engaged by the pCPA after—this is CADTH data only, as I don't have it for the INESSS—was 172 days in 2022, with an average time spent in the pCPA negotiations of 189 days.

There are different sources on what that total time is. You've referenced a data point that, as we said, we don't have in front of us. We have from 736 to, as another data source I have suggests, 900, but each of those steps is performing a function and....

I'm sorry.

● (1655)

The Chair: Thank you, Mr. MacDonald.

Mr. Peter Julian: Just as a quick follow-up, what was the shortest expedited approval?

The Chair: No, no. We're well past the time, Mr. Julian.

Mr. Daniel MacDonald: It was 180 days.

The Chair: Ms. Goodridge, you have five minutes, please.

Mr. Stephen Ellis: I have a point of order, Chair.

The Chair: Go ahead, Mr. Ellis.

Mr. Stephen Ellis: I guess the question is whether we are going to enforce this. I mean, you told Mr. Julian to stop talking. He still asked the question. He still received an answer.

Do you know what? I guess if we have rules here, Chair, I would expect that we follow them. If we're not going to follow them, then we'll have utter chaos, which we had with Mr. Julian at the last committee meeting when he chose to simply ignore the rules of the chair.

I would implore the chair to enforce those rules. I would also implore my colleague Mr. Julian, who is wont to not follow the rules, to actually follow them and be respectful to the committee.

The Chair: Go ahead, Mr. Julian.

Mr. Peter Julian: On a point of order, Mr. Chair, at the last meeting, of course, the chair made a mistake. I challenged that, which is absolutely appropriate. However, in this case, when an answer is something that all members of the committee want to hear, I think it's to the advantage of all members of the committee to actually get that answer.

An hon. member: We didn't hear the question, and nor did we hear the answer.

Mr. Peter Julian: It was 180 days.

The Chair: Let's try to get through the last couple of rounds of questions. Mr. Julian's turn is done and Ms. Goodridge's turn is about to begin.

Go ahead, Ms. Goodridge, please.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

I always find it very very interesting to listen to the questions that come from Dr. Powlowski. His experience when it comes to medicine is something that I truly do appreciate. Understanding the law background further makes it so that I don't feel nearly as stupid, because I also had some of those same exact concerns when it came to reading this bill. I just figured that maybe it was that I didn't necessarily understand it.

We have a very limited number of definitions in this bill, and yet we are using terms that are relatively new. Why did Health Canada choose not to define “first dollar” or “single payer” in this piece of legislation?

Ms. Michelle Boudreau: I'll speak first to “single payer”. It's a term that is used very commonly. It was used as far back as the 2019 panel report by Dr. Hoskins and that advisory panel. It's quite a well-understood term. For that reason, there was, in our view, no need to define it.

Similarly, “first dollar”, as I mentioned, does have a definition that's quite well understood. It's not unusual in legislation that if there is a technical term that's understood within a context, you don't define it, because it has a meaning already.

Mrs. Laila Goodridge: I appreciate that. So “minister” is not a defined term that is understood...?

Ms. Michelle Boudreau: That's more of a custom. Whoever the minister is that has oversight over legislation would typically be set out in the legislation.

Mrs. Laila Goodridge: Okay. Then is “indigenous peoples” not a defined term?

Ms. Michelle Boudreau: Again, that's in order to ensure consistent drafting and to respect drafting conventions with other legislation. That's why that term is defined as it is. It's to be consistent with other legislation throughout the Department of Justice legislation that we have in Canada.

Mrs. Laila Goodridge: It concerns me because it should be possible for a piece of legislation to be read as a stand-alone entity and be understood. While we have, effectively, a four-page pamphlet that is quite light, this is billed by the government as being quite substantive, although we have heard conversation that it's effectively a pilot. I'm not quite sure what we're actually dealing with here.

What's the rush? Was it just because of the timeline of the supply and confidence agreement? Is that why this legislation looks like it was basically pieced together?

Ms. Michelle Boudreau: No. I can tell you that we worked on the legislation for several months. In fact, it was probably almost a year. We also work with Department of Justice drafters, legal drafters and people who look at whether the French and the English are consistent. In fact, a great deal of time was spent on developing the legislation.

• (1700)

Mrs. Laila Goodridge: Was the timeline several months or a year? There's a difference between those two.

Ms. Michelle Boudreau: I'd have to go back and look, to be honest, because it has been a long path for us, but it's certainly been a number of months. Also, before leading to the legislation, you do all the policy work as well.

Mrs. Laila Goodridge: I appreciate all of that.

We have a guillotine motion, effectively, for a programming motion, so we have very limited time. Therefore, not understanding whether this was worked on for several months or a year is actually quite important when we're coming to making these decisions.

I would ask that you submit to the committee by tomorrow the exact time this started being worked on, so we can ensure that we have the adequate information as we're drafting amendments and considering the rest of this bill.

If it was a year, was that not enough time to adequately consult with provincial health ministers prior to bringing forward this legislation?

Ms. Michelle Boudreau: The legislation sets up a framework for that consultation. If you look at the preamble, you see that a couple of things are important. One is that it's very clear on the jurisdictional work and the role of the provinces and territories. That is set out very clearly in the preamble.

Also, throughout the legislation, in just about every substantive section, there's a clear statement that there will be consultation with the provinces and territories. This is, in essence, the beginning of those consultations.

Mrs. Laila Goodridge: Within a day of this legislation being put forward, we had Quebec and Alberta both coming out very firmly against it, saying they wanted to opt out of it. Is that not terribly concerning?

Saskatchewan also came along not very far thereafter, indicating their concerns with it. Is that not something that concerns you? The provinces and territories are responsible for the delivery of health care, by and large, in this country, and they are already opting out.

Also, many of these provinces—all of them, in fact—already have their own plans. There could have been work to try to expand their plans, but instead, we have a pamphlet of sorts that is a plan to create a plan to possibly create a piece.

The timelines of when this was worked on are extremely important.

The Chair: Thank you, Mrs. Goodridge.

We're well past the time. If you have a brief response, go ahead.

Ms. Michelle Boudreau: I will simply point out that in the legislation there is a clear commitment to consult with the provinces and territories, a recognition of their jurisdiction and a recognition of their role in drug coverage. This would build and expand on their coverage, as the minister mentioned; it would not replace it.

Finally, I'll just say there will be a lot of discussion in the context of bilateral agreements, which is also set out in the legislation.

The Chair: Thank you.

The last round of questions for this panel will come from Mr. Jowhari for five minutes, please.

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

Thank you to the officials for the hard work you've done on this and for coming here today.

Unfortunately, I'm going to follow on the same theme as my colleague Dr. Powlowski, who has led us down this path.

In clause 2 of Bill C-64, pharmacare is defined to mean “a program that provides coverage of prescription drugs and related products.” I understand “prescription drugs”. “Related products”, however, are not defined. I think that may leave a lot of room for interpretation.

What does “related products” mean in the context of Bill C-64?

Ms. Michelle Boudreau: “Related products” are also referred to in the pharmaceutical product definition. In terms of its intention, for example, if you look at the contraceptives, you will find that some of the products that are contraceptives are actually medical devices, like intrauterine devices. That's the idea with the term “related products”.

Similarly, there could be drug coverage for something like syringes, if that was chosen. Again, that's not a pharmaceutical product, so that's why that term is used.

Mr. Majid Jowhari: You talked about the contraceptives. Subclause 6(1) of the bill refers to “specific prescription drugs and related products intended for contraception or the treatment of diabetes.” I think the two examples that you gave—IUDs and the syringes—would be an example of a related product. Is there a list of prescription drugs and a list of related products that will be published later on?

• (1705)

Ms. Michelle Boudreau: The minister referred to the list in his remarks as well. There is a list that was put forward when the bill was first introduced on February 29, and as the minister noted, this is the starting point of those discussions with provinces and territories, so yes, there is a list available.

Mr. Majid Jowhari: Okay. There is a list, and the list is available. Thank you.

I want to go back to clause 4 of the bill, which states that the minister must, when working with the pharmacare partners to implement national universal pharmacare, consider principles relating to the accessibility, affordability, appropriate use and universal coverage of pharmaceutical products across Canada. The minister must also consider the Canada Health Act.

Can you explain the similarity that exists between the principles outlined in clause 4 of Bill C-64 and the criteria set out in the Canada Health Act?

Ms. Michelle Boudreau: There is some similarity around, for example, accessibility and also universality. There are also some differences, though. For example, under the Canada Health Act, we speak of portability, which is not a type of term that you would use when you're speaking of drug coverage. The principles that are reflected here are more closely aligned with the principles that would be more appropriate in speaking of drug coverage.

Mr. Majid Jowhari: You talked about portability. Can you explain what that is? It's not included in pharmacare under Bill C-64.

Ms. Michelle Boudreau: Portability would relate to what many of us would experience if we needed to go to a hospital or see a doctor when we're perhaps visiting family in a different province. It's a bit different with a drug plan, because if you're covered under a drug plan, it tends to be the plan that is reimbursed by that province, so you wouldn't necessarily be able to receive the same coverage in another province. That's what the term ”portability” refers to.

Mr. Majid Jowhari: I have about 40 seconds, which I'll yield back to the chair. Thank you.

The Chair: Thank you very much, Mr. Jowhari, and thank you to our officials for staying on. Thanks for all of the work that you've put into this piece of legislation to date, and for your service to Canadians.

We are going to suspend briefly to allow for this panel to take their leave and for the others to get set up, and for you to have coffee if you wish.

The meeting is suspended.

● (1705)

_____________________(Pause)_____________________

● (1720)

The Chair: I call the meeting back to order.

Welcome to our second panel of witnesses. Thank you all for being here. I know the circumstances didn't allow you to have that much notice, but you're here and in person, and we greatly appreciate that.

We have with us for the next 90 minutes the Canadian Generic Pharmaceutical Association, which is being represented by Jim Keon, president, and Jody Cox, vice-president of federal and international affairs.

From the Canadian Health Coalition, we have Steven Staples, national director of policy and advocacy, and Mike Bleskie, advocate for type 1 diabetes.

From the Canadian Life and Health Insurance Association, we have Stephen Frank, president and CEO.

From the Office of the Parliamentary Budget Officer, we have Yves Giroux, Parliamentary Budget Officer, and Lisa Barkova, analyst.

Welcome to all of you. We're going to invite you to start with a five-minute opening statement in the order in which you appear on the notice of meeting, so we're going to start with the Canadian Generic Pharmaceutical Association for five minutes.

Welcome to the committee. You have the floor.

[*Translation*]

Mr. Jim Keon (President, Canadian Generic Pharmaceutical Association): Thank you, Mr. Chair.

The Canadian Generic Pharmaceutical Association and its Biosimilars Canada division would like to thank the committee members for this opportunity to contribute to the study of Bill C-64, An Act respecting pharmacare.

[*English*]

Making medicines more affordable and accessible is the key value proposition of generic and biosimilar medicines, which today are used to fill more than three-quarters of all prescriptions in Canada. Expanding the use of generics and biosimilars helps drug plans to fund innovative treatments for patients and contributes to the overall sustainability of drug plans.

Not surprisingly, maximizing the use of these cost-efficient treatments to help fund pharmacare was a key recommendation of the pharmacare advisory council report in 2019.

We have provided a brief to members and will focus our remarks today on three main areas: the medications to be covered for patients under the proposed pharmacare regime, guiding principles for bilateral agreements, and bulk purchasing, which has not been defined.

On the list of drugs, expanding access to ensure all Canadians can benefit from the life-saving and life-altering medicines they need is an important objective. However, the list of diabetes and contraceptive medications in the February 29 pharmacare announcement is not comprehensive. There are important gaps that need to be addressed. We have highlighted these in our brief.

The current non-comprehensive approach also raises patient equity concerns, as it could lead to suboptimal prescribing of the medicines that are made available to the public for free and lead to suboptimal health outcomes for patients.

We are also concerned that the non-comprehensive approach may provide a disincentive for public drug plan formularies to continue their coverage of a broad range of prescription medicines and provide a disincentive to expand coverage to include new drugs in the future. These same concerns apply to drug plans provided by Canadian employers.

We recommend that all diabetes drugs and contraceptives that are currently reimbursed by public drug programs in Canada be covered if pharmacare is implemented. This principle should also apply to medicines added in the future.

On guiding principles, under Bill C-64 the federal government must negotiate and enter into bilateral agreements with individual provinces and territories. An important guiding principle for drug formulary management that is already employed by public drug programs in Canada is to reimburse for only the low-cost alternative product of a pharmaceutical active substance.

In order to help ensure the sustainability of the plan, Bill C-64 should be amended to clarify that only generic and biosimilar medicines will be reimbursed once they are authorized for sale by Health Canada and enter the Canadian market. This principle should be included in all bilateral pharmacare agreements.

On bulk purchasing, “bulk purchasing” is not defined in Bill C-64. It is not clear what this means. It is important to recognize that Canadian governments already combine their purchasing power to negotiate internationally competitive drug prices for Canadians. They do this through the pan-Canadian Pharmaceutical Alliance, or pCPA.

It is critical that the pharmacare regime respect the existing pharmaceutical pricing infrastructure to ensure stability of the Canadian drug supply. This will ensure that Canadians continue to benefit from access to both cost-saving generic and biosimilar medicines and the innovative new medicines Canadians need.

Prices for generic medicines are controlled through the pCPA tiered pricing framework. This provides a stable and predictable environment for generic manufacturers to continue to provide existing medicines for Canadians and make the investments to launch new cost-saving drugs.

According to pCPA, joint efforts between pCPA and CGPA have resulted in savings of more than $4 billion to participating drug plans over the past 10 years. These savings will continue to grow through a new three-year agreement between CGPA and pCPA that came into force on October 1 of last year.

The pCPA also negotiates prices for biosimilar medicines that are set to be significantly lower than the list price for the original biologic drugs. The expanded use of biosimilars has saved public drug plans hundreds of millions of dollars that have been reinvested into coverage for innovative new therapies and the overall sustainability of drug programs.

We recommend that governments continue to exercise their power to collectively negotiate drug prices in Canada through the pCPA.

In closing, thank you again for inviting the CGPA and its Biosimilars Canada division to appear as witnesses on Bill C-64. Jody and I would be pleased to answer any questions you may have.

Thank you.

● (1725)

The Chair: Thank you very much, Mr. Keon.

Next, on behalf of the Canadian Health Coalition, is Steven Staples, national director, who I presume will start us off.

Mr. Staples, you have the floor. Welcome to the committee.

Mr. Steven Staples (National Director, Policy and Advocacy, Canadian Health Coalition): Thank you, Mr. Casey. It's a pleasure to be back here.

Dear members of the committee, my name is Steve Staples. I'm the director of policy and advocacy for the Canadian Health Coalition.

Our organization was founded in 1979. Our members work to defend and improve our public health care system. We comprise citizens, frontline health care workers' unions, community groups, students and public health care experts.

Members of the Canadian Health Coalition welcome the introduction of the pharmacare act, Bill C-64. This landmark legislation is an important first step in continuing progress toward a universal national pharmacare program.

Canada is the only country in the developed world that has a universal health care system that does not include universal coverage for prescription drugs outside of hospitals. Pharmacare is needed urgently to improve the lives of those living in Canada. As we have heard, one in five people reported to Statistics Canada that they do not have access to prescription drug coverage. Importantly, low-wage workers, immigrants and racialized people are hit the hardest.

In addition, the overall cost of drugs to the health system must be reduced. According to the PBO, prices for prescription drugs in Canada are roughly 25% higher than the median for OECD countries, and a single-payer pharmacare system with the power of bulk purchasing is the best route to negotiate lower prices from pharmaceutical manufacturers.

Canadian Health Coalition members heartily endorse the recommendations of the 2019 national advisory council on the implementation of national pharmacare led by Dr. Eric Hoskins, which was referenced earlier.

A nationwide program to achieve public coverage for contraception and diabetes medicine and related equipment, delivered by a single-payer approach through provincial health systems, is a historic step in the direction recommended by Hoskins in his report on pharmacare, but there are many more steps to achieve universal coverage of a national formulary of medicines.

We urge the government to ensure that the legislation adheres to a single-payer, national universal public delivery in partnership with provinces and territories, along with adequate funding and accountability measures, in accordance with the principles of the Canada Health Act.

I would like to share the remainder of my time with my colleague, Mike Bleskie.

Mr. Mike Bleskie (Advocate, Type 1 Diabetes, Canadian Health Coalition): Through you, Mr. Chair, I thank you for the opportunity to be here.

My name is Mike Bleskie, and I have been a type 1 diabetic for 19 years. I'm also a gig worker in my 30s. As such, like many, I don't have private health insurance, and I either cannot qualify or cannot afford to pay for a plan myself.

Although Ontario's benefits cover a portion of my personal expenses, my out-of-pocket costs stand at about $450 a month, mostly from my continuous glucose monitor, which is not covered in Ontario, and my pump supplies. That leaves me with hard decisions about the cost of food and rent at the beginning of every single month. It also leads to situations in which I'm forced to consider rationing my supplies, which can lead to health complications.

My experience talking to nurses, doctors and other diabetics across Canada tells me that I am far from alone. Insulin is not a luxury for us; it is a basic necessity for every single type 1 diabetic. Without the proper treatment, we are exposed to complications like debilitating nerve pain, amputation and permanent blindness. A universal single-payer pharmacare system is the only policy that guarantees that every type 1 diabetic in Canada, regardless of their economic circumstance, can access live-sustaining therapy when they need it. Policies that attempt to fill gaps only leave more gaps that need to be filled later, such as what we have seen in Ontario with OHIP+ .

I urge this committee to support this bill promptly so that we can get insulin into the hands of diabetics as soon as possible. I'm also asking this committee to ensure that syringes, pen needles, pump cannulas and continuous glucose monitors are fully covered as part of the diabetic supply fund contained in Bill C-64, as these items represent the biggest expenses to most diabetics and, in many cases, are not part of public coverage in most provinces.

I appreciate your time, and we welcome your questions.

● (1730)

The Chair: Thank you both.

Next, we go to the Canadian Life and Health Insurance Association and Mr. Frank.

Welcome to the committee. You have the floor.

Mr. Stephen Frank (President and Chief Executive Officer, Canadian Life and Health Insurance Association): Good afternoon. It's a pleasure to be here.

My name is Stephen Frank, and I'm pleased to be here today in my role as president and CEO of the Canadian Life and Health Insurance Association. An important part of my job is representing the 27 million Canadians who are covered by workplace and other health benefit plans.

Canada's life and health insurers believe that all Canadians should be able to access the drugs they have been prescribed. To achieve this, we know that both public and privately-funded plans are a necessity. Unfortunately, Bill C-64 falls short of its goal to ensure that all Canadians have access to the medications they need. It puts what's working well today at risk.

[*Translation*]

Workplace benefit plans are an essential pillar of the Canadian health care system. In the most recent year, Canada's life and health insurers paid for over 35% of prescription drug spending in the country. Our plans cover more drugs than even the most generous public plan.

In fact, 85% of Canadians say that their health insurance plan saves them money. They don't want to see their plan disrupted. Given the choice, they would overwhelmingly prefer that the government focus on providing coverage to Canadians who don't have it.

[*English*]

On behalf of the majority of Canadians who already have drug coverage, I ask members what this proposal will mean for the average Canadian family. Despite much of the discussion about this bill by various stakeholders, it goes further than contemplating a new pharmacare program for diabetes and contraceptive drugs: It requires the federal government to begin the rollout of a broad pharmacare program for an essential medicines list no later than 12 months after the bill gets royal assent. There are material and many unknown risks to disrupting existing programs for millions of Canadians.

The Minister of Health has stated that people who have an existing drug plan are going to continue to enjoy the access they have to their drugs. If that's the minister's intent, it's not at all clear from this bill. As many of the questions reinforced today, its text is ambiguous. It repeatedly calls for universal single-payer pharmacare in Canada with no mention of workplace benefit plans. Read in its entirety, the bill could result in practical and even legal barriers to our ability to provide Canadians with the drug benefits that they currently have.

For the majority of Canadians, therefore, this plan, as it's currently written, risks disrupting existing prescription drug coverage paid for by employers, limiting choice and using scarce federal resources to simply replace existing coverage, while leaving a huge gap for uninsured Canadians who rely on other medications beyond diabetic drugs and contraceptives.

There is a better way.

For example, using the $1.5 billion that has been allocated to this program to target those without coverage would allow the government to provide thousands of medications to several hundred thousand Canadians who currently lack drug plans. In other words, we could, as a country, use scarce federal dollars wisely to make a profound impact on the lives of those who do not have drug plans, while protecting the benefits that are currently working so well for the vast majority.

In conclusion, we believe that this legislation needs to be significantly amended to focus on ensuring universal drug coverage for all Canadians by addressing any gaps in the drug insurance that currently exists and to be clear with Canadians about what exactly we're trying to do.

I look forward to your questions. Thank you.

The Chair: Finally, we have the Parliamentary Budget Officer, Monsieur Giroux.

Welcome to the committee. You have the floor.

● (1735)

Mr. Yves Giroux (Parliamentary Budget Officer, Office of the Parliamentary Budget Officer): Good afternoon, Mr. Chair and members of the committee.

We are pleased to be here today to discuss our analysis of Bill C-64, an act respecting pharmacare.

With me today I have Lisa Barkova, our lead analyst on pharmacare.

If memory serves, this is the first time that I'm appearing before the House of Commons Standing Committee on Health as a parliamentary budget officer, but this is not the first time that the office has responded to requests from the committee regarding pharmacare. In fact, in response to requests from this committee, in September 2017 my predecessor produced an estimate of the cost to the federal government of implementing a national pharmacare program.

Furthermore, following requests from parliamentarians, my office prepared an updated cost estimate of a single-payer universal drug program in October 2023.

[*Translation*]

Recently, on May 15, 2024, we published a cost estimate for Bill C-64, which you're studying today.

As the first phase of a national universal pharmacare program, Bill C-64 proposes to provide universal first-dollar coverage for a variety of contraceptive drugs and for the treatment of diabetes.

The purpose of the program is to enhance and expand the coverage provided by provincial and territorial plans, not to replace it.

We estimate that, if implemented, Bill C-64 would increase government spending by $1.9 billion over five years. This estimate assumes that any medications that are currently covered by provincial and territorial governments, as well as private insurance providers, will remain covered on the same terms.

Ms. Barkova and I look forward to answering all your questions regarding our analysis of Bill C-64 or other work done by my office.

Thank you.

[*English*]

The Chair: Thank you, Mr. Giroux.

Thank you to all of our witnesses today for being respectful of the time limits. I really hope that it's contagious and that it carries over to the parliamentarians in the room for the rest of the meeting.

Dr. Ellis, you have six minutes. Go ahead, please.

Mr. Stephen Ellis: Thanks very much, Chair. I've set a timer.

Thanks to all the witnesses for being here.

Mr. Keon, through the chair, maybe I'll start with you.

You talked a bit about bulk purchasing. For the medications on the list here that are potentially covered, can you explain to Canadians whether it's likely this is going to result in significant savings and lowering of the prices that currently exist?

Mr. Jim Keon: Thank you.

We do not think it will. We do not think it should. We have negotiated a very broad agreement with the pan-Canadian Pharmaceutical Alliance that covers public drug plans. It's the same price that private insurers pay. It is a price negotiated with experts from the provinces that is intended to provide good savings, good prices to Canadians and a sustainable revenue base for our industry, so no, we don't think it will provide savings.

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

Mr. Frank, in this pharmacare pamphlet there's the concept of the universal single-payer plan. The minister and the officials who were here previously couldn't tell us what that meant. They said, “Well, it's a term that's been used a lot. Everybody knows what it means.” You've been at this a while, and I would suggest that for the benefit of all Canadians maybe you could shed some light on what that term means.

Mr. Stephen Frank: I think if there's one point to underline today, it's that this bill is ambiguous. We actually don't know what it means, because it is not a defined term.

The building of this bill, when you read it in its entirety, references the Canada Health Act. The preamble makes references to previous studies that have been done. “Single payer” is mentioned multiple times, as is “universal”. Those as a package have been well understood in the courts, and over time in the provinces, to mean a single payer—not federal, provincial or private, but a single payer. “Universal” means it's the same for everybody. Our concern is that it could also be interpreted to mean that private industry is no longer able to provide coverage.

When we read this legislation, because of that lack of clarity and because those terms aren't defined, we are concerned with the way it's drafted and we think it needs to be amended, at a very minimum, to reflect whether the vision of the minister is what the government's intent is. We would be supportive of that, of targeting their efforts on where the need is, but I don't think that we can be confident that this is what the legislation reflects, so we are quite concerned.

We do believe there are some significant amendments required to reflect what we heard the minister saying earlier today.

● (1740)

Mr. Stephen Ellis: Thanks for that.

Through the chair, Mr. Frank, our understanding is that there are perhaps about 1.1 million Canadians who lack sufficient coverage. Is it fair to say that could perhaps mean that of the 40 million Canadians, 39 million Canadians currently have coverage that could be in jeopardy?

Mr. Stephen Frank: I can speak only to what we as a private industry cover. Today in Canada there are 27 million Canadians with private drug coverage. It's very broad coverage, much broader even than that of the best public system available across Canada, and they value that coverage greatly—90% of them value their coverage to a high amount or to a great amount—so they want to protect it and they are very strongly opposed to having it put at risk. Overwhelmingly, if you ask them what their preferred approach is and you give them a choice, they would like government to target their efforts to where the need is.

We listen to our clients every day. We provide excellent coverage for them. There are 27 million of them who are very happy with what they have, and they don't want to see that put at risk. Everyone would agree that people should have access to the medications they need, so let's target where the problem is and let's not disrupt what's working well for so many.

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

Through the chair to Monsieur Giroux, thank you for being here and thank you for your analysis.

We know that federal government spending is ballooning out of control. That does not mean that pharmacare is not important. We've heard now from Mr. Keon that there are not going to be any savings here, so this will continue to be an expense to the federal government and, of course, to taxpayers.

We don't have that much time, but maybe you could outline that expense, which is going to be a recurring expense to taxpayers, with respect to Bill C-64.

Mr. Yves Giroux: Yes. In fact, we estimate the cost to be about $1.9 billion over five years.

Mr. Stephen Ellis: I'm sorry, but is that “billion”, with a “b”?

Mr. Yves Giroux: Yes, I said “billion”, so that means about $400 million per year ongoing, and increasing with population and inflation over time, roughly speaking.

Mr. Stephen Ellis: Finally, sir, and through you, Chair, is it not true that this government has added more to the federal debt than all other governments combined? I think I've heard that said. Is that true, according to your analysis?

Mr. Yves Giroux: I'd have to look at the precise numbers, but if it's not true, it's not far off, due in large part to the pandemic, of course.

Mr. Stephen Ellis: Thank you, sir.

Thanks, Chair.

Again, what we've heard is that this government is adding significant amounts to the debt, and we have heard about the struggles of Canadians having to pay for that, of course.

When we look at this again, Mr. Frank, on behalf of all Canadians, could you help us understand the differences between private and public plans at the current time with respect to the percentage of medications that might be covered by a private plan?

Mr. Stephen Frank: A typical private plan will cover almost any medication that has a notice of compliance, so it would cover upwards of about 15,000 different drugs. A typical public program would cover less than half of that. That's the delta you tend to see.

What you will tend to see in the diabetic space in particular is that private plans will cover many of the more innovative, cutting-edge things things like weekly injections, fast-acting mealtime injections and insulin specifically for diabetic comas. These are things that are not covered by the public plan but that we do cover privately.

When we looked at the list that was published with this pharmacare act, we were concerned by how narrow it was. I think others have noted that too. The vast majority of Canadians have very robust plans that cover essentially everything in the market. We work really hard to make sure we're doing that in a sustainable way, and we know they don't want to see that put at risk with any new government programs.

The Chair: Thank you, Mr. Frank.

Mr. Naqvi, please go ahead for six minutes.

Mr. Yasir Naqvi: Thank you very much, Chair.

I want to thank all the witnesses for coming here today. I really appreciate it.

In particular, I want to thank you, Mr. Bleskie, for being here and sharing your lived experience. That has been the most important testimony I've heard. I was struck by some of the choices you have to make on a regular basis, given your health and the cost of medication.

Can you elaborate on some of the challenges you face currently? Talk to us a little bit about what impact this legislation will have on your life if it passes into law.

● (1745)

Mr. Mike Bleskie: In my case, I know that at one point when I had finished a work contract, I did have private insurance. When it came time to finish that work contract, I was told by the private insurance provider that because of my pre-existing condition, I was not able to go on to the bridging insurance that would normally be offered to an employee. Therefore, I had to pay significantly more in order to stay on an insurance plan with that company.

In another sort of tangential way, I recently started on an insulin pump. I have been on an insulin pump for about six months now. In the months before I was a diabetic—and I'm sure Dr. Powlowski will be able to agree that these numbers are a little bit terrifying—my A1C before I started with my insulin pump was 11.4. The target for a type 1 diabetic is to be under 7. Since starting the insulin pump, my numbers have now improved to 7.7. That is a huge increase in my personal health, but I made financial sacrifices to do that because I am paying out of pocket for a lot of these expenses.

One of the things that I've done in the past to try to make my dollar stretch was to take my infusion sets, the cannula that goes into my skin to deliver my insulin, and to try to squeeze an extra two days out of that infusion set. What that means is that I'm risking scar tissue damage on my stomach. I've seen folks, friends of mine, who have been on insulin pumps who have been in that same situation, and they have pockmarks all over their stomach from their infusion sets because they've had to ration the supplies that they have access to. Those are the kinds of things that you often hear about.

There are also the other knock-on effects. When I was talking to different patients from around the country, I got a letter from a family in Prince George who have a 16-year-old son with diabetes. They have not been able to go on vacation since his diagnosis because they put in upwards of $250 a month in order to try to pay for their specific supplies in order to keep him healthy. We see some significant challenges financially, but also in terms of the knock-on health effects of people who don't have access to these medications.

I think that this also stretches over to other areas of medications that aren't even in the current wave of this act. I think that as we start to expand access to medications, we'll start to see those upstream and downstream costs change significantly over time, which will lead to personal savings in people's pockets as time goes on.

Mr. Yasir Naqvi: Thank you. We appreciate that.

I come now to Mr. Frank.

I think you were present in the room when I asked the minister about the notion around choice and whether this undermines the choice that Canadians would have, or in fact enhances the choice that's available to them. He was very clear that the choice will be maintained and that people would have the choice, that this is really creating a floor on two sets of drugs and that there is an important role for the private health care systems that you are representing.

You in your presentation still made an argument in talking about practical and legal barriers, and I'd like you to elaborate as to what you think they are. Are you not satisfied, after listening to the minister, that the choice that Canadians have available right now will not be impacted by this legislation?

Mr. Stephen Frank: I was encouraged by the minister's comments and I think if we could see that reflected in the legislation, I think we'd be vehemently in accordance with what he has in mind, but we don't see that reflected in this bill. I think that's the issue that we have.

Terms have not been defined. They're used repetitively in different contexts in different ways, and they could be interpreted to mean different things in different sections of the act.

The preamble requires the minister to take into consideration some previous studies that have firmly recommended a universal single-payer pharmacare program, and the Canada Health Act is referenced throughout. When you read it in its entirety, it creates an enormous amount of uncertainty. Those terms have developed a meaning over time in Canada through the courts, through the provinces, to mean certain things. I think we take comfort in what the minister says, but we also would like to see that better reflected in the legislation.

We talked a bit about dental care today. A lot of care was taken with that program to ensure that it was targeted at those who didn't already have coverage, and protections were put in place to ensure that employers didn't drop plans. I think that this kind of care and attention needs to be brought to this legislation so that it actually, over time, doesn't drift away from the intent that the minister described for us today.

● (1750)

The Chair: Thank you, Mr. Frank and Mr. Naqvi.

[*Translation*]

Mr. Blanchette-Joncas, you have the floor for six minutes.

Mr. Maxime Blanchette-Joncas: Thank you, Mr. Chair.

I would like to welcome the witnesses taking part in the second part of this meeting.

My first questions are for the Parliamentary Budget Officer, Yves Giroux.

Mr. Giroux, I have looked carefully at your May 15 note on Bill C-64, which states the following: "The PBO estimates that the first phase of national universal pharmacare will increase federal program spending by $1.9 billion over five years. This estimate assumes that any medications that are currently covered by provincial and territorial governments, as well as private insurance providers, will remain covered on the same terms." This includes the Quebec program.

If I understand this analysis correctly, the $1.9 billion will benefit provinces that don't have a drug coverage program. Provinces like Quebec, which already have a drug coverage program, will receive less money.

Mr. Yves Giroux: That's a valid hypothesis. We may not have interpreted the program correctly. We gather that the program is meant to complement existing plans, not replace them. As a result, in provinces and territories where the existing plan is very generous, the top-up will be relatively affordable. However, where the public plan is less generous, the costs to top it up will be higher.

Mr. Maxime Blanchette-Joncas: Mr. Giroux, simply put, provinces that already have a drug coverage program, like Quebec, could be penalized as a result. That's my understanding.

Mr. Yves Giroux: That could be the case. However, the negotiations between the federal government and the provinces will determine this. We couldn't assume the outcome of these negotiations, so we opted for a more cautious approach.

Mr. Maxime Blanchette-Joncas: I would even call it a hypothetical approach. There are a lot of hypotheses in politics, as you know.

That said, hypothetically speaking, we can conclude that, if negotiations between Quebec and Ottawa on money transfers don't go well, Quebeckers may have to pay more to subsidize the pharmacare program in the other provinces.

I'm trying to understand the situation. Based on your analyses, in such a case, would Quebeckers be taken for a ride perhaps?

Mr. Yves Giroux: We would have to look at the coverage by province to determine the potential for subsidies, underfunding or overfunding, depending on the province or territory.

We can see that the coverage of public plans varies greatly from province to province. Ms. Barkova informed me that, for certain types of oral contraceptives, for example, some provinces reimburse a maximum of 20 cents per tablet, even though the lowest price in the country is 60 cents. Some public plans cover certain drugs, but only to such a small extent that it's almost like having no coverage at all.

Mr. Maxime Blanchette-Joncas: You can no doubt see where I'm going with this. I'm looking for solutions.

Under the current circumstances, what do you recommend or suggest so that Quebeckers get their money's worth and don't wind up paying more than they receive in services?

Mr. Yves Giroux: I'm not here to make recommendations.

However, the bill contains provisions enabling the minister to enter into negotiations with the provinces and territories, or even directing the minister to do so. This avenue is probably more promising, in my opinion. Obviously, we know when negotiations start, but we don't know how successful they are, or what kind of agreement they lead to, if any.

● (1755)

Mr. Maxime Blanchette-Joncas: I completely agree with you about the negotiations, Mr. Giroux.

Personally, however, I like to have the necessary data when I negotiate. With this in mind, could you provide figures, province by province, based on existing programs, to ensure fair treatment during the negotiation of this new pharmacare program, which the minister describes as essential and even vital?

Mr. Yves Giroux: If the committee wants this, we can consider the possibility of doing this work, as long as the available data is thorough enough. Regardless, we could certainly come up with a good approximation, if the committee asked for it.

Mr. Maxime Blanchette-Joncas: Thank you for your usual co-operation, Mr. Giroux.

I'd now like to talk about a study you conduct each year. This study is the report on the fiscal sustainability of the Canadian provinces and the country as a whole. Fiscal sustainability isn't easy to achieve everywhere. You probably know what I'm getting at, Mr. Giroux. According to your 2023 report, five provinces are sustainable, relative to the percentage of GDP and estimates of the financial gap between the provinces and subnational governments. The five other provinces are categorized as unsustainable, as are the territories. You can see where I'm going. Fifty per cent of provincial governments, including Quebec, face a potential long-term financial risk when additional public spending is introduced.

My question is hypothetical, but nevertheless based on your analysis of the fiscal sustainability of the various governments. Based on past experience, if the federal government rolled out a significant program such as pharmacare and decided to pull back and reduce its funding, how would this affect the fiscal sustainability of Quebec and the provinces?

Mr. Yves Giroux: Based on a hypothetical scenario where the government provides a large percentage of the funding for a national program and progressively decreases its share over time, for example by not indexing its contribution or through a reduction, as we have seen in the past, the provinces would inevitably need to make difficult choices. They would have to either reduce the coverage or continue to cover the costs. There would be financial pressure on the provinces that opt to continue the coverage as initially agreed.

The Chair: Thank you, Mr. Giroux and Mr. Blanchette-Joncas.

Mr. Julian, you have six minutes.

[*English*]

Mr. Peter Julian: Thanks very much, Mr. Chair.

I mentioned earlier that this is a historic moment and a historic hearing, and I cited a number of important organizations.

I want to give a shout-out to Canadian Labour Congress president Bea Bruske. They submitted a memo to this committee saying, “The [Canadian Labour Congress] calls for the speedy passage of Bill C-64, an act respecting pharmacare, before the House of Commons and the Senate adjourn for the summer, so that millions of Canadians can access contraception and diabetes drug and device coverage, giving them some relief from the high cost of living.” I would note that Elizabeth Kwan from the CLC is here in the room today.

I also want to give a shout-out to the Canadian Health Coalition and thank Mr. Staples for being here.

Mr. Staples, we've heard from one party in the House of Commons—the Conservatives—and a number of lobbyists that the system we have in pharmacare now works well in Canada. You deal with frontline workers, such as nurses. Is it true that everything is fine when it comes to access to medication?

My second question to you is about the issue of a pharmacare program. Is it true that a pharmacare program will help save health care dollars?

Mr. Steven Staples: Thank you very much.

Mr. Julian, I share your concern. When I hear witnesses say that the system's working very well, I ask, “For whom is it working very well?” We just heard from Mike Bleskie. It doesn't sound like the system's working very well for him. It seems to be working for industry and for insurance companies, but it's not working well for all Canadians. That's why this pharmacare act is so important. We must get Bill C-64 through.

Also, we heard that the Canada Health Act, in the view of industry, creates uncertainty. I would differ. I think the Canada Health Act is very important. For 40 years, it's made a guarantee that Canadians, when they need medical care, will get it, not based on who they work for, what insurance program they have or how much money they have, but because they need it. I'm very passionate that the CHA creates certainty for Canadians, and we want that system. We don't want a U.S. system.

When I hear frontline workers talk, and they do.... We had 100 frontline health care workers come here in February. They met with many members of this committee, and I express my gratitude for all of you who took time out to meet them at a very busy time. These are people who are working with all kinds of issues in their hospitals and in their health care environments, but they took time to come to Ottawa to talk about the importance of pharmacare with all the challenges that they face in the health care system.

Do you know why? What I hear them say is that filled prescriptions mean empty emergency rooms. They know that if people are getting their medications, if they're not cutting their meds, if they're not making choices today on whether to take their medicine or not, they don't end up presenting themselves with far worse conditions in the emergency wards. That's where a lot of cost savings can come in that we're not hearing about.

Of course there are cost savings for individuals. Of course there are cost savings through bulk purchasing; we can get those prices down to the median of OECD countries because they're so high, but there are also savings in the health care system.

St. Michael's Hospital did a study. It took 700 patients who had trouble economically in paying for their medication, and these patients went out into the world after they were diagnosed. The hospital mailed free medication to half of them. The other half it just let fend for themselves, based on that system that we were talking about a minute ago, however that system works out. Well, they found that those people who had free medication provided to them did far better. They recovered faster. In fact, they could even put a number on it; every patient who received free medication saved the system $1,600 per year. That's an important factor in looking at how we can save money in a national universal single-payer program.

● (1800)

Mr. Peter Julian: Thank you very much.

I want to go on to Mr. Bleskie, and I hope you get questions from the Conservatives, because you're a real-world person who lives in the situation that exists right now, which is catastrophic for so many Canadians.

What would happen if you simply don't have any contracts, if you do not have money for a month? What would happen to you if you're not able to purchase the medication and devices?

I also want to ask where you buy your diabetes supplies.

Mr. Mike Bleskie: In my case, I have very little of a safety net left, so it would mean dipping into my line of credit. That's basically what it comes down to, because, once again, I'm part of the Ontario drug benefit. That is basically what is offered to all Ontarians who are low-income, and that low-income assistance for prescriptions covers only the insulin itself. It doesn't cover all the other aspects. For those who are taking injections, it doesn't cover syringes or cover needle tips. It does cover a glucometer, but for those who, like me, are using an insulin pump, it doesn't cover the CGM, which I actually need in order for the pump to work properly.

When it comes to purchasing my supplies, I can give an example here. I end up buying my stuff directly from the suppliers in many ways—

Mr. Stephen Ellis: Mr. Chair, I hate to do this to the witness, but we've already discussed previously at this committee that there are not going to be any props and that we are not going to be doing a show-and-tell here. I think that that's been well established. It may well be helpful, but I think that we need to continue to follow the rules here.

Mr. Mike Bleskie: Okay, then I'll do without.

In terms of the individual aspects that I have to order, I have to order CGM on a subscription model directly from the company, Dexcom. That is $200 per month, and then they ship it every three months. That is basically a three-month contract that I have to renew all the time.

When it comes to the individual pump supplies, the company that makes my pump, which is called Tandem, offers only one supplier, a company called Diabetes Express, which is a subsidiary of Bayshore HealthCare, which is a subsidiary of Shoppers Drug Mart. They are the only people that I can order those supplies from, so I have to wait for those things to come in from Toronto. In one case, I actually ended up nearly missing a shipment because there were delays in the mail system.

If I was able to actually have more access—

The Chair: Thank you, Mr. Bleskie.

Next is Dr. Kitchen, please, for five minutes.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you very much, everyone, for being here. I appreciate your presentations.

It's interesting that we heard one of our members repeat something I've hit on a number of times, which is basically targeting efforts where the need supposedly is. Mr. Frank, you hit that nail right on the head. You talked about the use of that $1.5 billion and putting it into a situation where it may be more effective.

Ultimately, when we look at statistics that suggest that 1.1 million Canadians don't have any type of plan, and that up to 3.8 million Canadians are either not aware of a plan they could have, don't have the funds, or choose not to do it, we see that roughly 10% of the population of Canada don't have access to it.

On putting that $1.5 billion toward that population, I wonder if you could expand on where you think that might be of great value.

● (1805)

Mr. Stephen Frank: I'll run some simple math on this. It's going to depend on how broad a list of medications you cover, but the typical cost for someone on the ODB program here in Ontario is roughly $1,900 a year. If you took that $1.5 billion, and it was an annual thing, you could probably cover most of that gap and provide access to the ODB.

This is just an illustration of the choices we can make to target federal funds where they will make the most impact. Using money to simply replicate what's already in place for 27 million people is, in our view, not the best use of scarce federal resources. In fact, switching people off a private plan and onto a public one risks their actually having weaker coverage than they have today.

We are completely aligned with the vision the minister outlined this morning. I'm not aware of anybody who's suggesting the system can't be improved. I don't think anyone has argued that today. However, we should be targeting our efforts where the need is, not risking disrupting what's working for the large majority of Canadians. As you said, that's 90% of Canadians today.

Mr. Robert Kitchen: Thank you for that.

We've heard throughout today a lot of comments and talk that this legislation isn't clear and that it doesn't define things appropriately. It puts in definitions for a minister, but it doesn't put in a definition for a first payer. It's very unclear in many ways.

Mr. Keon, you also talked about issues that we're not defining, particularly when we talk about bulk purchasing. If there's a way to take a look at that bulk purchasing, are there any suggestions you might have to add to that?

Mr. Jim Keon: Thank you.

We would remove the term. We don't like the term. I mentioned that we negotiate our prices with provincial governments. The three large federal plans are included in those negotiations. Our prices apply to all Canadians. Publicly and privately reimbursed prescriptions are all at the same price for generic medicines. It is a universal plan. It is a national plan that we have. It is negotiated with our industry and the experts who run the drug programs and know what the drugs do.

The most recent one just came into force in October. We would like to see that continued and respected. We think the term “bulk purchasing” is very unclear, and we're not sure what it means in the bill, so we would like to see it removed.

Mr. Robert Kitchen: Thank you you for that. I appreciate it.

Mr. Giroux, it's good to have you here. I recall one of the first meetings we had when I was chair of the government operations committee, and the discussions we had about finances. In many ways, I felt you were apologizing for the fact that where we had been using the terminology of millions of dollars, we're now using the terminology of billions of dollars. I think Canadians need to understand that. They really don't understand that we've made.... As I said to you at the time, my wife and I used to talk about nickels and dimes. Now, instead of talking about millions of dollars, we're talking about billions of dollars with this government and the huge amounts and costs.

When we look at the costs, in particular, you talked about $1.9 billion. One of the things I'm wondering if you can clarify—I have your report here with me—is your mention of how the public drug plans will cost $14.8 billion in 2024 and increase to $17.3 billion in 2027-28.

People who hear these numbers being thrown about will question them. They ask, “What are we talking about here, when we hear $1.9 billion over five years, versus numbers like that?”

● (1810)

The Chair: Dr. Kitchen, you're over time. If you can get to your question, we'll ask for a brief response.

Mr. Robert Kitchen: Could you just comment on that, please?

Mr. Yves Giroux: The costs that we referred to in our October 2013 report are the aggregate expenditures on public drug plans. They are expected to increase. That's the cost of the drugs that would be covered under a national pharmacare program.

The Chair: Thank you, Mr. Giroux and Dr. Kitchen.

Next up is Ms. Sidhu, please. You have five minutes.

Ms. Sonia Sidhu: Thank you, Mr. Chair.

My first question is for the Canadian Health Coalition.

Mr. Julian touched on this a little bit. We know that one in 10 Canadians with chronic conditions have ended up in emergency rooms due to worsening health because they were unable to afford prescription medications. This is a serious burden on our nurses, doctors and health care teams in general.

Do you have any numbers to share with this committee on how this legislation would reduce the burden on the health care system?

Mr. Steven Staples: There's a term I've read, “cost-related non-adherence”. It refers to people cutting pills and skipping the medication their doctor or care provider has prescribed to them because they can't afford it. It's not even just a simple matter of having insurance, because many insurance programs have copays, and some of these copays can be very big.

I live in the community of Regent Park in Toronto. It's a very mixed community. I was in my drugstore just the other day, and there was a customer in front of me who went up to the counter and had to ask what the copay was. The pharmacist said it was $14 for whatever he was getting. He paused and mumbled to himself, “I think I can get that cheaper,” and turned and left. I don't know what happened. How long does that go on? Do they end up in a hospital somewhere?

We've seen this. I've had nurses tell me they've seen patients who have cut their medication and have ended up in very serious condition in the hospital. As I mentioned, I would refer to the study from St. Michael's that found $1,600 per year per patient could be saved by giving people free access to their medication. That's just a start.

I'm very excited to see what this program brings in for these two classes of medications. We'll have the expert panel. We'll get a report back. I think it's going to be very encouraging.

Ms. Sonia Sidhu: Thank you.

My next question is for Mr. Bleskie.

You said insulin is a necessity, not a luxury. Before this, I worked on Bill C-237 to establish a national framework for diabetes. I know untreated diabetes has serious consequences.

Do you feel that this legislation would definitely impact quality of life for a person like you? Do you want to elaborate on what you think about that?

Mr. Mike Bleskie: Absolutely.

This is something I have been asking for and advocating since I was in grade 7. One of the very first things I did as a type 1 diabetic was attend an all-candidates debate in 2006 and ask how I could make my life more affordable.

I know that there are so many different diabetics out there who want to be able to say, “I have access to the life-sustaining therapy that I need.” As has been said before, rationing is a huge problem. It means that people are facing the complications of blindness, nerve damage and amputations. I believe that if every single person with type 1 diabetes had access to the medications they need in order to survive, the overall burden on the health care system would be measurably reduced.

Personally, I've had those scares when talking to an expert about what my eyesight will look like in 10 or 20 years. I can be more comfortable knowing that my eyesight is being protected and that I'm not going to have to face permanent disability. Those are the kinds of things I look forward to if this bill comes into play.

● (1815)

Ms. Sonia Sidhu: Thank you.

My next question is for Mr. Giroux.

Your report mentioned the behavioural effects of this legislation.

Have you considered possible savings to our health care system through increased support for people with chronic conditions, thereby avoiding them going to the emergency room and reducing the health care burden and cost?

Mr. Yves Giroux: The short answer to your question is no.

The mandate of my office is to provide costing and cost estimates. We rarely do cost-benefit analysis for that very reason, unless we're specifically mandated to do that through a very focused request. Generally, we don't do that.

Ms. Sonia Sidhu: Thank you.

The Chair: Thank you, Ms. Sidhu.

[*Translation*]

Mr. Blanchette-Joncas, you have two and a half minutes.

Mr. Maxime Blanchette-Joncas: Thank you, Mr. Chair.

I'll continue with questions for Mr. Giroux.

Mr. Giroux, I have here your analysis report on Bill C-64. Under the heading “Sources of Uncertainty”, which is quite striking, it states the following: “The estimate has high uncertainty and is contingent on the number of drugs listed for coverage. Drug expenditures have several cost drivers and the projections are highly sensitive to the projected growth rate of those cost drivers….” You also mention “behavioural effects such as substitution from the drugs not listed on the formulary to the drugs [currently] on the formulary.”

I have a simple question for you. Could the number of drugs covered decrease after pharmacare is implemented?

Mr. Yves Giroux: Possibly. Based on our understanding of Bill C-64 and the technical documents included with the first portion, there's a list of drugs that will be covered. There may be other types of contraceptives or diabetes drugs, but they wouldn't be covered. There may also be a behavioural effect such as substitution. In other words, people would be encouraged to use or obtain prescriptions for drugs that are covered, rather than drugs that aren't covered.

Mr. Maxime Blanchette-Joncas: Okay.

Does your report contain any other essential elements that you would like to share with us, for the common good of the committee?

Mr. Yves Giroux: No.

I don't know if Ms. Barkova would like to add anything.

Mr. Maxime Blanchette-Joncas: In that case, I'll ask Ms. Barkova a question.

I noticed that you did draw data from organizations such as the Canadian Institute for Health Information. Obviously, your findings and analyses of the data they provided to you only involve the Office of the Parliamentary Budget Officer. However, I'm trying to get a more accurate picture, because at the moment, it's very much hypothetical.

We have a picture of the government's directions, but what additional data would you need from the government to do a truly in-depth analysis and a much more specific exercise?

[*English*]

Ms. Lisa Barkova (Analyst, Office of the Parliamentary Budget Officer): The first thing that comes to mind is having clear terms and requirements for the program, such as a specific list of drugs. We know now that it's still to be negotiated. Once we know for sure which drugs are included, it will help us have a better understanding of how to cost such a program and provide a better estimate.

The Chair: Thank you, Ms. Barkova and Mr. Blanchette-Joncas.

Next is Mr. Julian for two and a half minutes.

Mr. Peter Julian: Thanks, Mr. Chair.

Mr. Bleskie, I want to come back to you.

My question to you in the last round was this: What would happen if you couldn't go into your line of credit? If you simply don't have contracts and are unable to take your medication, what does that mean in terms of your own personal health?

I think that's important to share with the committee, as all members need to understand what the impacts are in the current situation when people can't pay for their medication.

Mr. Mike Bleskie: If we're talking about the hypothetical of cutting down my insulin, either by rationing it or stopping it entirely, it means things like becoming blind due to diabetes-related macular problems, or diabetic retinopathy. It means neuropathy, which starts with a tingling and numbness in your legs that end up turning into excruciating pain. It also means there's low blood circulation in your limbs, so you're more susceptible to injuries and cuts. As you don't feel those injuries, they fester. Those complications end up leading to amputations.

Other effects are long-term kidney damage and long-term liver damage. All that sugar in your system has to be flushed out somehow, so your kidneys and liver end up working overtime to get that glucose out of your system.

● (1820)

Mr. Peter Julian: Is that reversible?

Mr. Mike Bleskie: No, pretty much any change as a result of high blood sugar.... There are acute symptoms, and then there are long-term symptoms.

The long-term symptoms are completely irreversible, which eventually leads to fatalities, especially when it comes to ketoacidosis, which is the most acute form of high blood sugar. Oftentimes, that comes on very quickly as soon as a diabetic loses access to their insulin.

Mr. Peter Julian: How long is that? Is it a few weeks?

Mr. Mike Bleskie: If I had to stop taking insulin, I would probably be in the hospital within a day or less. It can be that fast.

Mr. Peter Julian: Thank you.

I can't understand why anyone would oppose this legislation.

The Chair: Thank you, Mr. Julian.

Ms. Goodridge, please go ahead for five minutes.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

Thank you to all the witnesses.

I have a series of questions, but I'm going to start out with you, Mr. Frank, on workplace benefit plans.

If a workplace decides that they want to add a particular drug or service, is there a possibility to add just one service?

Mr. Stephen Frank: Well, yes, certainly, if you mean by “service”.... A typical plan will cover prescription drugs, will have dental and vision coverage, and will have all the paramedical services and travel coverage, so there are a suite of solutions that can be provided there, and employers can have some flexibility in what they want to offer. At the end of the day, the package that they want to offer to their employees is their choice.

With respect to the drug class, yes, we absolutely do see employers covering certain classes of drugs and not others. You tend to see that in the higher-cost areas—in some of the rare disease spaces, as examples. Certain medications are considered on and off, and different employers will have a different tolerance for how much risk and cost they're prepared to sustain.

We do have a variability in what's offered to Canadians and—

Mrs. Laila Goodridge: Based on that, if this bill were to go forward, would you be concerned that employers will come to you asking to have these two classes of drugs removed from their current plans, thereby driving up the cost to taxpayers?

Mr. Stephen Frank: That is a concern, and I think, again, if you read the legislation, it doesn't stop at those two drugs. I think that's one of the big things we need to keep reminding ourselves about. It contemplates, within a year, going well beyond that, and so if you get into a situation in which hundreds or thousands of medications are covered, then employers are absolutely going to start asking themselves, “Why should I be still in the game?”

We work really hard to educate them on the value of the programs that they're offering their employees. As I said, it tends to be more flexible and much broader than what they might get on a public plan, but that pressure and those questions will start if this bill, two years down the road, comes to fruition.

Again, that's not the vision that we heard from the minister today, so I think that disconnect is what's giving us pause.

Mrs. Laila Goodridge: I appreciate that.

I really do appreciate, Mr. Bleskie, your sharing your lived experience when it comes to the OHIP plan or OHIP+. As someone from Alberta, I'm not terribly familiar with Ontario's plan, so I did find that to be quite insightful.

I'm frustrated, in large part, that as we're studying this bill, we don't have the opportunity to hear from all the different provincial plans and to hear where those gaps are in particular, because I don't necessarily know whether those gaps are the same in every province.

By going down this path, are we potentially solving a problem that might not exist equally across the provinces and creating a situation in which we are going to reward provinces that have done very little and perhaps don't provide that? That would therefore raise the question of whether provinces would continue to offer these kinds of plans if they were to not do this. It becomes this very circular question of creation and complications.

Mr. Giroux, when you put forward your prescription costings in your most recent budget, did you factor in the record-breaking inflation we're facing in the future costings?

● (1825)

Mr. Yves Giroux: Yes, we took into account inflation, past inflation as well as our projections for future inflation.

Mrs. Laila Goodridge: Did you also factor in the effect if provinces were to drop some of these drugs from their existing plans?

Mr. Yves Giroux: No, we did not include any provinces potentially reducing coverage for diabetes and contraceptives.

Mrs. Laila Goodridge: Could this potentially cost substantially more if provinces and territorial plans decided to remove these drugs as a result of this legislation?

Mr. Yves Giroux: It is indeed a risk, as is the case if some employers decide to reduce their coverage, knowing that there is a public plan that would cover their employees.

Mrs. Laila Goodridge: Effectively, we have very little idea how much just these two drug categories will cost the federal government, so we're being asked to vote on something whose cost we have no clue about.

Mr. Yves Giroux: Well, I wouldn't say we have no clue, but there's quite a bit of uncertainty regarding the costing of such a plan, given the potential for public plans and private plans to offload some of their responsibilities onto the public plan.

Mrs. Laila Goodridge: I find that very concerning.

I want to thank all of you guys for being here today.

Thank you.

The Chair: Thank you, Ms. Goodridge.

We'll go now to Dr. Hanley, please, for five minutes.

Mr. Brendan Hanley: Thank you very much to all of you for being here and for the interesting testimony.

Just briefly, Mr. Giroux, to follow up on some of your answers, I note that there's no territorial analysis. Is there a reason? Is it a difficulty in obtaining data? Is it about small numbers, or...? Can you just clarify why territories are not included in the analysis?

Ms. Lisa Barkova: It just simply comes down to the fact that the data we used for this analysis contains only provincial data. Had we had territorial data, of course we would have liked to include that in our analysis.

Mr. Brendan Hanley: Yes. We'd love to see that included in a future analysis. Thank you.

Forgive me for perhaps not understanding the part about economy-wide savings as well as I should, but maybe I'm representing Canadians to some extent as well.

You say that drug expenditures in Canada would be reduced by having a single payer due to a few factors, including increasing negotiating power. Could you just comment on or give me a bit more explanation on what you mean by “economy-wide savings”?

Mr. Yves Giroux: Sure. You're probably referring to our October 2023 report, where we costed a Canada-wide single-payer universal plan that would cover most drugs. In that case, we assumed that the bargaining power of the federal government would allow the single payer—well, I say “the federal government”, but it could be individual provinces. Let's not get lost in these details.

A single payer would have a negotiating power and could presumably also be able to negotiate additional rebates. That's where the economies would come from. They would probably more than offset the coverage of those who don't have any coverage right now. That's why we say that there would be overall economies if you look at the cost of drugs as a whole, as a big bubble.

Mr. Brendan Hanley: Okay. Thank you. That's very helpful.

Mr. Staples, perhaps I can turn to you for a comment. You've been very helpful in your passionate testimony, whether you've talking about system-wide concerns or the individuals you've been hearing from. On what Mr. Frank talked about—putting the money into just targeting where the need is and leaving the rest alone—what are your thoughts?

Mr. Steven Staples: I mean, I hear you. We want to make effective use of public dollars and we want the money to get to places where it is needed most, but the aim of the program, of the legislation, is not just to provide medication to Canadians; it's also to get the price of drugs lower. We have to get the price down.

Again, it's no surprise to hear criticism of bulk purchasing in the discussion today from certain quarters that don't want that, but I think Canadians do. Our health care system does. Right now we spend as much on drugs in our health care system as we do on doctors. In fact, only hospitals are the next higher up. We have to get the overall price of drugs down to a lower level. That will require a coordinated bulk buying strategy.

You know, not all provinces pay the same amount for pharmaceuticals. There are different arrangements that are made. As Mr. Giroux mentioned in his very interesting October 2023 report, increased transparency from a bulk buying strategy will help lower the costs to everybody, because all provinces will get the same price, as opposed to one—

● (1830)

Mr. Brendan Hanley: I'll cut in here, because I want to hear from Mr. Bleskie before my time is up.

Mr. Bleskie, you may have noted that Yukon Territory was the first jurisdiction in 2020 to cover CGM. Other provinces have now come on board with that. When you look at the piecemeal approach versus a coordinated national approach, how do you feel about doing better with a coordinated national approach, incorporating Bill C-47 into this?

Mr. Mike Bleskie: I think that a coordinated national approach is really important, because we're starting to see that the international research consensus shows that CGM usage is tied very successfully to better health outcomes. I think the research in Canada shows the same thing.

When it comes to the federal government coming in and being a partner in supplying CGM technology to Canadians, I think it's a very strong step forward, especially given not only its effectiveness for type 1 diabetes, but also in monitoring blood glucose levels in type 2. In fact, there are companies that are coming out with new CGM technologies that are specifically designed for type 2 diabetes, for pre-diabetes, and those with pregnancy, who are monitoring their blood glucose levels.

The Chair: Thank you, Mr. Bleskie.

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

Mr. Stephen Ellis: Thanks very much, Chair, and again, thank you to the witnesses for being here.

Mr. Keon, I think we've heard some testimony that perhaps you could clarify, or a question from Mr. Staples that medication costs might differ across the country.

Could you tell us if that's true, and are there some jurisdictions that have better prices than others in Canada?

Mr. Jim Keon: Thank you for the question.

I should clarify. I'm here today representing the off-patent industry—the generic and biosimilar industry. We fill 75% of prescriptions for about 20% of the costs, so 80% of the costs don't go through the companies that we represent here today.

However, as I have said twice already, we have a national system on pricing. Quebec participated in the latest round of negotiations for the first time. It is a national system. All provinces pay the same price. All payers in Canada pay the same price for generic medicines. When I say that we don't like bulk buying, I think we already have a national system that's negotiated with experts who run drug programs, leading to low prices, and that's what we want.

We are concerned with terms like “bulk buying” if it implies that there's going to be some attempt to drive pricing down lower. Countries like New Zealand are bulk buying. When we look at the data, we see that fewer drugs are available there than elsewhere, so that's not a system that we recommend. We have worked very hard with the pCPA, with the provinces, and the three federal drug plans to get a system, and we think that system should be respected.

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

Through you, Chair, to the Parliamentary Budget Officer, one of the things that does concern me is the loss of coverage on behalf of all Canadians. If you do some napkin-based math, perhaps this program was based on a million people. If 40 million people are going to have to enter into this program, I can do the math in my head, but I would like to perhaps hear you say it out loud, with your credibility as the PBO. What would be the cost for simply these two classes of medications on the basis of 40 million Canadians?

● (1835)

Mr. Yves Giroux: That, unfortunately, I don't know off the top of my head.

Mr. Stephen Ellis: Would it not be three times the amount? Is that not the math?

Mr. Yves Giroux: I'm sorry. Lisa tells me that we have the numbers, so I'll probably let her speak.

Ms. Lisa Barkova: If you look at the table that we provide in our costing note, you see in the very first line that the cost will amount to approximately $5.7 billion, which would give you an estimation for how much that would cost for these same drugs if the program covered everyone in Canada. Then you can see the cost recovery due to public plans or the private drug coverage. Yes, the cost recovery is pretty much what currently the public and private plans cover.

Mr. Stephen Ellis: Very good. Again, I don't have that table in front of me.

That being said, are you suggesting that public plans would continue to cover these medications, because they're funded by provinces in that estimate, or are you suggesting that this is for all Canadians?

Mr. Yves Giroux: The numbers that Lisa mentioned are the expenditures that are currently being covered by public, private and out-of-pocket expenditures. For the drugs under Bill C-64— contraceptives and diabetes—it's about $5.7 billion. Assuming that all these expenditures would be covered by the federal government, that's how much it would cost.

Then we don't make any assumptions as to whether provinces would continue. We assume they would continue, because there's no sign that they will withdraw, but if they were to withdraw their coverage, then the federal price would go up, obviously.

Mr. Stephen Ellis: Right. Great. Thanks for that.

When we begin to look at this, we see that it's a small fraction of the medications out there. That's not to say that the medications for diabetes and contraception are not important; certainly they are. As a former family doctor, I wrote lots of prescriptions for both of those medications.

I know you don't have a crystal ball, Monsieur Giroux, but when we look at the costs of other medications that are currently coming down the pipeline, they're significantly more. They're thousands or hundreds of thousands of dollars.

What might that look like? To me, it's a catastrophic number. It's $5.7 billion multiplied by hundreds of thousands. Is that a fair estimate?

Mr. Yves Giroux: Everybody needs these expensive drugs, unfortunately, but it's true that while generic drugs tend to be a relatively small portion of all prescriptions, they are a much higher portion of total expenditures.

You're right that when new drugs come onto the market, they tend to be much more expensive than generic drugs, as I'm sure Mr. Keon will attest to, so there's a potential for new drugs to push expenditures on drugs upwards.

The Chair: Thank you, Mr. Giroux and Dr. Ellis.

Next is Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski: Mr. Frank, there are private and public drug plans. If you look at private plans like Blue Cross, Canada Life and Manulife, they're all for-profit and run by for-profit companies.

Is that right? Are any of them not-for-profit in the private sector?

Mr. Stephen Frank: Thank you for that question. That's a common misunderstanding.

In fact, the majority of the companies operating in this space are not-for-profits. Medavie is a not-for-profit company, as are GreenShield, the Blue Crosses and Beneva.

Mr. Marcus Powlowski: Which ones are not-for-profits?

Mr. Stephen Frank: Those are all of the Blue Crosses across the country. Beneva, which is a large player in Quebec, and GreenShield are all not-for-profits.

If you look at the number of carriers in the country, you see that probably over half are actually not-for-profits, and they reinvest everything they make back into their communities.

There are certainly large players that are for-profit as well. It's a mix.

Mr. Marcus Powlowski: Do you know the percentage of employer plans that are not-for-profits and the percentage that are for-profits?

Mr. Stephen Frank: I don't have that number in front of me. I apologize.

● (1840)

Mr. Marcus Powlowski: Why would an employer not get a not-for-profit insurer right away?

Mr. Stephen Frank: The for-profit companies provide a very compelling solution to clients, and so do the not-for-profits. It's a very competitive market. There are over 20 insurers that compete for business, and employers will make decisions based on what's best for them.

Mr. Marcus Powlowski: Do you think for-profit insurers can provide the same sort of plan at the same cost as a not-for-profit one? Are they that competitive?

I would have thought the concern with any private insurer in a private, for-profit company is that a percentage of what would otherwise be its employees' benefits and income instead goes to the profit of the corporation. Therefore, unless they can be so efficient that they can actually provide the service cheaper than a not-for-profit, why would anyone have a for-profit insurer?

Mr. Stephen Frank: You know, that's a case-by-case thing. You'd have to look at the situation of each employer and what they're looking for in their benefits plan, but it is a very competitive space. The majority are not-for-profits, as I mentioned, and I think you can infer that the profit being made in this space is quite low, even for the for-profit companies.

It's very important. We offer incredible value to Canadians. We're very proud of that, and as an industry, we compete really hard to make sure that we're doing the best we can for them and ensure that they have the ability to access what they're entitled to.

Mr. Marcus Powlowski: Can I assume that for-profit companies would argue they provide broader and better coverage than the not-for-profit ones?

Mr. Stephen Frank: I don't think you could make that general statement, no. It's an extremely competitive space. Everyone's competing with a very broad suite, and employers make decisions based on what's in their best interests.

It's case by case. There are hundreds of thousands of employers out there who have different reasons for going with different providers.

Mr. Marcus Powlowski: An employer has to basically buy a plan for their employees. In the case of for-profits, what percentage of the money that goes toward that plan ends up in profits? You said it's small.

Mr. Stephen Frank: It's very small.

Again, I don't have that detail in front of me, but what I can say is that it's a mixed system, with for-profits and not-for-profits competing aggressively. The thing that unites them is we provide coverage for 27 million Canadians. All of them get much better coverage than they would on any public program, and we're very proud of the service that we offer to Canadians. We also know that, overwhelmingly, they don't want that disrupted.

Mr. Marcus Powlowski: I'm going to sound like someone in Peter Julian's party when I say this, but—

Mr. Peter Julian: That's a good thing.

Voices: Oh, oh!

Mr. Marcus Powlowski: —why would you, as a company, as an insurer, want to enter the business if your margins are so small? Why form such a company?

I'm being a bit skeptical of the fact that you're saying, “Oh, well, you know, they hardly make any money at all.” Well, I don't think that when you're a corporate executive with those companies, you have that kind of mindset.

Mr. Stephen Frank: Well, it's a business that's important to us. It's a very competitive business. The margins are low. We're competing every day to offer the best service we can for Canadians.

I'll just reiterate that the 27 million Canadians who have that coverage today do not want to lose it. I think that as the government contemplates its go-forward plan with pharmacare, what the minister was talking about today makes a lot of sense. That's not what's reflected in this legislation, so I do think that amendments need to make sure that it maps to what we heard this morning from the minister. We would work very closely with the government to try to target the solutions to those who need it and to leave what's working well in place today.

The Chair: Thank you, Mr. Frank.

[*Translation*]

Mr. Blanchette-Joncas, you have two and a half minutes.

Mr. Maxime Blanchette-Joncas: Thank you, Mr. Chair.

I'll continue my line of questioning.

Mr. Frank, you know that Quebec has had a pharmacare program for close to 30 years now. It's a good thing. We want other people in Canada to be able to have the same thing, if governments want to draw inspiration from it.

In Quebec, people have to pay a deductible ranging from $0 to $731, depending on their income. I'm trying to understand, from your point of view, the functionality of the program we're talking about right now. How can the plan work with a $0 deductible on the first dollar, keeping the same range of drugs, plus the possibility of adding innovative drugs? How do you see the situation?

Mr. Stephen Frank: What I can say is that we greatly value the Quebec system. We believe that it works quite well and that it could be a model for the rest of Canada. We completely agree with you. It's a system that works well between public and private. It provides exceptional coverage for Quebeckers.

I can't speculate on how it might work, based on what's described in this bill. In my opinion, it isn't clear. As I mentioned, the terms aren't defined and what is considered isn't very clear. That's one of the big risks: People can read the bill and come to different conclusions. As I mentioned, I think this bill should be revised so that its purpose is very clear and transparent.

I repeat that the Quebec system works very well, and it would be acceptable for us to have such a system in place elsewhere as well.

● (1845)

Mr. Maxime Blanchette-Joncas: Thank you for recognizing Quebec's expertise, Mr. Frank.

Since you're in the business, I'm curious to hear your take on this question: Where in Canada is the best pharmacare program?

Mr. Stephen Frank: Each province is completely different, but I can say that the system in Quebec works well. It's a good partnership between the public and private sector. It provides universal coverage for all Quebeckers. It's a system we're very comfortable with.

Mr. Maxime Blanchette-Joncas: Can you tell us who you think will decide which drugs will be allowed? Is it the Canadian Drug Agency? Is it the Institut national d'excellence en santé et en services sociaux, or INESSS, which is administered by the Government of Quebec? What's your view on that?

Mr. Stephen Frank: I would say once again that, for us, it works quite well with INESSS in Quebec and now with the Canadian Drug Agency elsewhere in the country. We're not recommending any changes in that regard. I know that INESSS works very closely with the federal system and that it works quite well.

That said, what we see in the bill raises questions for us. Who's going to decide what's covered? What will the process be? Where will that list be published? How often is that going to be changed?

The Chair: Thank you, Mr. Frank.

[*English*]

The last round of questions for this panel comes from Mr. Julian for two and a half minutes.

[*Translation*]

Mr. Peter Julian: Thank you, Mr. Chair.

Apparently, certain members from Quebec didn't understand what I said, so I will repeat it. A coalition representing nearly two million Quebeckers put out a statement today. All the major unions—from the Fédération interprofessionnelle de la santé du Québec, the Table des regroupements provinciaux d'organismes communautaires et bénévoles and the Union des consommateurs to the Centrale des syndicats démocratiques, the Confédération des syndicats nationaux and the Fédération des travailleurs et travailleuses du Québec—pointed out in their brief that the current pharmacare program in Quebec has failed to ensure that everyone has reasonable and equitable access to drugs. The organizations go on to say that the various charges people have to pay for prescription drugs are actually user fees that serve to deter people, causing them to skip doses or go without their medications because they can't afford them.

My question is for the Canadian Health Coalition representatives.

According to two million Quebeckers, Quebec's public-private system is broken. What does it mean when people tell us that the system is working, that things are fine and that the government should continue to fund the hybrid system instead of establishing universal pharmacare?

[*English*]

Mr. Steven Staples: Thank you for the question.

Who is it fine for? That is what we have to talk about. Is it fine for Canadians?

Clearly, we hear that people in Quebec are not happy with the system they have. Talk to one of the leading health economists, Steve Morgan from the University of British Columbia. He ran the numbers. He says that Quebeckers are paying for drug medication in one of the highest-cost jurisdictions in the world. In fact, per capita, they're only topped by the United States. They pay more than Switzerland. In fact, if that system in Quebec were translated to other provinces, costs would actually increase because of the problems in the system.

I take the word of experts and health economists who looked at the Quebec model very closely. Listen to what people are saying. Is that the system we want to have for the rest of the country, or do we want to go with the kind of single-payer national universal system envisioned in Bill C-64?

The Chair: Thank you, Mr. Julian.

Thank you, Mr. Staples.

Thank you to all of our witnesses for being with us today. There was certainly a great variety and diversity of expertise, all of which is valued and appreciated.

We're going to suspend until seven o'clock to allow this panel to take their leave and get the next panel installed.

The meeting is suspended.

● (1845)

_____________________(Pause)_____________________

● (1900)

The Chair: I call the meeting back to order.

I'd like to welcome our final panel of witnesses for this evening. Under the programming motion that is guiding us through these proceedings, we are not to sit past 8:30, and I'd like to wrap up a little before 8:30 so that we can pass the budget, just to give you an idea of the timeline.

We extend a big welcome to the witnesses who have joined us here this evening. We have, from the Canadian Pharmacists Association, Joelle Walker, vice-president, public and professional affairs.

We welcome, from the Heart and Stroke Foundation of Canada, Manuel Arango, vice-president, policy and advocacy. From the National Indigenous Diabetes Association Incorporated, we have Céleste Thériault, executive director; and from the Society of Obstetricians and Gynaecologists of Canada, we welcome Dr. Diane Francoeur, chief executive officer.

You're probably aware that opening statements are five minutes in length and are given in the order in which you're listed on the notice of meeting, so we're going to begin with the Canadian Pharmacists Association.

Ms. Walker, welcome to the committee. You have the floor.

● (1905)

[*Translation*]

Ms. Joelle Walker (Vice-President, Public and Professional Affairs, Canadian Pharmacists Association): Mr. Chair and members of the committee, thank you.

We are pleased to have the opportunity to share our views on Bill C-64.

I will be giving my opening remarks in English, but I would be glad to answer questions in either English or French.

[*English*]

Our testimony tonight is really aimed at providing the committee with a very practical perspective on what could happen at the pharmacy counter as changes are contemplated and considered as part of the legislation. My testimony will focus on three points.

The first is around the role of pharmacists in pharmacare. As anyone who has used a prescription drug will know, the pharmacist is the last person the patient will see before they get their medications. While the act of dispensing is complex, pharmacists do a lot more than simply fill prescriptions and sell medications; they provide critical care and counselling that are integral to the effective use of medications. Their daily interactions with patients place them in a unique position to understand their needs, educate them on proper medication use and advise on potential drug interactions. Pharmacare really should not be just about the cost of the drugs, but also the care that goes along with them.

Pharmacists also play a significant role in drug plan management and navigation, and that's not often seen by many patients. Every day, they submit millions of claims on behalf of their patients, they spend time on the phone with insurance plans and they help patients identify alternative treatment options that are covered by their plans. For this reason, it's essential that we have a pharmacist on the government's proposed committee of experts.

The second point I'd like to make is around how best to target medication coverage. Contraceptive and diabetes medications are two very important drug classes, and there's no doubt about that. There's also no doubt that there are too many people in Canada who don't have access to these drugs for cost-related reasons.

However, the focus of Bill C-64, which aims to provide free contraceptive and diabetes medications to all Canadians, irrespective of their existing coverage, could warrant reconsideration. The intent of reducing the burden of these drugs is the right one, but our view is that the projected cost of over a billion dollars could provide even more comprehensive coverage if directed toward expanding coverage for a broader range of medications for those who currently lack adequate coverage, rather than replacing coverage for those with existing drug plans. We believe such an approach would be more feasible, fit better with the needs of provinces and limit disruptions, all while ensuring universal coverage for all.

That brings me to my third and last point. While change is sorely needed to ensure universal pharmacare, the potential for significant disruption can't be overstated. As members of this committee can likely attest from the recent changes to the PSHCP, or Public Service Health Care Plan, changing drug plans can be very disruptive for plan members and for pharmacists. Switching patients from a private drug plan to a public drug plan can be equally disruptive, so changes must be implemented carefully to avoid confusion and reduce administrative burden.

The reality is that public drug plans across Canada are far less comprehensive than private plans, which means that if the legislation shifts patients from their private plans to a public plan, pharmacists and physicians will likely have to spend a considerable amount of time switching patients to new therapies, especially if their drug is no longer covered under a public plan; filling out paperwork to get special exemptions; and communicating these changes to patients.

In conclusion, I'd like to provide a personal example. I'm on a birth control pill that is not on the current list proposed by the federal government, and it took me three years to find the pill that worked for me and didn't have side effects that I would have had to live with daily as a woman.

This raised some very real questions for me when I looked at the intent of the bill. Will my employer continue to cover contraceptives if that's not covered? I'll certainly lobby for it, but it's definitely a question in my mind. Will my pharmacy continue to stock products that aren't broadly covered? If there are exemptions, will my pharmacist have to apply for that exemption on my behalf, as they often do with many drug plans?

I hope this gives you a sense of frontline issues that could arise.

I thank you and welcome your questions.

● (1910)

The Chair: Thank you, Ms. Walker.

Next, representing the Heart and Stroke Foundation of Canada, we have Mr. Arango.

You have the floor.

Mr. Manuel Arango (Vice-President, Policy and Advocacy, Heart and Stroke Foundation of Canada): Thank you very much.

Heart and Stroke applauds the Government of Canada and Parliament for introducing Bill C-64, which will lay the groundwork for equal access to life-saving drugs for all.

People in Canada appreciate our universal health care system, but the reality is that Canada is the only country with medicare that does not include prescription drugs as part of its universal health care program. The current patchwork of public and private plans in Canada has created fragmented drug access, leaving millions struggling to afford their prescription medications. I don't think there's any disagreement with this.

While many people in Canada have some form of drug coverage, it is often insufficient and poses affordability issues. The 2019 Hoskins report indicated very clearly that 7.5 million people in Canada had either no coverage or insufficient drug coverage.

As well, the 2021 survey on access to health care and pharmaceuticals during the pandemic found, once again, that one in five people did not have insurance to cover any of the cost of their prescription medications in the previous year.

Furthermore, a poll commissioned by the Heart and Stroke Foundation and the Canadian Cancer Society in 2024 found that one in five people in Canada do not have sufficient prescription drug coverage. One in four had to make difficult choices to afford prescription drugs, such as cutting back on groceries; delaying paying rent, mortgage or utility bills; and incurring debt. The same poll also found that one person in 10 in Canada who had been diagnosed with a chronic health condition was more likely to visit the ER due to a worsening health issue because they were not able to afford their prescription medications.

A study in 2016 also found that 16% of people in Canada went without medication for heart disease, cholesterol and high blood pressure because of cost.

With the introduction of this bill, the foundation is being laid for the first phase of national universal pharmacare through single-purchaser coverage of diabetes and contraceptive medications. This will ultimately provide equal drug coverage for all people in Canada, regardless of their gender, race, geography, age or ability to pay.

We do feel that this needs to be expanded in the future to cover drugs for heart disease and stroke. The reality is that millions of people in Canada live with heart disease and rely on daily prescription medicines to help keep them alive and to manage their conditions at home. In fact, in 2022, 105 million prescriptions were dispensed for cardiovascular diseases, making it the second-highest disease category for prescriptions.

Universal coverage of essential medicines will reduce pressure on the health system by cutting costs, because treating a condition such as high blood pressure, which is a leading risk factor for stroke, is more cost-effective for our health care system than the specialized care required to save a life after a stroke.

The Heart and Stroke Foundation has made a number of recommendations for amendments in its submission, but I would like to highlight one today. It pertains to subclause 8(1), regarding a national formulary.

We recommend that a definition be inserted here for “essential medicines”. In particular, essential prescription drugs should initially be defined as those included in the CLEAN meds trial. That's one way to define essential medicines.

We feel that the government must take quick action to close the gap in coverage that leaves out essential medicines for chronic diseases, including heart disease and stroke, that affect many in Canada. We also recommend that the minister prioritize the signing of bilateral agreements with provinces and territories in tandem with the progression of the bill and to pass this bill before the House adjourns for the summer.

Finally, I would like to address some other key points and misinformation about pharmacare. The reality is that the federal government, as a single drug purchaser, would be able to negotiate much lower prices compared to the myriad private and public plans. This would have a significant deflationary impact on the average drug price.

● (1915)

We heard comments earlier on about bulk purchasing. It's very well known in the world of business procurement that a company that buys 100,000 widgets from a manufacturer is going to get a much better price per widget than is a company that buys five widgets per year from the manufacturer. The reality of bulk purchasing and the fact that it leads to lower prices is well known throughout the world. In New Zealand and Australia, with respect to drug purchasing, or even just in general if you look at Costco, bulk purchasing leads to lower prices.

Another point is the notion that coverage is going to be decreased through a national pharmacare program. In fact, it's going to be the opposite. We're going to get enhanced coverage. The reality is that we have 7.5 million people who have no coverage or inadequate coverage. The objective is to increase coverage for those people. It's just not a reality that we're going to get reduced coverage. If the government, the federal payer, is covering a diabetes generic drug, whether that's in the private plan, the public plan or the federal plan, it doesn't matter: It's going to be covered one of those three ways. I don't foresee a reduction in potential coverage. It's the opposite. We're aiming for the opposite.

To conclude, the Heart and Stroke Foundation applauds the federal government and Parliament for the introduction of this legislation and for proposing an affordable plan that will give 7.5 million uninsured and under-insured people access to prescription drugs for diabetes and contraception. We really hope that in the future this can be increased and expanded. As my colleague mentioned, I think we do want an expansion of this formulary in the future, but this is a good start.

Thank you very much.

The Chair: Thank you, Mr. Arango.

Next, on behalf of the National Indigenous Diabetes Association, we have Céleste Thériault.

Welcome to the committee. You have the floor.

Ms. Celeste Theriault (Executive Director, National Indigenous Diabetes Association Inc.): Thank you, Chair.

Good evening, everyone. My name is Céleste Thériault and I'm the executive director of the National Indigenous Diabetes Association, located on Treaty No. 1 lands in Winnipeg, Manitoba. It's an honour and a real privilege to be speaking about this bill in front of you as it relates to indigenous people in Canada.

I'll talk a bit about the National Indigenous Diabetes Association. We refer to ourselves as NIDA, and we're a charitable, non-profit, member-led organization established in 1995 as a grassroots initiative by women on the side of Lake Winnipeg who were advocating because diabetes was taking too much from their people. That was almost 30 years ago. It is inclusive of first nations, Inuit and Métis in Canada.

This bill really provides the beginnings of a comprehensive pharmacare program for all Canadians and represents a significant step towards addressing social health inequities across Canada, including within indigenous populations.

I may refer to indigenous people—first nations, Métis and Inuit—with a pan-indigenous term to represent them, but they are distinct nations with distinct interests. They suffer disproportionately from socio-economic constraints and illnesses, but they stand to benefit substantially from the provision of much-needed diabetes care, especially Métis individuals who are not covered under NHIB, the current non-insured health benefits program, and so the current government of the day is really commended for this first step and for including diabetes medication in that first step.

That said, we should be continuing to do this in a good way. What does that mean?

It means talking with indigenous nations, political leaders and individuals with lived experience to make sure that no one gets left behind. We know changes that affect indigenous people in Canada should be done with us—“nothing about us without us”, and I would like to mention that because of the short period for big decisions between the tabling of the bill and this consultation, we didn't have adequate time to consult all of our members of interest on the implications of the bill. Our organization by no means can talk on behalf of all indigenous nations across Canada, so there should be continuous and ongoing meaningful dialogue with many indigenous people and nations, especially with our political leaders. The Minister of Health talked about not only provincial and territorial governments but also our indigenous governments, which have some sovereign right to having their voices heard on this legislation.

It's vital that we roll out this new program very carefully and really consider the context of the existing benefits, particularly through NIHB, the non-insured health benefits, which presently are the right of status first nations and Inuit beneficiaries in Canada and provide for medications for the treatment of diabetes and for other pharmacological care. However, it's not all of them, and that is to the detriment of the individual.

It also remains unclear whether the NIHB and the new pan-Canadian pharmacare program will be responsible for providing medication coverage to these individuals. However, the minister said earlier today, all the programs would kind of remain in place, so we believe that would be helpful.

The coverage of medications for first nations and Inuit can be bureaucratically burdensome, and we know this. Individuals and health care providers on reserve are already administratively overwhelmed, so we need to ensure that the policy is reducing those burdens and that our providers can directly impact patients and deliver patient care in a good way. We don't need to burden them with getting their patients' medications covered.

We also want to make sure there's a comprehensive list of medications, allowing both the prescriber and the patient to be advocates in the health care journey of diabetes management. Of course, we want to steer away from a two-tiered health care system, where the best and strongest medications are only available to those with deep pockets, privilege, and secure employment with strong health benefits.

Similarly, we want to ensure that no indigenous person is left behind, because Métis individuals are not included in the NIHB. This bill means that Métis will have much greater access to care through this bill. We have to remember that when we walk forward in this legislation. We need to be at the bare minimum of equal or better than current coverage for all indigenous people in Canada.

● (1920)

We must make sure that we are working together to ensure that there is equal access to brand name medications for diabetes care when the generics are not available, again supporting timely access and ease of use for indigenous people so that those living with diabetes can keep their healthy blood flowing now and several generations from now.

As an indigenous woman, I would be remiss if I missed the opportunity to also comment on the contraceptives. As someone who had to use three IUDs to get my last one successfully put in, I know IUDs are quite expensive, and that would be not have been possible for me had I not had some support in place to be able to do that and make that a reality. All indigenous people need to be able to access whatever form of contraception need and to to determine what is best for their own person, and the funding should be provided for each of those types, without exceptions, just as it should be with diabetes care, as it is an extremely personal journey.

We look forward to a Canada where first nations, Métis and Inuit have equitable access to life-saving medications, although more consultation is required to move forward in a good way. We invite further collaboration on this vital project to ensure that no one is left behind. We want to ensure that everyone, from our indigenous elders to our youth to our lived-experience people in indigenous nations to governments and politicians, is adequately involved in the decision-making process of this bill, not just, as I said, our provinces and territories.

Let's continue to work together in a good way to ensure that we are raising health outcomes for all indigenous people in Canada and representing a significant step forward in addressing social health inequities across Canada—

The Chair: Can I get you to wrap up, Ms. Thériault, please?

Ms. Celeste Theriault: *Marsi.* Thank you. Thank you for your attention.

The Chair: Thank you.

Next we have Dr. Francoeur, representing The Society of Obstetricians and Gynecologists of Canada.

Welcome. You have the floor.

Dr. Diane Francoeur (Chief Executive Officer, Society of Obstetricians and Gynaecologists of Canada): Thank you, Mr. Chair and members of the committee.

My name is Dr. Diane Francoeur. I am a practising obstetrician and gynecologist, as well as the chief executive officer of The Society of Obstetricians and Gynaecologists of Canada.

I am here today to discuss the aspect of Bill C-64 that proposes to offer universal coverage of a full range of contraceptives for Canadian women. Specifically, I wish to highlight why this measure is important and long overdue; why it's not just a women's issue or a nice-to-have measure but a necessary economic policy that benefits all of society; and why we hope that you, as legislators, will ensure that coverage of all forms of birth control is included in the final bill and that the bill passes without any undue delay.

Today, somewhere in Canada, a woman will have to choose between buying groceries, paying her electrical bill, filling up her gas tank or paying for her birth control. It's no secret that the rising costs of almost all goods and services have become a significant burden for many Canadians. However, nine million women of childbearing age in Canada bear the additional cost of preventing unintended pregnancy, a basic need that often flies under the radar but that is no less fundamental to the way of life of millions of Canadian women.

Contraception allows women to plan their lives, their families and their pregnancies. They are more likely to finish school. They participate more fully in the workforce. They enjoy more economic stability and they have healthy pregnancies when they do choose to have children.

Canadian women spend, on average, 30 years of their lives shouldering the associated cost of trying to avoid a pregnancy, but financial barriers can limit birth control options for many women, as you so rightly said.

Canada currently has a patchwork of coverage for contraceptives, which varies according to income and where you live. This forces some women to choose the cheapest method, and not necessarily the most effective or best method for their bodies. In some cases, they may not be able to afford any birth control at all. This can result in an unintended pregnancy. I see this every week in my practice.

We can do better than that for Canadian women. Approximately 40% of pregnancies in Canada are still unintended. This doesn't impact only women and their families, but also the economy. The direct cost of unintended pregnancies in Canada is estimated to be at least $320 million per year, a figure that doesn't include the downstream cost to society or to parents. The B.C. modelling indicates that the health system will save $5 for every dollar it invests in contraception every year.

We urge you, as legislators, to ensure that Bill C-64 passes smoothly and without undue delay.

To fully implement the commitments in this bill, Ottawa will need to negotiate agreements with the provinces and territories, which will take time. Any parliamentary holdup would only force women to wait longer for this much-needed assistance. Already, my patients, my neighbours and my nurses with whom I practice every day have been asking me when this coverage will become available, because it's never soon enough for those in difficult economic situations.

We also urge you to ensure that the final version of the bill and any budget measures attached to it include coverage of a full range of contraceptives, including the pill, the patch, the ring, the IUDs, the shot and the implant. By ensuring that all options are available, nine million women in Canada will no longer be forced to make decisions about their family planning based on their income.

Thank you.

● (1925)

The Chair: Thank you, Dr. Francoeur.

We will now begin with rounds of questions, starting with the Conservatives.

Dr. Kitchen, you have six minutes, please.

Mr. Robert Kitchen: Thank you, Mr. Chair.

Thank you, everybody, for being here at this late hour and on such short notice. It's greatly appreciated.

I think that's part of what Canadians want to see—true conversations and discussions of what this piece of legislation says and what this piece of legislation means. Canadians want to be able to decipher it in such a way that the average person watching this evening can understand what is going on and the challenges that we have.

To you, Ms. Thériault, thank you very much for your comments and your insight.

In my past life, before I became a member of Parliament, I was a consultant for the FNIHB, the First Nations and Inuit Health Branch, so I'm aware of things along the lines of providing health care services to first nations through different avenues. I'm wondering if you could explain that to those watching who don't understand, because FNIHB is covered by the Government of Canada.

What could you say on the coverage for diabetes and other coverages that might be available?

● (1930)

Ms. Celeste Theriault: You mean under the NIHB program, correct?

Mr. Robert Kitchen: That's correct.

Ms. Celeste Theriault: In the NIHB program, specific diabetes medication coverage is more extensive than in the formulary list that was the backgrounder list that was circulated. There are some disparities between the NIHB list and the Canadian practice guidelines that are published. They're not all-inclusive and comprehensive in the first place, if we really wanted to pick them apart, but they are better than the formulary list that was proposed here as a base minimum. There are some that are covered only if specific requirements are met, such as being an insulin user to get a specific medication covered.

It varies in terms of all of the medications. One big one that we see that is not included is GLP-1s. That's something that our indigenous people use extensively to manage their blood sugars in a way that works for them.

I think that we need to look very holistically on what it also provides outside of pharmacological care, because pharmacological care is only a certain portion of what is covered under non-insured health benefits.

Mr. Robert Kitchen: Thank you.

To be clear, you're basically saying that what's being proposed in this legislation is less than what is available for first nations at this present time, under the understanding that the services that are provided to first nations are universal across Canada. They don't vary from province to province.

Ms. Celeste Theriault: First of all, it is for status first nations and Inuit beneficiaries. Yes, for status first nations and Inuit beneficiaries, the NIHB program currently provides more coverage.

Now we are missing an entire other population of indigenous people, and also our non-status individuals within that scope. We cannot make a sole judgment just based off that one thing, but yes.

Mr. Robert Kitchen: Thank you; I appreciate it.

Granted, you did touch on the fact that you weren't able to have conversations with all groups because of how quickly this came about. Are you aware of whether the government talked to first nations about this before this piece of legislation came about?

Ms. Celeste Theriault: I am not aware, and I wouldn't be privileged to that information in my current role and position, but I do make it clear that our Minister of Health does need to have those conversations.

Mr. Robert Kitchen: That was going to be my next question.

Do you think it's important that this Minister of Health should be talking to our first nations before we even get this out on the table?

Ms. Celeste Theriault: I believe that our Minister of Health has to have conversations with provinces and territories as well as our first nations, Inuit and Métis, and not just first nations governments. That can be done in a good way through moving the bill forward. I think that the minister said today that he cannot have concrete conversations with the provincial and territorial governments, that he would be in breach of Parliament, or something along those lines.

We want to make sure that the indigenous voice is heard first and foremost. I think everyone can work together towards that.

Mr. Robert Kitchen: Likewise, as you indicated, it should be also for the provinces and the territories to have those conversations.

Ms. Celeste Theriault: Of course.

Mr. Robert Kitchen: Thank you.

Ms. Walker, thank you very much. I have huge respect for the pharmacists I have, my own personal pharmacists, because of the advice that they provide.

A lot of Canadians don't understand the knowledge base that they have. Oftentimes they are much more knowledgeable on all medications, more perhaps than even the doctor who's providing that information. I don't mean that disrespectfully; it's just that you spend four years studying to become a pharmacist.

Your comment about the expert committee, I find, is very discerning about this piece of legislation, because it doesn't clearly define what that committee will be. It doesn't say how many people will be on that committee. It doesn't say what their role will be or what qualifications they need to have. Your comment about having a pharmacist on it I think is very important. I wonder if you could expand on that.

● (1935)

Ms. Joelle Walker: Absolutely.

I think it's very natural to think of your pharmacist first and foremost as the person who's managing your medication treatments on an ongoing basis. They really can provide a very practical, real-life view of what any changes would propose.

Whether the legislation goes in any particular direction, the end result is it's going to be an interaction between the pharmacist and the patient at the pharmacy counter. The pharmacist needs to be able to explain what the change is and why the change has been made.

Depending on the spectrum of the changes that are considered, changing millions of people from different programs could be hugely challenging, just from a logistics and burden perspective. Having somebody like that on a committee would be essential.

The Chair: Thank you, Ms. Walker.

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

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

Thank you to the witnesses for coming.

I want to follow up on what Dr. Kitchen talked about.

I want to also thank you for advocating for pharmacists. One of my very good friends, my mentors, and the one whom I trust with all of my medication, is Akil Dhirani, who's running many practices. I often go to him for advice on many things, especially around pharmacare.

I'll ask you a very simple question. I believe you are familiar with the health care plan that we have. If I develop type 1 diabetes, what would be the scenario today for me? What would be the difference between today versus tomorrow, when this bill passes? What would it be when I go to Akil and say, “Akil, now I have type 1 diabetes, but insulin is universally available now. What change would I see in treatment? What change should I anticipate from my insurance provider?”

Ms. Joelle Walker: It really depends a little bit on the treatment that you're currently using. We certainly fielded an enormous number of questions from pharmacists when the PSHCP transition was made, because there were changes that affected patients.

Some members might be familiar with one of the biggest ones, which was compliance packaging for elderly people. That was a service that was provided with an understanding from the pharmacist and the physician that was noted in the file, but now the patient has to apply, go into their paperwork and get a response back from the plan provider. I'm illustrating that just to mention that there can be additional processes to go through.

The difference might be that if you're on a drug that isn't currently envisioned on the list, such as a GLP-1, the question will be whether your current plan will cover that and pick that up.

We're also very familiar with the challenge that employers will be looking to cut the costs of their plans. If a drug class is already covered, they may look to reduce those costs so that they can invest in other areas of their plans. Those are the questions that we would ask.

If you're not currently covered.... This is sort of what happened with some people. In Ontario, the OHIP+ program for kids was introduced, and pharmacists had to do a lot of triaging of patients who had lost coverage for a particular drug and had to apply for special exemptions. That just adds to the burden that's already existed on a very pressured profession and health care system at the moment.

Mr. Majid Jowhari: Making it simple, if I am covered today, the pharmacist's concern is whether the amount of coverage would potentially be reduced because of the type of diabetes medication that's made available as part of the universal plan. That's one area that you're....

The other one is that if I don't have medication, if I don't have coverage, that means at least I'm one step ahead in being able to get the medication that I need. Is that a fair summarization of what the concerns and the benefits are?

● (1940)

Ms. Joelle Walker: We've always advocated that the best way to serve patients is to help fill the gaps for people who don't have coverage or to help people who don't have enough coverage. Those are slightly different issues, and they need to have really tailored solutions.

Absolutely, this could be a step up for somebody who doesn't have coverage, and we would support that, but in terms of the legislation, we would like to see a more explicit reference to maintaining private coverage so that it would go to that private coverage first.

Mr. Majid Jowhari: If you were going to make one recommendation along those lines, what would that recommendation look like?

Ms. Joelle Walker: We would look to some of the definitions around single payer, and specifically coordination of benefits. If you have a spouse, you might be familiar with a pharmacist having to coordinate and first apply to one spouse's plan and then coordinate with the other spouse's plan so that you don't have to pay out of pocket, but doing so in a way that the private plan is charged first. The public plan picks up the remainder of the difference, if there is one. If you don't have coverage, then the public plan would jump in first.

Mr. Majid Jowhari: Okay. Thank you.

With my remaining time, I would like go to The Society of Obstetricians and Gynaecologists of Canada.

I'm developing an understanding of the many different contraceptives that are available and how they best fit, depending on the situation. I think you touched on this, but can you give a sense of, or explain further, the fact that this current scope is covering a broad range of contraceptives and supporting products?

I think the IUD was mentioned as one of the items in the first panel. Can you expand on how this is helping Canadians, especially women who want to have the choice to be able to plan their lives better?

Dr. Diane Francoeur: Absolutely. Thank you for this question, because it's really, really important. I'll give you two quick examples that are easy to understand.

In 2006, I was president of the obstetrics and gynecology society of Quebec, and we made a presentation to the government to have the hormonal IUD covered. That was a long time ago, in 2006, and in other provinces it's still not covered. These methods have made an amazing change in the teenage pregnancy rate, because they are very, very effective. Once the IUD is there, it's there to stay. Now we can leave it there for up to seven years, unless the woman wants to remove it.

Every one of these methods has some advantages and some side effects that sometimes adolescents or women don't like. That's why having all medication covered will really help us fit the need.

As you said, now I have a Canadian position, and my heart is broken when I hear that, because since 2006 we've been putting in IUDs, and women are happy. There's a decreased rate of hysterectomies. There are a lot of good side effects, like decreased bleeding. It changes women's lives.

That's a good example of what needs to be done.

The Chair: Thank you, Dr. Francoeur.

[*Translation*]

Now we go to Mr. Blanchette-Joncas for six minutes.

Mr. Maxime Blanchette-Joncas: Thank you, Mr. Chair.

Thank you to the witnesses for being with us.

Ms. Walker, in your opening statement, you said that pharmacare should be about more than just the cost of drugs. It should also be about the care or counselling that goes along with the treatment.

Can you talk more about that? What exactly do you mean?

Ms. Joelle Walker: Yes, of course.

If pharmacists didn't need to monitor the medications people were taking or if their advice wasn't useful, drugs would be sold on store shelves, with no follow-up.

It's important to recognize that the work pharmacists do when they provide patients with prescription drugs is quite complex. They check for drug interactions. It is thanks to pharmacists that patients can be sure they are taking the right drugs. That is the kind of care I was talking about.

It is a pharmacist's job to review the list of medications that a person is taking. For example, if an elderly patient is taking multiple medications, the pharmacist has to make sure that the drugs are accurately listed in the patient's file. They have to do that for all patients. More and more pharmacists are providing those types of primary care services in pharmacies. That is part of the care that pharmacare involves.

Mr. Maxime Blanchette-Joncas: Thank you.

You also said you had concerns about the drugs that the public system would cover. You're familiar with Quebec's system, which has been in place for 30 years now. It's worth pointing out to certain people here today and those who are following these proceedings.

The system isn't perfect, but it has a formulary of about 8,000 medications.

Given your expertise, do you think that's reasonable, or do we need to stop and think about the fact that many of the medications currently covered won't be under the new pharmacare plan?

● (1945)

Ms. Joelle Walker: I believe the Parliamentary Budget Officer mentioned this in his first report, but when it comes to the formularies in use, Quebec's is the strongest in the country.

The committee will be meeting with our colleagues in the Association québécoise des pharmaciens propriétaires tomorrow, and they'll be able to tell you all about the system.

The risk of certain people losing coverage for certain drugs is definitely heightened given that they could be moving from a private insurance plan to a publicly funded plan. The details will matter. It will be important to know what the proposed formulary will look like and whether it's the right use of the funding, which is limited. To begin with, consideration could be given to including drugs that support cardiovascular health for individuals whose medications aren't currently covered.

Mr. Maxime Blanchette-Joncas: Nonetheless, do you have any recommendations so that coverage of certain drugs isn't eliminated when the new plan is introduced?

Ms. Joelle Walker: We think Bill C-64 is a bit vague when it comes to the coverage of certain drugs under private plans. We need clearer information on that. Today, the minister suggested that they would continue to be covered, but the current bill makes no mention of that. It really needs to be laid out.

Mr. Maxime Blanchette-Joncas: Ms. Walker, I feel the same way and I'd like to know the same thing. I would go so far as to say it's confusing. It's like the government is building the plane while flying it. It can try, but I'd rather be safe than sorry.

With pharmacare being introduced so summarily by the federal government, what consequences could the pharmacy industry face? Do you have a sense of that?

Ms. Joelle Walker: It will have consequences for every facet of the industry. It will depend on the details.

First, I talked a bit about the fact that pharmacists will have to spend a lot of time communicating these changes, given how significant they are.

Second, the government's cost projections should capture the cost of closing the coverage gap between the public plan and private plans. It's also important to make sure that pharmacists continue practising their profession and are compensated for all the counselling they provide.

The difference between a public plan and a private one can be quite significant. For instance, Ontario's dispensing fees are quite low as compared with the national average. If everyone took up that model, it would have a major impact on pharmacies, especially independent pharmacies and rural ones.

Mr. Maxime Blanchette-Joncas: Thank you.

On your association's website, you say this:

> Given Canada's constitutional make-up and the provincial and territorial management of health care, we believe that a pan-Canadian mixed payer approach to drug coverage is more feasible, will face fewer barriers to implementation and can be achieved more quickly than through a complete overhaul of drug plans across the country. This approach can provide comprehensive coverage to those who need it, and minimize disruption for those with existing plans.

Can you tell us more about your vision for a pan-Canadian mixed payer approach?

Ms. Joelle Walker: It's clear that not all the provinces are at the same point when it comes to pharmacare. In Quebec, people already have drug coverage, even though the system may not be perfect. The situation really varies from province to province, from British Columbia to Newfoundland and Labrador.

We think the most practical and impactful approach, starting now, is to provide funding to the provinces so they can each strengthen their existing plans according to their needs. As we know, each province has its own needs.

Mr. Maxime Blanchette-Joncas: Thank you.

Can you tell us specifically the kinds of problems that could arise after the transition from one system to the other? Have you thought about that?

Ms. Joelle Walker: Yes, we have, and I can give you a few examples.

When the federal non-insured health benefits program was transferred to British Columbia, around 17% of the medications that were covered under the federal program were no longer available through the province's publicly funded program. Those kinds of changes have to be made to ensure that patients don't lose their coverage suddenly.

I mentioned OHIP+ in Ontario, which had similar problems. Parents were showing up at the pharmacy to get a prescription filled for their child only to find out that the drug was no longer covered. Generally speaking, public plans provide less coverage. Pharmacists were having to fax doctors—because we still communicate with doctors via fax—but they weren't always available to respond. That gives you a sense of the problems that can arise.

● (1950)

The Chair: Thank you, Ms. Walker.

[*English*]

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

[*Translation*]

Mr. Peter Julian: Thank you, Mr. Chair.

Thank you to the witnesses for their input, which is extremely useful.

Quebec's current drug insurance plan, a hybrid public-private system, has come up a number of times. Recently, a major coalition representing two million Quebeckers called on Parliament to pass Bill C-64.

The coalition is made up of all the major unions in Quebec, from the Fédération de la santé et des services sociaux and provincial groups to the Union des consommateurs. In its brief, the coalition states that the current pharmacare program in Quebec has failed to ensure that everyone has reasonable and equitable access to drugs. It also states that the various charges people have to pay for prescription drugs are actually user fees that serve to deter people, causing them to skip doses or go without their medications because they can't afford them. Higher drug costs are putting more strain on private plans, and as a result, workplaces are terminating their insurance plans and workers are losing all their coverage.

Quebec's system is broken, and these organizations are asking us to pass the bill quickly.

Under hybrid systems, many people can't afford to get the drugs they need. When it comes to women having control over their own reproductive health, Dr. Francoeur, what does it mean to have a universal, as opposed to a hybrid, system?

Dr. Diane Francoeur: The major benefit is that it takes money out of the equation. In other words, it gives us the opportunity to discuss the benefits of the plan for a specific individual. We want the same model as the one implemented in British Columbia. That said, patches weren't included in that province's model.

If a person has been through bariatric surgery and has issues with their intestines or with taking a medication, they can't use a pill, because it may be less effective. With a patch, the medication enters the body directly. It's much more reliable. This example explains why it's sometimes necessary to choose one method over another.

Our president, Dr. Amanda Black, conducted a study of young Ontarians aged 20 to 29. It clearly showed that unwanted pregnancies were associated with methods that failed to meet the needs of young people. When young women wanted implants, they couldn't have them. When they asked for an IUD, they were told that another method was covered by the plan.

I'm from Quebec. I'm obviously familiar with the province's drug coverage. It's better than nothing. However, it isn't true that everything is free. Young girls who don't want their parents to know about their pill use have no choice. They must report everything. It isn't true that everyone will be covered. If the girls are covered by their parents' insurance, their parents will have access to a statement. Unfortunately, this often constitutes just another step to protect them against an unwanted pregnancy that will change their adult lives.

Mr. Peter Julian: Thank you.

[*English*]

Mr. Arango, I want to come to you. All of your testimony was very important.

I was particularly touched by your speaking about heart and stroke and the 600 Canadians who die every year because they can't afford to pay for their medication. What I hear you saying is that we can't stop with diabetes medication and contraception: We have to move as quickly as possible to cover heart disease medication and medication that prevents strokes.

I know of constituents who are paying $1,000 a month for heart medication that keeps them alive. They have to make that difficult choice every day: Do I put food on the table and keep this roof over our family's head, or do I stay alive?

What impact would it have if universal pharmacare were extended to all the medication that the Heart and Stroke Foundation and the research prescribe for people with heart and stroke issues?

● (1955)

Mr. Manuel Arango: It would be very significant, because in fact 16% of the 1.6 million people that live with heart disease and stroke cannot afford these drugs.

What they end up doing is splitting pills, skipping doses, not renewing their prescription or not even filling the prescription in the first place. Of course, if they don't have proper access to those drugs, they end up going to the ER, and then it's much more expensive to treat.

I understand that Rome was not built in a day and this first step won't cover necessarily CVD drugs, cardiovascular disease, but in the future, we would like to have that covered.

I should mention as well, though, that someone with diabetes has a threefold increase in their risk of dying from heart disease. Diabetes is an important comorbidity for heart disease and stroke. Addressing that as a first step is really key.

If I may, I really would like to address the point regarding the potential threat that's been raised of loss of coverage through private and provincial plans.

The reality is that if the federal government is providing a generic diabetes drug, I do not believe that the person who needs that drug is going to care whether it comes from a private plan, a provincial plan or a federal payer. As long as they get that generic drug, they're going to be happy, in my opinion.

Of course, they would be very concerned if we had brand name drugs that address adverse effects for them being removed from the private plan or the provincial plan. I can't see that happening. The demand would be really great to have that brand drug coverage in those private and provincial plans, so I don't think it's a very realistic scenario that those drugs are going to disappear.

The Chair: Thank you, Mr. Arango.

Next we have Mrs. Goodridge. Please go ahead for five minutes.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

Thank you to all the witnesses for being here today.

Celeste, I really appreciated that as you were sharing your testimony, you were talking about doing things in a good way. It was very reminiscent of the many conversations I've been blessed to have with many of the elders in my region on how the intention has to match with the steps.

Given that you have been unable to consult with all of your appropriate stakeholders prior to doing that, do you believe that we have put you into a space where you perhaps are not moving in a good way, even just having to be here on such a short timeline?

Ms. Celeste Theriault: No. Any time an indigenous person has an opportunity to raise their voice and their opinion when it's been chronically neglected through our colonial structures and systems, we must take that opportunity to voice those concerns.

I really hope that every bill looks at the indigenous component, whether that's pharmacare or whether that's any other thing that the House is trying to pass.

Mrs. Laila Goodridge: I appreciate that.

I guess what I was trying to ask was whether you would have preferred more time to be able to consult with a variety of stakeholders to assess the impacts of this bill.

Ms. Celeste Theriault: Not necessarily. We have done an extensive amount of work on talking to people about diabetes through some specific work on Bill C-237, the framework. NIDA is actually leading the indigenous engagement for diabetes in Canada regarding that bill, so we have been having ongoing dialogues ever since. I guess we signed with the Public Health Agency of Canada on July 7, 2022, I believe, and I got to NIDA in October 2022.

Ever since that day, we have been having those conversations and hearing about people and what our health care system can provide and what it is currently providing.

That information is on our website, and it is a report. That is a first step. We need more, and we're working on that.

● (2000)

Mrs. Laila Goodridge: I appreciate that.

When was your association first consulted on this bill?

Ms. Celeste Theriault: We were not first consulted on this bill. I actually had to make sure that I had a spot at this table to raise my voice, and I will make note that we do have gaps, but I can't comment on all the other pressures on people who want to have their voices heard. I think it's a privilege to be here.

Mrs. Laila Goodridge: I'm grateful that you are here and I am grateful that you are raising your voice. It's always wonderful, to me, to have a Prairies voice at the table. We don't often have them here in person.

I'm trying not to say anything negative. I'm more trying to figure out.... You had to fight to get here. The government didn't reach out, even though you guys are the leading voice when it comes to indigenous people with diabetes in this country. You had to fight to be here. Is that correct?

Ms. Celeste Theriault: Yes, but we also have indigenous politicians, leaders and governments doing some political work that our organization doesn't necessarily do. We come from that grassroots perspective to make sure that we're not leaving anyone behind.

Mrs. Laila Goodridge: Mr. Arango, when was your association first consulted by the government on this particular bill?

Mr. Manuel Arango: Admittedly, we reached out to the departments—the Canadian Drug Agency and Health Canada—to discuss this issue well over a year ago. We initiated the contact, but I think, as members of civil society, we often have to initiate it ourselves.

Mrs. Laila Goodridge: Could you share whom in the department you reached out to a year ago?

Mr. Manuel Arango: We reached out to some of the folks who appeared earlier on. I'm sorry; I wasn't here.

We reached out to Michelle Boudreau and her colleagues, and others. We've had quarterly meetings with them. Once again, as I mentioned, we initiated the contact, but that's usually our job, as members of civil society.

Mrs. Laila Goodridge: Minister Holland often talks about his experience with the Heart and Stroke Foundation. Did you work with him when he was at the Heart and Stroke Foundation?

Mr. Manuel Arango: Yes. It was many years ago. It was in 2015, briefly, for maybe two years.

Mrs. Laila Goodridge: Okay. Have you talked to him specifically about this bill?

Mr. Manuel Arango: I haven't talked to the minister. I've talked to people within the department. I've talked to people in the minister's office and I've talked to MPs, but I haven't talked to the minister directly.

Mrs. Laila Goodridge: Wonderful.

Ms. Walker, I'll ask you the same question. When was your association first consulted on this bill by the Department of Health?

Ms. Joelle Walker: I would probably share some of the same observations. We engage regularly with the department and we reach out when we see certain areas. We have been active on this file for many years, and we have discussed it regularly with officials at both the political and department level.

The Chair: Thank you, Ms. Walker. Thank you, Mrs. Goodridge.

Next is Mr. Naqvi, please, for five minutes.

Mr. Yasir Naqvi: Thank you very much, Chair.

Thank you to all the witnesses for being here. I really appreciate your testimony.

I'm going to start with Dr. Francoeur. Thank you for being here.

One of the things I'm hearing a lot about in my constituency—I represent Ottawa Centre, here in downtown Ottawa—is contraceptives. This bill ensures that contraceptives are available for women and gender-diverse people who need them, and it takes that cost barrier away. I recently had a conversation with Planned Parenthood here in Ottawa as well, and they raised some really important issues.

From your experience, can you talk to us a bit about the importance of making contraceptives available in the way we are proposing, and the kinds of impacts it will have on the lives of women in Canada?

Dr. Diane Francoeur: Thank you for that question.

We have been lucky, in that B.C. started earlier. They have been covering contraception for a year now. From all the good news we hear about it, it's obvious that it's making a change, so we're eager to know all the numbers and the results associated with this coverage.

Obviously, money is a big issue. We were talking about the Quebec model. As someone mentioned in a prior group, we see women delaying when they get just a part of it, because it's still a lot of money. Nothing is free. In Quebec, don't have any expectations: Nothing is free. They still have to pay for a part of it when they go on a monthly basis, and sometimes they wait. They postpone. They want to make sure that they are going to take all the medication at once so that they pay for just the minimal coverage.

All of these actions are a burden that makes contraception less effective and promotes unintended pregnancies, and there's a cost to that. There's a cost to the future of Canadian women, because we know that when young people have a baby at a younger age, they are more likely to stop going to school. This has an impact on all of us, because there's a cost associated with that, which we all pay.

● (2005)

Mr. Yasir Naqvi: We have been talking a lot about the social impact of having contraceptives available to women and girls. We have talked about the example of a young woman who may not want her parents to know that she's using contraceptives, and using private insurance creates a notification, so the parents may find out. I think we have a good understanding of those impacts and the freedom this type of measure will give women and girls in Canada.

Can you speak from your experience on the health side about what this access, by breaking down this barrier, means for the health of women and girls in Canada?

Dr. Diane Francoeur: Well, 15% to 20% of women have many problems related to their period. There could be a hemorrhage or bleeding problems that they experience. It could be endometriosis, with which they have pain. When they are using a hormonal contraceptive method, these symptoms are all alleviated. It's a good side effect of these drugs, and we can use them.

Unfortunately, sometimes they're not going to be able to afford them. In the last year, we have had a lot of new immigrant women who have not been covered by all of our refugee coverage, especially in Quebec. I can tell you that it is a burden. They have no money—none at all, not even to pay for the cheapest method they could get. An IUD is going to be at least $450 or $500. That's a lot of money. If you keep it for seven years, it's going to be cheaper, but it makes a big difference.

That's why we want to make sure these newcomers are going to be able to settle, learn the language, become Canadian and then plan their family and their pregnancy instead of being surprised by an unintended pregnancy because they were not able to afford the contraceptive they wanted.

Mr. Yasir Naqvi: Do you see a lot of stigma—cultural stigma and social stigma—around the sexual health of women?

Dr. Diane Francoeur: Absolutely. We are afraid of what's happening to our neighbours down south. We have to make sure all Canadian women will have the right to question and to engage in their sexual reproductive rights.

Mr. Yasir Naqvi: That's a really good point, because we are so influenced by what happens in the United States. Sometimes people think that's the reality in Canada. When we saw Roe v. Wade being overturned in the U.S., I heard from very many people who thought that was the case here in Canada as well.

We have a lot of hard work to do in creating that education, that safe space for women where they can be free sexually, from a health perspective. Hopefully this bill will do that.

Thank you.

The Chair: Thank you.

[*Translation*]

Mr. Blanchette-Joncas, you have the floor for two and a half minutes.

Mr. Maxime Blanchette-Joncas: Thank you, Mr. Chair.

Dr. Francoeur, thank you for joining us this evening. I would also like to thank you for your commitment to the health and well-being of the people in our area. I know that you served for almost seven years as president of the Fédération des médecins spécialistes du Québec, and that you're now taking on new challenges. Congratulations on all your hard work.

I would like to understand the process that led to the proposed national pharmacare program. When you were president of the Fédération des médecins spécialistes du Québec, you supported the Quebec government's calls for increased health care transfers. The agreement reached with the federal government stipulated that it would cover 50% of the costs. However, it currently pays roughly 22% of the bill. We were realistic and reasonable. We asked the federal government to cover 35% of the costs. For Quebec, this meant an increase of about $6 billion. We received $900 million, which isn't even one sixth of the amount requested. In my opinion, this isn't enough.

A pharmacare program is being proposed. However, without increased health transfers, there isn't any hope of revolutionizing the system and solving all the problems. It seems that the next logical step is missing.

If the goal is to improve health care and provide a better pharmacare program, like our program in Quebec, shouldn't health transfers be increased?

● (2010)

Dr. Diane Francoeur: I'll let you play politics. I'll just stick to the medical side of things.

Obviously, these are excellent questions and they should be asked. Nothing is free. That's Canada's issue. In my current role, I work a great deal with other countries, including England and Australia. Their systems are comparable to ours. Our system is extremely complex. The system is federal and the provinces manage health care. We must find a solution. We're one of the last countries in the Organisation for Economic Co-operation and Development, or OECD, to not provide free access to medication. The situation is becoming a bit embarrassing. This is affecting people's health.

To answer the question put to me earlier, remember that women in Canada still die in childbirth. Contraception prevents this.

Mr. Maxime Blanchette-Joncas: I understand.

Dr. Francœur, I don't want to embarrass you. I simply want to talk about some positions that you previously supported. You said that you know the Quebec system well, so you're in a good position to talk about it.

From your perspective, what can the federal government do that the Quebec government can't do?

Dr. Diane Francoeur: Of course, I don't know all the state secrets. I think that our system in Quebec was a good starting point. It would be good for the other provinces to also reap the benefits of this system. However, I can't know how the negotiations will go, since I don't have access to these secrets.

That said, it isn't just drug coverage that sets Quebec apart. Ontario's day care system makes things difficult for young families. The service costs a fortune and prevents women from returning to work. Yet we're facing a labour shortage across Canada. Delivery rooms are being closed, and emergency services will be shut down over the summer.

Given the current significant labour shortage, it's necessary to take care of women and determine what they need to return to the job market.

The Chair: Thank you, Dr. Francœur.

[*English*]

Mr. Julian, please go ahead for two and a half minutes.

Mr. Peter Julian: Thanks, Mr. Chair.

I'd like to come back to you, Ms. Thériault. Thank you so much for being here.

I asked a question earlier of Mr. Bleskie, a witness who is diabetic, about what would happen if he were unable to take his medication. What he described was horrific. I don't know if you were present and heard his testimony.

You specifically flagged Métis people and non-status indigenous people who don't have access to medication right now. What is the impact if you do not have that medication? What would be the positive consequence of ensuring a large number of Métis people and non-status indigenous people can access all of the diabetes medication and devices that are prescribed to them?

Ms. Celeste Theriault: It's important to note that I don't live with diabetes, although it affects many of my family members, and we are Red River Métis.

What I see in my personal family network is that we don't have type 1 diabetes—I did hear the testimony earlier today—but they do live mostly with type 2 diabetes. It's extremely hard to get a CGM device covered when you're a type 2 diabetic, by the way, but that's what we know is needed. If you get calloused fingers and you have a desk job and you're typing all day, you're able to monitor your blood sugar levels so that you have better in-range time.

We also see it with regard to insulin, because some people will ration insulin just to make sure they can put food on their table. I don't think that's a choice that people should have to make when it comes to their health. People should have access to the things they need in a timely manner so they can manage their health in the way they need to.

That's for Métis, non-status and status first nations, Inuit beneficiaries. It's all-encompassing.

Mr. Peter Julian: Do you have an estimate of how many Métis and non-status indigenous people would benefit from this universal access who can't access it now through the NIHB program?

● (2015)

Ms. Celeste Theriault: I don't have specific numbers, but I have some percentages here in front of me. This is older data, because we struggle with some data points and with data collection from governments sometimes. For Métis, it's 7.3%, but that is from 2010, and the most recent 2022 “Framework for Diabetes in Canada” report stated it has found an increase in the prevalence of diabetes across all indigenous populations since 2012. It didn't specifically outline the percentages.

We don't have data for non-status people; they get lumped in with non-indigenous people, because they're not recognized. I would probably refer to some of the organizations that do work on behalf of non-status people to answer that question. I can make some inquiries to see if we can get those answers.

The Chair: Thank you, Ms. Thériault.

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

Mr. Stephen Ellis: Thank you very much, Chair, and thank you to the witnesses for being here.

Ms. Walker, you're a pharmacist, and you're still working as a pharmacist. Is that true?

Ms. Joelle Walker: I'm actually not a practising pharmacist. I work for the Pharmacists Association and with those members to navigate some of the issues they encounter in their work.

Mr. Stephen Ellis: Great. Thank you for that.

One thing that is not captured in Bill C-64 and that Canadians have relied on now for many years is the expanded scope of practice in the professional life of pharmacists. Is that something that you think should be captured in this bill?

Ms. Joelle Walker: Absolutely. I think there are many services that pharmacists are delivering now to Canadians across communities. In many rural and remote parts of the country, the pharmacy is the closest access point that they have to health care.

Pharmacare, as we mentioned, isn't just about the cost of the drug, but really the care that goes around it. It would be like dental care without dentists. We absolutely see that, and increasingly pharmacists are doing a lot more to serve their communities.

Mr. Stephen Ellis: I was going to say something smart, but there is a dental care program without any dentists. Anyway, that's a whole other issue.

It's interesting, though, especially when we're talking about diabetes, because many pharmacists are diabetes educators, which helps diabetics better control their blood sugars. Often there is a cost now built into provincial plans and private plans to pay for that, but this bill in particular doesn't capture any of that cost.

Do you think, on behalf of your members, that it would be an important piece to have as part of this legislation?

Ms. Joelle Walker: There are a number of different services that are associated with drug management. Clearly there's the dispensing aspect, which makes sure that the person is getting counsel, that they're getting their drugs safely and effectively and that there are no drug interactions with other things. Then there are things like medication reviews for people who might be on multiple medications, and appropriate use is really important.

We know that many aging Canadians are taking medications to address a side effect of another medication, and that's an unfortunate way to live. Certainly for smoking cessation, diabetes management and care, and hypertension, there's been a lot of evidence showing that those services provided by pharmacists actually improve the quality of life of Canadians and the use of those medications.

Mr. Stephen Ellis: It's interesting, Ms. Walker, that you talked about looking at the plans and this concept of a universal single-payer program that's introduced here in this bill. In your experience, on behalf of your membership, would you suggest that it would mean that the federal government would be the first payer? Is that not true?

Ms. Joelle Walker: Some of the questions that we've so far heard, and that we've posed ourselves, question how that's interpreted in the legislation. I think what we're looking to see is a clearer definition of which payer would come in and whether a private payer will be maintained. I think a number of the provinces that have spoken publicly on this issue have also raised the fact that they would be looking to add to their current public plans while maintaining the private aspect that they have in their jurisdictions.

It really would come down to some of the negotiations that would take place. In the legislation, we would recommend that there be clear reference to a mix of public and private payers to make sure that this mix is maintained in looking forward beyond diabetes and other potential medications that might be under consideration.

● (2020)

Mr. Stephen Ellis: What I've heard you say is that this would be an incredibly important part of our rapid deliberations in our clause-by-cause consideration of this bill, which must happen by Monday.

Ms. Joelle Walker: Yes, I think we would support that, absolutely.

Mr. Stephen Ellis: Great. Thank you.

One of the things that have been talked about in this last panel a bit and in previous panels is semaglutide or Ozempic, which is a drug used to treat diabetes. It's been an absolute blockbuster drug. Do you have any information for the committee with respect to the cost on a monthly basis of Ozempic or semaglutide?

Ms. Joelle Walker: I don't have that number handy, but I will share a couple of examples that might be helpful in your deliberations around Ozempic.

It's obviously not covered under the proposed list of medications. It's widely used. We've recently had a shortage of Ozempic across the country, and my association works very regularly to address shortages that are a growing problem in the country. When we talk about pharmacare, it's not just about the cost of drugs or the services that are being offered; if that medication is not available in the country, no amount of coverage is going to help that.

One thing that we've noted is that the number of available medications in each drug class can decrease significantly, depending on how many companies are in the market, and we are most vulnerable to drug shortages if only one or two manufacturers are producing a particular drug.

Let's say that there's a national disaster in one country that's producing some of the API, and the one company there can't produce that drug, and the other companies aren't able to readily increase their production. In cases like that, we've really suffered significantly with many drug shortages, so I think there's a really complicated ecosystem that this pharmacare approach needs to also recognize.

The Chair: Thank you, Ms. Walker and Dr. Ellis.

The last round of questions today will come from Ms. Sidhu for the next five minutes.

Ms. Sonia Sidhu: Thank you, Mr. Chair.

Thank you to all the witnesses for being with us. My first question is for you, Ms. Thériault.

With the dental program, we know that within three weeks 100,000 Canadians got benefits and one million have already registered. With this legislation, could you elaborate on what the biggest barriers are for indigenous people seeking care for diabetes prevention? With this legislation, what do you think about contraceptive care? Do you think it will be of benefit to indigenous people?

Ms. Celeste Theriault: Yes. Certainly there will be a benefit to indigenous people. That's without a doubt.

To comment on your first question, we need to also ensure that we are making wholistic—with a “w”, for the note-takers—decisions around public policy that affects our health and doesn't look at just the pharmaceuticals and all those things. I know that we're here specifically for the pharmaceuticals, but there are so many other things that impact health, such as socio-economics and social determinants of health. I think this is the first step in the right direction for opening up the conversation and the dialogue to all those other sectors that this bill obviously does not cover.

Of course, indigenous people, if unfortunately their medication cannot be covered—and most likely they cannot afford to even take the medication—may not even get the prescription filled, as we know. I think that would be interesting data to look at. They will also make sure they feed their family first, or do whatever they might need to do first, before taking care of their own health. Often we're faced with that decision every day, that hard decision.

My chair often speaks very openly about the ideal type of diabetes treatment for her as a person living with type 2 diabetes in Alberta. It is currently not available to her because of the lack of coverage, and it simply would be way too expensive for her and her family of six children to afford. Therefore, it is just not an option. She has to look at other alternatives.

Ms. Sonia Sidhu: Thank you.

Dr. Francoeur, you talked about teen pregnancy and sexual and reproductive health. Could you outline what the biggest barriers are for Canadians seeking contraception? What would you recommend to combat this?

Dr. Diane Francoeur: First of all, I think cost is definitely one of them, especially in choosing long-term contraceptives like the IUD or the patch. The finance around it is really the biggest barrier.

Second, something that we don't talk enough about is the coercive aspect of contraception. A woman will pay for 30 years. If she herself doesn't have the money to pay, it will be her partner who should, hopefully, share part of the bill, but we don't see that. Unfortunately, during a conversation on which method they should choose, money has an impact. If women are allowed to make their own choice and they don't have to beg to have help to pay for the contraceptive method of their choice, that will have a huge impact on their self-esteem. They will feel more respected.

● (2025)

Ms. Sonia Sidhu: Would you agree that oral contraceptives are not used solely for pregnancy prevention but for other health concerns as well, and that we should therefore reduce the health care costs there as well?

Dr. Diane Francoeur: Absolutely. Even if we want every woman to be able to choose the method of her choice, as I said, 15% to 20% of women will have problems with pain, with bleeding or with fibroids that may grow over time. They'll use a contraceptive method for the side effect, because we know that it will treat the problem. It's absolutely an added value for these women.

Ms. Sonia Sidhu: Thank you.

Dr. Arango, you said in your submission that heart disease has been the second leading cause of death in Canada across all ages in the last decade. You said, “Millions of people in Canada live with heart disease and rely on daily prescription medicines to help keep them alive and to manage their condition at home.”

However, many cannot afford them. Do you have any recommendation on how people with diabetes can reduce the risk of heart disease and stroke?

You already mentioned that the comorbidity rate with diabetes is threefold more. What is your recommendation there?

Mr. Manuel Arango: In terms of reducing your risk, I think a lot of people will know, obviously, that being physically active, not consuming tobacco and having a good diet is going to be huge. It's going to be very important in reducing the incidence and probability of developing heart disease, stroke and diabetes.

I would just add another point, which is that, as mentioned earlier by my colleague, social determinants of health also have a huge impact. Socio-economic status and access to clean drinking water and to a safe environment are also very important. All those factors, and access to income as well, are extremely important. All those factors play into the likelihood of whether one will develop diabetes or cardiovascular disease.

The Chair: Thank you, Ms. Sidhu.

Thank you, Mr. Arango.

Thanks to all of our witnesses for being with us today and for your thoughtful and patient testimony.

Don't run away, colleagues. We have a budget to deal with.

A budget has been circulated for the work to be done on this study. You would have received it either earlier today or yesterday.

Is it the will of the committee to adopt the budget as presented?

Some hon. members: Agreed.

The Chair: The budget is therefore adopted.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

We're adjourned.

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