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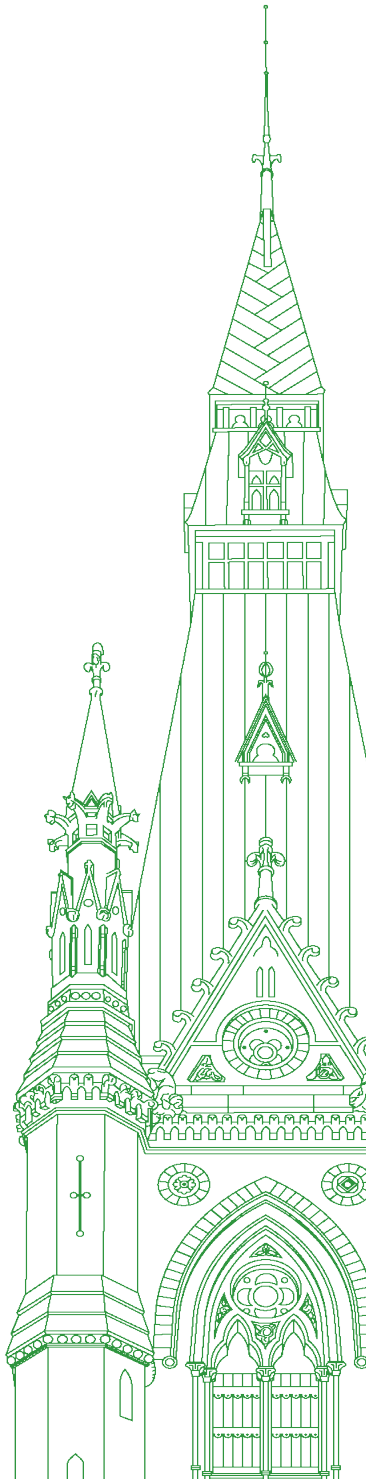

Chair: Mr. Sean Casey

Standing Committee on Health

Friday, May 24, 2024

● (1210)

[*English*]

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

Welcome to meeting number 117 of the House of Commons Standing Committee on Health.

Before we begin, I would like to ask all members and other in-person participants to consult the cards on the table for guidelines to prevent audio feedback incidents.

Please take note of the following preventative measures in place to protect the health and safety of all participants, including the interpreters. Please use only the black, approved earpiece. The former gray earpieces may no longer be used. Keep the earpiece away from all microphones at all times, and when you are not using your earpiece, place it face down on the sticker placed on the table for this purpose. Thank you for your co-operation.

In accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting. As a result of those connection tests, one connection was unsatisfactory to participate in the meeting, so we have a smaller witness panel than is contained in the notice of motion. Jessica Diniz from JDRF will not be with us on this panel. I have taken the executive decision of adding her to one of the later panels today, provided that we can come up with the right technology so that she can fully participate.

Pursuant to the order of reference adopted by the House of Commons on May 22, 2024, the committee is commencing its study of Bill C-64, an act respecting pharmacare.

As indicated in the memo that was sent out a couple of days ago, I would like to remind members that amendments to Bill C-64 must be submitted to the clerk of the committee by four o'clock today. It's important for members to note that, pursuant to the order adopted by the House on May 22, 2024, 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.

Without further ado, I would like to welcome our panel of witnesses and thank them for their patience as we attempted to overcome our technical difficulties.

We have with us today from the Canadian Association for Pharmacy Distribution Management, Angelique Berg, president and chief executive officer, appearing by video conference. In the room with us representing the Canadian Federation of Nurses Unions, we have Linda Silas, president. Also online for the Canadian Organization for Rare Disorders, we have Durhane Wong-Rieger, president and CEO.

Welcome to all of those who have joined us to help us out with Bill C-64. We are going to start with opening statements in the order that appears on the notice of meeting, so we are going to start with the Canadian Association for Pharmacy Distribution Management.

Ms. Berg, welcome to the committee. You have the floor.

Ms. Angelique Berg (President and Chief Executive Officer, Canadian Association for Pharmacy Distribution Management): Thank you, Mr. Chair and members of the committee. Thank you for your attention today.

I'm Angelique Berg, president and CEO at CAPDM, the Canadian Association for Pharmacy Distribution Management.

CAPDM is the nation's trade association for wholesale distributors that channel over 90% of the medicines our country consumes. With their trading partners, distributors form our efficient, accurate and reliable supply chain that ensures physical access to medicines, so naturally we support the aim of Bill C-64. We support both affordability and access in balance and not at the expense of one or the other.

Importantly, we recognize the enormous challenges that government and our citizenry face: slowed economic growth, regulatory overburden, health care system insufficiency and a growing percentage of the population over 65. I mention these to tell you that we're aware of the broader context, and we stand with you in navigating solutions where we can be of value.

To appreciate our comments relative to Bill C-64, I'll provide some basics about the supply chain because we rarely think about how our medicines get to us, just so long as they do.

The supply chain begins with manufacturers, who sell to distributors, who then sell to pharmacies and hospitals. Purchases flow the opposite way: from pharmacies, who buy from distributors, who buy from manufacturers. Rounding out that supply chain are service providers to this core supply chain, like third party logistics firms and transportation companies. The majority of Canada's pharmacy supply chain stakeholders are CAPDM members.

Distributors streamline orders and deliveries for 15,000 product SKUs between hundreds of manufacturers and over 12,000 points of dispensing over nine million square kilometres, creating efficiencies that save the country over $1 billion annually. Their safety stock also provides a short-term shortages buffer against drug shortages. The sector has over 30 distribution centres, all of which comply with at least three overarching acts, up to seven different Health Canada licences and very high technology to meet the conditions of all of those. The sector has roughly 20,000 employees—experts in inventory turnover and the secure and complex handling of all medications—and they are the backbone of our pharmacy supply chain.

Our market is challenging. It's a controlled market where funding is limited, yet operating and regulatory costs are not. Distribution is largely funded as a factor of the listed drug prices: The lower the price, the less funding is available to get medications to Canadians.

Costs have increased at least 2.5 times faster than volumes in the last five to 10 years, with market forces and increasing regulation. The gap is estimated at over $100 million annually, and distributors have so far absorbed that through eliminating expenses to stay in business and with only minimal impact to Canadians.

Assuming that it is striving for lower drug prices, we see that Bill C-64 has the potential to erode physical access and to exacerbate drug shortages. Because they run so efficiently, reduced funding means that distributors have few options left but to reduce services. Some examples are that they could stop carrying money-losing products, which would be those of the lowest cost; reduce safety stock, which eliminates the buffer against shortages; or reduce delivery frequency to high-cost regions or eliminate them altogether.

CAPDM members are understandably concerned about some of Bill C-64, generally about reduced drug pricing and specifically about a restrictive national formulary, which was addressed in last evening's panel, and bulk purchasing. Evidence suggests that these types of policies limit suppliers. When the government awards a contract to a single manufacturer, that firm effectively becomes a monopoly, so competitors have little incentive to stay in the market. Concentrated marked power increases the risk of limited supply, and therein lies our concern.

We recommend that this policy change be approached with caution, that further regulatory burden be avoided and that time be taken for consultation with all supply chain actors to uncover potentially unintended consequences so that Bill C-64's aims can be successful.

We don't have all the answers—we dearly wish that we did—but we're most willing to collaborate with government to find them in order to ensure safe, secure and timely physical access to medicines for all Canadians, and that's why we exist.

Thank you on behalf of the CAPDM board of directors, and I welcome your questions.

● (1215)

The Chair: Thank you, Ms. Berg.

Next, on behalf of the Canadian Federation of Nurses Unions, we have Linda Silas.

Ms. Silas, welcome to the committee. You have the floor.

Ms. Linda Silas (President, Canadian Federation of Nurses Unions): Thank you, Chair.

As mentioned, my name is Linda Silas and I'm the president of the Canadian Federation of Nurses Unions. As a nurse, I don't have to do what Angelique did and explain what we do. CFNU is the largest nursing organization in Canada. We represent over 250,000 unionized nurses and nursing students working everywhere, including in home care, long-term care, community care and acute care.

I'm so honoured to finally speak to you today on a bill that has been considered a leading priority for nurses for many years. It is a step towards a universal pharmacare program. CFNU has commissioned numerous studies and polls over the years to help build the case for the overwhelming merits of a public, single-payer pharmacare program in the country. You will be hearing from Dr. Marc-André Gagnon later on today, who was the author of one of our first reports.

There are many reasons why nurses support a public, single-payer pharmacare program: the positive health outcomes it would bring to our patients, the equitable access it would provide everyone in Canada, and the capacity it would free up in our health care system through avoidable hospital room visits and costs related to non-adherence to prescription drugs.

The latter point is the critical point I want to talk about today: the health human resources crisis. Each quarter, we witness the number of nursing vacancies rise to record heights across the country. Sadly, nurses are still working in our crippling system. We see patients unable to access their medications. They really should be at home, but they need to stay in our waiting rooms and hospital beds just to take their medications.

Members of Parliament, you have the power to change this today. We are thrilled to see Bill C-64 move ahead in the direction Canada's nurses have long advocated for. It is in sync with the recommendation of every major government study and commission on the matter, including the advisory council on the implementation of national pharmacare of 2019.

Ensuring universal access to contraceptives and diabetic medication and supply through a single-payer public system is a hugely significant improvement to our universal public health care system. It marks a fundamental step towards a truly comprehensive and universal national pharmacare program. Every day, nurses see firsthand the consequences of failing to provide equitable coverage for birth control and diabetic medication to our patients, from unwanted pregnancies to individuals who lack access to diabetic medications and supplies. They end up in our hospitals. This includes children and working Canadians. Patients divide their pills or go without them to buy food. This has to stop.

Canada's nurses have been lobbying parliamentarians like you for 30-plus years to move toward a universal national pharmacare program. Yes, it has to be single-payer and public, because that's what the evidence says is the best way to be fiscally responsible with our public dollars. That's what Canadians expect of us—to not have our health care services stop at a visit to the doctor or nurse practitioner.

Sadly, we are seeing many voices out there in support of the status quo. They say that Canadians are adequately covered by the patchwork system in place, and that a fill-in-the-gaps approach is the best way.

Nurses are motivated by the great care we can provide in this country. We say the best way to do that is through a universal public approach to prescription drugs. We urge you to follow 20 to 30 years of evidence, push ahead the passing of this bill and continue on the path of implementing a comprehensive, universal, national and public single-payer pharmacare program.

I stand proudly with all of you who will vote yes on Bill C-64.

Thank you.

● (1220)

[*Translation*]

The Chair: Thank you, Ms. Silas.

[*English*]

Next is the Canadian Organization for Rare Disorders. Dr. Durhane Wong-Rieger is joining us via video conference.

Welcome to the committee, Dr. Wong-Rieger. You have the floor.

Dr. Durhane Wong-Rieger (President and Chief Executive Officer, Canadian Organization for Rare Disorders): Thank you very much, honourable chair and members of the health committee.

Thank you for the opportunity to speak to you today. My name is Durhane Wong-Rieger, and I am the president and CEO of the Canadian Organization for Rare Disorders. I'm here to discuss Bill C-64 and, in part, its implications for the rare disease community in Canada.

I'd like to start, though, with a few facts that paint a bleak picture for Canadians with rare diseases. You may know that rare diseases affect over three million Canadians, the majority of whom are children. While most rare diseases affect children, we also know there are a significant number of adult-onset rare conditions that are being diagnosed.

Among the 7,000 known rare diseases, only 5% have an effective drug therapy. Unfortunately, one in three rare disease patients in Canada cannot access their treatments. In fact, only 60% of the treatments for rare disorders are made available in Canada, and most get approved up to six years later than they do in the U.S. or in Europe.

Even after the treatments are approved in Canada, many patients continue to face immense hurdles and delays in accessing new treatments due to the challenges related to the evaluation and funding of these medicines. When there are effective, available therapies, access can often be very challenging for patients. As you may know, they vary from one province to the other. As a result of these challenges, many patients experience an avoidable decline in functionality, and certainly many experience early death.

In an effort to respond to these challenges, on March 22, 2023, the federal government announced measures in support of Canada's first-ever rare disease drug strategy, including, at this time, a $1.4-billion investment for provinces and territories to improve access and affordability of rare disease medicines. This money had already been promised half a decade ago as part of budget 2019.

However, it's now been over a year since the funding announcement, and not a single penny has been spent to help fund rare disease drugs. While CORD supports efforts to improve access to medicine for all Canadians who need them, we're also concerned that the federal government has taken on another major commitment to fund a national pharmacare program when it hasn't even delivered on this promise to fund rare disease treatments—a promise that, as we said, was made over five years ago.

Notably, clause 5 of today's Bill C-64 would commit the government to long-term funding, beginning with products for rare diseases. We have to say it's unconscionable and unethical, and certainly really challenging for patients, to introduce a program designed to transform and save lives, and then fail to execute on it.

Moreover, given the lack of promised progress on rare diseases, what does that say in terms of the prospects for success of this pharmacare legislation? We need to see the prioritization for rare diseases in action. It was a promise made. When it comes to improving medicine access and affordability, CORD strongly believes that rare diseases represent the area with the greatest unmet need in Canada.

The federal government should focus first on rolling out the promised funding for rare disease treatments before undertaking another major pharmacare plan.

However, with respect to the bill itself, CORD has a number of comments. The predetermined categories, lists of medicines and proposed single-payer approach all risk limiting treatment options and potentially bringing everyone's level of coverage down to the lowest-common denominator. This is a concern.

Additionally, Bill C-64 outlines specific timelines for its key components, yet the rare disease drug strategy lacks a detailed implementation plan and time frame. The rare disease drug strategy must also be afforded clear timelines, publicly accountable milestones and opportunities for patient and clinical input. This is not in the current rollout.

Lastly, the formation of expert committees, as stated under Bill C-64, must ensure genuine advisory roles. CORD's experience with the current rare disease drug strategy implementation advisory group has highlighted significant issues with transparency, communication and accountability. Effective implementation of national pharmacare requires these committees to provide meaningful input, rather than service mere formalities.

● (1225)

I'd like to close by noting that Canada has an opportunity to become a leader in providing access to cutting-edge therapies that significantly impact patients' lives. We must aim high, ensuring that our national pharmacare program and the rare disease drug strategy deliver the best possible outcomes for patients with rare and common diseases alike.

Thank you very much for your attention. I'm open to any questions you may have.

The Chair: Thank you very much, and we'll now begin with rounds of questions, starting with the Conservatives' Dr. Ellis for six minutes.

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

Thank you to everyone for being here again today. This legislation, sadly, is being pushed quickly without adequate consultation, but that's a whole other story.

Dr. Wong-Rieger, could I start with you, please? I tried to make a point here yesterday, and sadly, when the minister was here and two officials, they couldn't answer questions about the drug approval process. You talked a lot—not a lot but a fair bit—about the approval process and how long it takes in Canada.

Could you explain, perhaps, for the members on behalf of all Canadians how we're falling behind on how long it takes to get drugs approved in Canada?

Dr. Durhane Wong-Rieger: Certainly. First of all, I would just say that because the approval process is so complicated many companies do not want to come to Canada first. It takes too long. Quite frankly, it means then that, even for the drugs that come in, it's oftentimes months and sometimes years after they're brought into the other OECD countries, so that's the beginning.

We obviously have a multistep process. We have Health Canada, the regulatory process, which I must say has actually done a great deal to shorten the timelines. We then have to go to the Patented Medicine Prices Review Board, which provides guidance in terms of the cost, the maximum price of the drugs. It goes to the health technology assessment groups. Now in Canada, there are the drug agencies, CADTH and INESSS, which, again, adds months and sometimes longer than that to the process. The big challenge comes when, for the public drug plans, the drugs then go—if they're recommended by the technology assessment groups—to the pan-Canadian drug agency. There, they can actually take months and sometimes years.

We have drugs that have been sitting there for multiple years, even before they get picked up to be negotiated. They negotiate the price there. There is no timeline. There's no transparency. There's no input into the process, so there they can languish. Then even if they get a negotiated price, it is not necessary that every province lists these drugs, even though they signed on to say, yes, we will be part of it. Again, we have the problem that these drugs now, sometimes not just months but years later, are not even listed in the public drug plan. In some cases, they never get into the public drug plans. There's no way of making them be there.

This is the challenge, and we can say for patients, of course, it is a terrible problem, especially for these patients who are waiting for life-saving therapies. For rare diseases we oftentimes do not have another therapy. As I say, it's also a disincentive for companies to even bring the drugs to Canada, and we oftentimes have to really beg them to bring the drugs here because they know it is not only a long but also a very complicated process.

● (1230)

Mr. Stephen Ellis: Thank you very much, Dr. Wong-Rieger. I think then it's really quite fair to say that there doesn't appear to be any oversight on this process. Of course, when we look at some of the statistics from 2012 to 2021, there were about 460 medications that have come to Canada and only 44% have been here. Of course, that can certainly acutely affect those with rare diseases, as you've highlighted. Thank you for that.

You talked a bit about the government's announcements that they've made specifically around rare diseases and its failure to deliver. Do you have concerns that this is simply another photo op here and nothing's actually going to happen?

Dr. Durhane Wong-Rieger: I certainly hope not. I think there was sincerity around understanding the needs of Canadians with rare diseases. The money's there that was put into the budget, we've been assured. We are extremely concerned though that it is not coming out. Again, as I said, we've seen that the majority of that money, $1.4 billion out of $1.5 billion, is to be allocated through bilateral agreements.

This is, again, what we're hearing in pharmacare. What we know is that, well over a year later, none of these agreements have been put in place. We don't even know if there have been discussions around them. Whether it's just bureaucracy, whether it's just the cumbersome nature of the process, whether it's really hard to get provinces to agree, I don't know. However, this is not the way it's needed to be. We're hoping it's not a photo op. We're hoping that it doesn't become just a hollow promise. That's why when I said we were concerned about pharmacare coming out, one, does it delay getting the rare disease drug strategy out, and two, is it going to fall to the same kinds of issues that our drug strategy has?

Mr. Stephen Ellis: Thank you very much for that, Dr. Wong-Rieger. On behalf of Canadians, you are very insightful.

Ms. Berg, if I can, I'll turn to you. I think we have a little under a minute left.

You talked about supply chains in Canada. From the list of medications we have seen, it appears that with some medications—let's just pick metformin, which is incredibly common—there's a suggestion that there may only be a single-source supplier.

Can you tell us a bit about how that may be a problem for Canadians with respect to drug shortages?

Ms. Angelique Berg: As I mentioned, when a government awards a contract to a single supplier, others have no incentive to stay in the market. I can't speak specifically to metformin, but there are other examples.

When one firm gets, let's say, 70% or 80% of the market, the other competitors are not going to make any money on this. They're likely going to stock the product, and it might go bad. It will expire and they will lose money that way. They're businesses. They need to cover their costs. Globally—and a lot of our pharmaceutical manufacturers are global—they will make the decision not to sell that product in Canada because they simply can't recoup the dollars. It's that simple. It's dollars and cents and economics.

Mr. Stephen Ellis: Thank you very much.

The Chair: Thank you, Ms. Berg.

Thank you, Dr. Ellis.

It's over to Dr. Hanley, please, for six minutes.

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

Thank you to all the panellists for appearing today.

I just wanted to begin by pointing out that in the testimony, Dr. Wong-Rieger, you gave.... I think one of the important pieces to highlight is how important this program is. This is Canada's first-ever strategy for rare diseases. I know Canadians, particularly the Canadians you represent, were very happy to see this.

I would interpret this as complementing pharmacare as part of the package, as it were. Admittedly, it requires some time for implementation. We're all looking forward to that.

I'm going to begin my questions with Ms. Silas.

Ms. Silas, you and I have had many discussions over the last couple of years about pharmacare. Thank you for the socks. On my socks, it says “comprehensive”, “accessible”, “universal”, “portable” and “public”. I understand that—

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): How long are the socks?

Mr. Brendan Hanley: You have to unwrap them. The socks have been waiting for some time. I think they have been in storage.

Can you tell me a bit about that?

● (1235)

Ms. Linda Silas: We all remember the 2019 report from Eric Hoskins. Dr. Hoskins and I were planning the pharmacare party, and then COVID hit.

I have to join you in congratulations to Dr. Wong-Rieger. I've been on many panels with Durhane. When I read the brief on Bill C-64, I was as excited to see rare diseases there, because 20 years ago, we weren't talking about it.

I believe that bureaucratic rules and obstacles shouldn't stop us from doing the right thing. We are improving health and we are improving the lives of Canadians with this bill. It's a door open, and we need to move on it.

Mr. Brendan Hanley: Thank you.

I wonder if you can talk about this from your point of view. You have travelled around the country on this. You have talked to front-line nurses everywhere in the country.

What is your perception about there being a fear that this is going to have an adverse impact on private insurers and on employment plans, like the one we enjoy as members? Maybe you can talk about what you think and what you've learned from other countries on what the effect of pharmacare will be on private insurance.

Ms. Linda Silas: About 90% of nurses are unionized, so they are not worried about themselves. They are worried about their patients, and that's why they gave us a mandate to work on a national pharmacare program.

As a union negotiator, I remember the days of negotiating with an insurance company when we had to beg to have a smoking cessation program, but the plan couldn't afford it because of the usage. We represent a membership that is 92% women. We could not add contraceptives. We won that fight.

I have a very small staff team here in Ottawa, but because it is so small, our plan is very restrictive. There are so many rules and so many restrictions that I'm just glad no one is really sick, because they wouldn't be covered properly. That is the game we play with insurance.

However, as a negotiator, I also know we will be at tables and asking for.... For example, I'd expect pharmacare to provide four pills a day, but an insurance company will provide the richer pill of one pill a day. When we talk to our members about it, they understand that. Their dear commitment is to those children who can't have puffers and are asthmatic, or to those children and parents who can't afford the better diabetic care programs. That's what they want us all to work on.

Mr. Brendan Hanley: Thank you. We know there are concerns about the cost outlay to implement pharmacare. It will be an investment. It will cost money. We know that the reports such as the Hoskins report contain analysis showing that, overall, this is going to represent a cost savings to our health care system.

Can you comment on the financial cost and benefit of pharmacare such as we are now embarking on?

Ms. Linda Silas: I think you'll have great experts to talk about the dollars and cents later on. Our point of view is that the money's already being spent, and the money's being spent by Canadians who cannot afford it. They either pay for their drugs or pay for their food. One in five families can't afford their drugs.

The money Dr. Hoskins was talking about six years ago already was different. We have to give the support to the Parliamentary Budget Officer to look at a universal program, not a patchwork, and to come up with the right formula. As a taxpayer, I know the money is already being spent. It's just not being spent at the right place.

All the evidence from the economists we've worked with over the last 30 years tells us that the best way, similar to our health care system, is to have a public system provide the evidence with regard to the best drugs to give. That's probably more to you, Dr. Hanley, because you're a doctor, but when I met the minister yesterday, I said that it wasn't really up to him to decide what was on the formulary, which diabetic drug, and that a group of experts should deal with it. That's what we're promoting.

● (1240)

The Chair: Thank you, Ms. Silas and Dr. Hanley.

[*Translation*]

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

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

Welcome to the witnesses who are here for the first hour of this meeting.

Ms. Silas, welcome to the committee and congratulations for your more than 20-year commitment to the Canadian Federation of Nurses Unions. You are a proud graduate of the Université de Moncton. The people of Moncton are people we appreciate, but I have to admit I also appreciate the Université de Moncton, which proudly represents Acadians.

As you know, Quebec has its own drug insurance plan. We acknowledge that it isn't perfect, but it was established 30 years ago.

What more do you think the federal government could do than what the Quebec government is doing now, or that it could do better?

Ms. Linda Silas: Thank you for your question, Mr. Blanchette-Joncas.

Quebec's program is recognized around the world, but it's also one of the costliest to any government.

Quebec's unions and health coalitions are asking the federal government to get involved to a greater degree.

In fact, every federal agreement will recognize Quebec. I'm not concerned. What does concern me and what concerns the nurses and health professionals of the Fédération interprofessionnelle de la santé du Québec, for example, are those who slip through the net, the ones who aren't represented by a program offered by their employer and those who aren't represented by a provincial program. This program should cover everyone.

Mr. Maxime Blanchette-Joncas: I'd like to go back to the cost of prescription drugs.

You mentioned that this is one of the most costly programs. As you know, the Pan-Canadian Pharmaceutical Alliance is trying to buy wholesale in an effort to lower prices.

However, I'm trying to make the connection with health transfers. I know that the federation, in particular, is in favour of them.

Under the initial agreement between the federal government, the provinces and Quebec, the federal government was supposed to pay 50% of health, health care and social services costs. That percentage declined to 22% some years later. We were realistic and reasonable, and the figure was then set at 35%. For Quebec, that represented $6 billion, but Quebec has only received $900 million.

If we're supposed to receive $6 billion, but have only received $900 million, we may have less money to invest in modernizing and improving pharmacare. What do you think about that, Ms. Silas?

Ms. Linda Silas: We're on the same wavelength, Mr. Blanchette-Joncas.

I don't understand the bureaucratic problems involving the federal, provincial and territorial governments. It's absurd that the $1.5 billion that was promised for rare diseases a year ago hasn't yet been spent. Ms. Wong-Rieger discussed that. The same goes for the federal transfer negotiated last year. It makes no sense that the provinces and territories haven't received that funding. The Minister of Health needs to address this.

Mr. Maxime Blanchette-Joncas: I agree.

Ms. Silas, I'd like to tell you a documented true story.

The federal government has cut its health transfers. If it introduces pharmacare and ultimately decides to withdraw its investments, what impact do you think that might have?

The provinces are juggling two health care systems. They have to make decisions and cut services. As you can see in the system right now, we're witnessing the increasing privatization of certain services, particularly nursing services. I know that's a major concern for you, and I can tell you it is for me as well.

If we have a good idea, how should we go about making sure it's implemented as efficiently as possible and that the selected solution is permanent?

Ms. Linda Silas: That's a tough question. In 2019, the federal government committed to introducing a national pharmacare that would provide for a formulary of essential drugs.

Then came the pandemic. However, in the negotiation they conducted, the NDP and the Liberals took a cautious approach to the two classes of drugs and guaranteed that we were headed in the right direction.

They couldn't say at the time that they would adopt all the Hoskins report's recommendations, but Canadians can be given a guarantee regarding two classes of drugs. We'll join the plan once we can test it and confirm that it works. I'm very confident about that.

● (1245)

Mr. Maxime Blanchette-Joncas: That's excellent. All right.

Ms. Silas, witnesses told us yesterday that they're concerned about the potential loss of certain drugs. The Quebec plan covers a formulary of approximately 8,000 drugs. That's not perfect, but we could improve matters in many respects.

We've been told, however, that national pharmacare might lower the number of approved drugs on its formulary, such as Ozempic, even though it's a well-known drug. For the moment, there aren't even any plans to put it on the formulary.

I'd like to hear your comments on that matter. How can we make sure that we don't lose what are considered essential drugs?

Ms. Linda Silas: I tip my hat to Quebec and British Columbia because their formularies of 8,000 drugs are among the longest in Canada.

As I told Mr. Hanley during one of my appearances, it's not up to politicians to decide what drugs will be on the formulary, and no advertising campaigns should be used for that purpose either. I honestly don't even think doctors should have a say; it should be up to expert committees.

The Chair: Thank you, Ms. Silas.

[*English*]

Next, we'll go to Mr. Julian, please, for six minutes.

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

Thank you to our witnesses.

Ms. Silas, there is no doubt that Canada's nurses are the folk heroes of the pharmacare act. You'll recall three years and three months ago, we were working together on the Canada pharmacare act. It was a bill I sponsored on behalf of the NDP.

Canada's nurses did an extraordinary job. Some 120,000 Canadians wrote to Liberal and Conservative MPs to tell them to pass this legislation. We were all profoundly disappointed, as were most Canadians who supported pharmacare, that the bill went down to defeat with both Liberal and Conservative MPs voting against it.

Now, three years and three months later, you're testifying on behalf of the pharmacare act, which is extraordinary. You've sent a message to all parliamentarians. You wrote:

> Passing this bill will help patients with diabetes and women who face the impossible choice between buying groceries and filling their prescriptions. This is not just a health care issue; it is a matter of fairness, equity and access. Investing in pharmacare will save lives, reduce overall health care costs and enable people in Canada to lead healthier, more productive lives.
>
> We need you—

You are speaking to all parliamentarians:

> —to act quickly and decisively. Your job is to protect and help build a public health care system that works for all people. Nurses across the country are doing their part, so put aside partisanship and let us make Pharmacare a reality.

That is an extraordinarily important message you're sending to all parliamentarians and to members of this committee.

I'd like you to tell us: What have Canada's nurses seen on the front lines with the lack of pharmacare, the lack of medication being available and people struggling to pay for their medications? What are some of the stories and the things that Canada's nurses have seen with the current system that lobbyists say are fine, but that Canadians want to see fundamentally changed?

Ms. Linda Silas: Today, what we hear on the news is about the long lineups in the ERs, the long waits for surgeries and of course the shortage of nurses and other health care professionals.

The reality is about the simple things. The reality is those families that cannot afford their medications and stay in the hospital longer. Doctors and nurses will, for the health of the patients, keep those patients in the hospital longer so they can get their full treatment. That is where nurses get frustrated. We have patients in hallways because they don't have any other choice.

We have to do better. We're the only country that has a public system.... I guarantee you that I'd stand on any tribune to defend our public system, even as difficult as it is due to the attack the pandemic had on us, but we need to give that extra to our doctors and nurse practitioners.

Right now, they're stuck. If they don't have a sample to give to that family that doesn't have an insurance plan, the patient has no other choice but to go in the ER and get their treatment. That's not fair.

Mr. Peter Julian: What does that mean in terms of cost to our health care system, when people are being kept in an acute care bed because nurses understand that if they're released, they won't be able to pay for their medication?

Ms. Linda Silas: It's the cost of hospital days, but it's the worse than that. It's the human cost.

Go take a walk in any of our hospitals today. The hallway nursing is scary. I feel for those families, especially our seniors, for what they're going through in hallways. It's a ripple effect. They're in a hallway because there's a bed for somebody who can't pay for their medication or didn't adhere to their prescription.

Family docs, specialists and nurse practitioners know what they're doing. If they prescribe a medication or a series of medications, we should have a system that continues to protect them and continues to give them access to their medication.

● (1250)

Mr. Peter Julian: When people don't have the ability to pay for their medication—I know you and Canada's nurses have done remarkable work on this—what does that mean in terms of the cost of human lives?

Are Canadians dying because they can't afford to pay for their medication? What does that mean in terms of numbers?

Are we seeing Canadians losing their lives because of the lack of universal pharmacare in this country?

Ms. Linda Silas: MP Julian, you're really hitting a hard line with the nurse in me.

We did a report a few years ago on the number of patients dying. Just with two categories, which were diabetes and heart disease, we are talking in the thousands who are dying every year because of the lack of medication.

I didn't even understand that Stats Canada was collecting the data of patients who were not able to take their prescription drugs and the impact it would have in the long term and in dying. That's the extreme. What we're talking about today is giving them a chance with these two types of drugs to have a healthy life, to have more control and to not enter our hospitals or our emergencies to get their prescription drugs.

Mr. Peter Julian: Ms. Silas, do you recall the numbers per year?

Ms. Linda Silas: I don't recall them. I was looking at my notes. They're not there because that's a report from probably 2013. I will provide it to the committee.

Mr. Peter Julian: That would be very helpful. People are losing their lives because they're not able to pay for their medications. This is extraordinary that in a country like Canada we would permit that.

When company lobbyists come forward to this committee and say that everything's fine the way it is, would you agree with that assertion—that everything's fine the way it is—when people are dying?

Ms. Linda Silas: After that report, the Heart and Stroke Foundation partnered with us to lobby for a national pharmacare program, realizing that heart disease is big and it's the same thing with diabetes.

It's hard to understand.... As I said in my statement, we believe in a national pharmacare program because we believe in the care we provide to our patients, and we want to do the best job possible on pharmacare—

The Chair: Thank you.

Ms. Linda Silas: Others have other motives.

The Chair: Thank you.

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

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

Thank you, everybody, for being here. It's greatly appreciated, especially on such short notice to get through this quickly.

I think most Canadians who have been following this expect us to be discussing the legislation. They want us to be here to discuss the legislation, to sit around the table and come up with changes that we think need to be done to make it an even better piece of legislation, and that's a challenge as we move forward. They assume that, when we come up with points that are pertinent points, they will get passed. The unfortunate part is that they probably may not get passed. That's unfortunate, because Canadians who are watching us and hearing what has been going on expect this legislation to be improved. It's scary to believe that this coalition that's trying to push this through may not do that.

A number of people have brought up an issue I would like to address to start off with. Many of you, in particular Ms. Berg and Dr. Wong-Rieger, mentioned the issue of committees and experts and how we address that. When you look at where the legislation does that, it doesn't talk at all about how big this committee of experts will be, who the members will be and what their qualifications are—will they be from each province, or will they be from a select group that's determined by the minister and by the minister only?—not to mention the cost, etc.

My first question to you, Ms. Berg, would be this: When we look at that from a pharmacy point of view, last night some of our witnesses from pharmacy brought up the issue of having a pharmacist as one of those experts. I'm wondering if you would be able to comment on that.

● (1255)

Ms. Angelique Berg: Certainly. I think that the Canadian Pharmacists Association yesterday made a great assertion to have a pharmacist on that expert committee, and we fully support that. CAPDM's distribution members get medication to patients, but they also arm our professionals with the tools of the trade. They're extremely important, and they should be on that expert committee.

We would like to participate on that expert committee. We're very concerned about the unintended consequences on the supply chain that delivers medicines to Canadians. We would like to work with government and make sure that we're helping inform you to be sure there's enough money to support that.

We're at a precipice where there has been so much expense driven out of the distribution system that we're really at a place where the only way to take the impact of any further price reductions is to cut services. That's going to hurt, and nobody wants to do that. We'd really love to be part of that as well.

Mr. Robert Kitchen: Thank you, Ms. Berg.

Dr. Wong-Rieger, you also indicated that in the aspect of that advisory role. I would like to hear your comments on what you see that role being.

Dr. Durhane Wong-Rieger: As I said, we have the implementation advisory group right now with the rare disease drug strategy. I've been on other advisory groups with the government as well. The challenge, I think, is that in many cases we're not really advisers. There are already decisions being made. The decisions are oftentimes being made behind closed doors. We've been begging the government to tell us what's going on in terms of these bilateral agreements. What are the talks that are taking place? What are the drugs that are being considered? Can we provide some input in terms of what those drugs are? We're given no opportunity to do that.

I think the challenge is that, if we're going to have these committees, they must be transparent. There must be accountability. We've been asking for the opportunity to let the public know what the progress and plans are, and again, we've not been given that opportunity. I think part of the challenge is in the details and making sure.

The other thing I'd like to say is that, as we've heard already, it takes so long to get drugs through the public drug plans. I'm not saying whether or not things can be improved through the public drug plan, but we know that, if you have private insurance today, if a drug is approved, a rare disease drug, you almost always get it as soon as possible. I've had two or three years with patients on a public plan asking, “Where's my drug?”, and it's not yet there. Even though it's going through so-called expert committees, there's no the transparency and there's no ability to have the right people push for those decisions.

Mr. Robert Kitchen: Thank you, Dr. Wong-Rieger.

The Chair: Thank you, Dr. Wong-Rieger.

Thank you, Dr. Kitchen.

Next is Dr. Powlowski for five minutes.

Mr. Marcus Powlowski: We've heard from the Canadian Association for Pharmacy Distribution Management and the Canadian Organization for Rare Disorders. I think both of them sounded a note of caution about Bill C-64 being potentially a threat to access to drugs for rare diseases. Perhaps I'm not so surprised about that coming from Ms. Berg, but I am a little from Dr. Wong-Rieger.

Certainly, this bill does not create a single-payer system. We don't know as yet what national pharmacare would look like. Potentially, though, it would be a single-payer system.

I would have thought, particularly for Dr. Wong-Rieger, that there would be benefits with a single-payer system. I would have thought it would be more efficient. There are certainly cost savings to be had. There are certainly economies of scale in having one system. Right now, we have all these different providers. Each of these providers has its own management, and each of these managers and CEOs takes a bit of that money. This is money, in an employer-employee drug plan, that would probably otherwise be going to the employee. Instead it goes to the profits of the company providing the plans.

If you were to have one big plan administered by the government, you get economies of scale. There would be no money being siphoned off for profits, and there wouldn't be these many bureaucracies dealing with these different plans. There would be savings. In addition, if you buy 10 million pills at one time, you're going to get a better deal from a manufacturer than if you buy 100,000. If there was more money overall in Canada to buy drugs for everyone, wouldn't we then be able to afford drugs for rare diseases, which are often expensive?

Also, Ms. Berg, you were talking about shortages. Wouldn't we have money to provide for an emergency stockpile of medications, so we wouldn't have those shortages?

Perhaps I'll start with you, Dr. Wong-Rieger.

● (1300)

Dr. Durhane Wong-Rieger: Thank you very much.

I love your ideal approach here. This is absolutely what we would love to see—the ability to move these drugs through in a timely fashion, make them available to everybody at the same time and certainly, as you say, have equitable access right across the provinces.

What we know—this is where the details come in—is that, with the way the system works now in the public plan, they get bogged down. They get bogged down in many steps of bureaucracy. Quite frankly, we know the drug plans themselves do not allocate enough money. In many countries—let me get outside of the U.S.—there is a sense that the best drugs are an investment. I heard what Ms. Silas was saying. The trouble is that, if you're not providing people with their optimal therapy or not making sure they get the medication that's actually going to keep them alive or out of hospital, if you're providing everybody with the same therapy, which is sometimes what happens or you won't invest in the best therapies, then, in fact, it doesn't work.

That's our concern. In many cases, it comes down to the lowest-common-denominator drug.

Mr. Marcus Powlowski: You're concerned that any government-provided plan would get the basic medication. If you needed something a little better than the basic medication or a variation on it, you wouldn't be able to get it in the public plan. This wouldn't necessarily be the case, though.

Is that your concern?

Dr. Durhane Wong-Rieger: It is the case right now, and that's the problem. The public plans balk. They put in very high restrictions in terms of access, so this is the problem. Look at the recommendations coming out. The recommended price they'd be willing to pay is so low. You're asking a company to take a 90% reduction off the proposed price. Companies are not going to do that. In many cases, they won't even come to Canada.

I'm not saying this cannot be done. I'm just saying that, when you have a bulk plan that says, “Fine, we will negotiate, but we expect you to give us a 90% reduction”.... If you read the recommendations coming in and see what's going into the pan-Canadian drug alliance, that is exactly what's happening.

In reality, this is the problem. Ideally, I would love your plan.

Mr. Marcus Powlowski: Can I suggest, then, that maybe your argument isn't so much with the public provider, but rather with the fact that the providers are limited in their willingness to go outside the box and want to stick to a formula? In that case, perhaps you don't have any problem with public systems per se, just the way they are administrated.

The Chair: Answer briefly, please.

Dr. Durhane Wong-Rieger: As a patient, I don't care who's paying for it. We need to make sure it's paid for and affordable to the patients, quite frankly. Yes, we very much agree with the idea of having that single price available, but it needs to be done in a way that's realistic.

The problem we have is that, if we roll out the public plans we have now, and if we make that the only plan, it means people are going to be waiting two or six years to get access to the best medicines.

The Chair: Thank you, Dr. Wong-Rieger.

[*Translation*]

Mr. Blanchette-Joncas, go ahead for two and a half minutes.

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

I'll continue putting my questions to Ms. Silas.

Ms. Silas, I entirely agree with what you said earlier, that it isn't for politicians to decide what's on the formulary of drugs available under pharmacare. I repeat: some 8,000 drugs are covered by the plan and are on the present drug formulary in Quebec.

However, I do wonder who will decide what's on that formulary. Is it the Canadian Drug Agency? Is it the Institut national d'excellence en santé et en services sociaux, or INESSS, which already manages a formulary of 8,000 drugs? Who would be the best people for that job? Someone with 30 years of experience in drug insurance or someone else who knows the field and could somehow improve Quebec's present drug formulary by adding to it?

● (1305)

Ms. Linda Silas: I think you just answered your own question.

As MP Robert Kitchen said, the bill states that it's really up to the federal minister to conduct consultations with the provinces, territories and experts in order to determine what will be on the formulary.

We obviously have to work with Quebec and its experts, but we also have to look at what's going on beyond our borders. Canada is a small country with a population of 38 million or 39 million inhabitants. Experts around the world are far more advanced than Canada. Some countries have a public drug insurance plan and formularies of essential drugs that work very well.

Mr. Maxime Blanchette-Joncas: Thank you very much, Ms. Silas.

We're already at 40 million inhabitants. That's world-leading demographic growth.

Ms. Linda Silas: They must all be New Brunswickers.

Mr. Maxime Blanchette-Joncas: You'd have to check New Brunswick's demographic growth. However, I can confirm that Canada has the greatest demographic growth of all countries in the world.

When I asked you my questions, I wanted to know what more the federal government and the Canadian Drug Agency could do than what INESSS, the Institut national d'excellence en santé et en services sociaux, is already doing.

Ms. Linda Silas: That's beyond my expertise. However, when I listen to the comments from Ms. Wong-Rieger, with whom I have appeared many times, I realize there's a red tape problem in the way drugs are approved and distributed. It's a major problem, and we have to look into it. I don't think it will alter the bill under study here in committee, but the government definitely has to look into this red tape issue.

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

[*English*]

Next up is Ms. Zarrillo for two and a half minutes.

Welcome to the committee. You have the floor.

Ms. Bonita Zarrillo (Port Moody—Coquitlam, NDP): Thank you so much. It's a pleasure to be here.

My questions are for Ms. Silas. It's nice to see you today.

I want to talk about two things. One is gender equity, which you brought up earlier, and the other is poverty. As the critic for disability inclusion, I know that the Canada disability benefit is not going to fill that gap to help lift people at least to the poverty line.

First, I want to understand, based on your experience and that of your members, how poverty affects health and how this pharmacare bill could help alleviate some of those outcomes that are tied to poverty.

Second, could you follow up on the gender equality note that you introduced? For instance, how is the access to free contraceptives going to generate equality in our society?

Ms. Linda Silas: Poverty has a long list of issues to be dealt with, and I don't think anybody is suggesting one solution. This proposed act is not one solution to eliminate poverty, but it's one solution to give equal access to the necessary prescription drugs, regardless of whether you have a high or low income or you are living in poverty. That's where nurses come in. Getting your prescription drugs should not depend on your level of income or whether you're insured. That has been the case for as long as we've been supporting a national pharmacare program.

In regard to gender, if I look at our nurse practitioners and our regular registered nurses, the whole contraceptive movement is changing day to day. It is not the same way it was when I was in my mid-twenties, when it was just one pill. Today, it's a concept where the health domain has expanded and is helping women of all ages. This is one way to help more than 50% of the population, and it's important to go forward with the bill to make sure we do that.

Again, it's one piece of the puzzle to help gender equality, and it's one piece of the puzzle to help our poverty situation.

The Chair: Thank you, Ms. Silas.

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

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

It was interesting, when our colleague from the NDP, Mr. Julian, was here previously he was perhaps making some disparaging comments about lobbyists who were here yesterday. Ms. Silas, you too are a registered lobbyist. Is that not true?

Ms. Linda Silas: Proudly. Do you want to a pair of socks?

Voices: Oh, oh!

Mr. Stephen Ellis: No, but thanks. I am afraid that might be a conflict of interest, lobbyists giving gifts to parliamentarians—

● (1310)

Ms. Linda Silas: They're below $50. You're safe.

Mr. Stephen Ellis: —currying favour with their votes, perhaps, but that's a whole other story.

One of the things you talked about previously, Ms. Silas, related to patients being in hallways in health care. It appears you conflated that, actually, to patients not having medications, which could be one of the issues, but is it really not more of an issue that almost 10 million Canadians don't have access to primary care?

Ms. Linda Silas: Yes, and that is similar to the question on poverty. Access to health care is about primary health care and about access to medication, acute care and long-term care—and I'm forgetting, I'm sorry, mental health. If we're not able to fill all those silos—right now they're working in silos—our society will not be as healthy as possible, so availability of prescription drugs....

Mr. Stephen Ellis: Thanks very much for that.

You know, it's interesting. I would suggest that, over my career as a family doctor, I've known many nurses. They're quite happy to have their private drug plan, which covers many things. Sadly, the difficulties of their jobs require them to have access to physiotherapy and, often, chiropractors and mental health practitioners. What do you say to the nurses out there who might be afraid that they're going to lose their plan?

Now, you would suggest that's never going to happen. We had other witnesses here who said, “Yes, it's a really good likelihood that's going to happen with a national universal single-payer system.” If that happens, what do you have to say to nurses out there, when they lose their plan and all they have is a couple of birth control pills, no physiotherapy, no chiropractic, no support hose and no mental health access? What do you have to say to your nurses about that?

Ms. Linda Silas: First of all, this bill doesn't deal with physiotherapists and support hose. It deals with two categories of prescription drugs. What it will do is bring equity across the country. For our nurses, I never got the mandate to examine their own plans. That's at the bargaining table in every province and territory, and they do a great job. They're not worried about themselves. They're worried about the patients they take care of. They're worrying about that patient who falls through the cracks in Quebec, like I was telling Mr. Blanchette-Joncas, or they're worrying about the patient who doesn't have any plan.

Mr. Stephen Ellis: Ms. Silas, I'm just going to interrupt you there because that wasn't my question. My question to you was, if this comes to fruition and nurses out there do lose their plans.... I know your contention is that it's never going to happen. We heard from other witnesses who said that's a definite possibility, with previous court cases, etc. What do you have to say to your nurses out there when we know, as our colleague from the Bloc mentioned, that public plans cover significantly fewer medications and, as you mentioned, perhaps no physiotherapy, chiropractic and other important things on behalf of nurses?

What do you have to say to your nurses if they lose their coverage?

Ms. Linda Silas: I'll negotiate a better plan for them.

Mr. Stephen Ellis: Ms. Silas, that's absolutely not true because there's going to be only one plan available to them. I mean, this is not something that I find humorous because I know many nurses. You represent them. What will you tell them when they don't have a choice? How are you going to negotiate another choice when there is no choice?

Ms. Linda Silas: Dr. Ellis, I have 20 years of mandate—nationally—to negotiate a national pharmacare program from nurses from every sector of this country, and they are not worried about not having a plan. They'll always have a plan. Some are richer. If you look at Alberta, the plan is very rich in Alberta, on every facet compared to my own province of New Brunswick, but that is negotiated at the provincial level and will continue to be negotiated at the provincial and territorial levels. We're looking to alleviate some of the costs of those plans to enhance them—so maybe better mental health services, physiotherapists and support hose.

Mr. Stephen Ellis: I don't share your optimism, but thank you very much for your opinion.

The Chair: Thank you, Dr. Ellis.

Next is Mr. Jowhari, please, for five minutes.

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

I'll continue on that topic with Ms. Silas.

Am I right to understand that as a result of the preliminary introduction of these two types of products—diabetes products as well as contraceptives—it will allow more room in the broader insurance programs and benefits, so it can help to actually broaden the scope of other services, as you were saying? Did I understand you correctly? Can you expand on that?

● (1315)

Ms. Linda Silas: That would be the best scenario, but in 2024, until the act and until the program has some experience, where it will have an impact on our employer-funded health programs, for sure, and where that money will be reinvested will depend on the committees in the provinces and in all employment.... I'm talking about the public sector and health care, but it'll be the same thing in an auto company somewhere in Ontario. They will negotiate the excess of money when that happens.

Mr. Majid Jowhari: When you say that it will have some impact by 2024, can you explain what that impact is?

Ms. Linda Silas: I can't explain it, honestly, not with specific numbers. What I can explain.... Let's say the diabetic drugs are 10% of your health care costs, and it's spread around. That 10% will be reinvested in something else, because it will be covered by the province and the federal government's plan. That's the best example.

Mr. Majid Jowhari: Okay.

Ms. Linda Silas: Until we have experience, nobody will be able to tell you the exact amount. Now, saying that, I'm sure there's an economist that might testify and be able to do that.

Mr. Majid Jowhari: I understand you're a nurse practitioner as well. Based on your experience, or based on the experience of the nurses you represent, how many times has it happened in a hospital, in an emergency, that a Canadian has shown up with symptoms that relate to diabetes and, because of a lack of access or because of rationing, they ended up in emergency? How much does the emergency visit cost?

Ms. Linda Silas: I haven't practised in over 25 years, so I'm really not the person to ask. I'm a registered nurse, not a nurse practitioner. What we have done over the years is that we've brought practising nurses—and physicians have come also—to talk to parliamentarians on the lack of access to drugs.

Most of the time, we leave the dollars and cents to the economists to explain the cost impacts. What we're saying is that there's a human impact to people having to go to see a physician or a nurse practitioner and beg for a sample drug or for the rare disease that Durhane was talking about.... We should not be in a situation where we beg to get care in this country, and access to what your doctor or nurse practitioner prescribes should be included.

Mr. Majid Jowhari: Okay. Thank you.

I'm going to go to Ms. Berg.

Ms. Berg, you talked about the supply chain, the distribution and the potential impact of this bill, especially the buying power, and about distributors actually stocking less or eliminating products from their offerings and also that other manufacturers, who are as successful in their bids, are going to completely stop manufacturing or distributing in Canada. How realistic is that?

How realistic is it that a global pharmaceutical company is going to basically say, “I'm not going to manufacture penicillin anymore. I'm not going to sell it directly to the government”? I only have about 10 seconds, but can you quickly respond to that?

Ms. Angelique Berg: Sure. I would be happy to.

It's not that they will stop manufacturing; they'll stop sending it to Canada. That's happened. Durhane has spoken to that also.

We hear that kind of skeptical assertion that medicines will always be distributed everywhere, just like groceries. Unlike groceries, drug prices are controlled. They're not uncontrolled. They have thin margins and low volumes. They are not high-volume things that you can throw on any old truck. Their handling is extremely complex. It's highly regulated and it requires dedicated transport in temperature-controlled vehicles. They do not store easily and they don't move cheaply. When we think that they will just go along with the toilet paper, that's not true. That can't happen. We have all kinds of regulations on that to prevent that from happening and to maintain product integrity and patient safety.

It will happen. It won't happen overnight. It really won't. We'll watch it erode slowly. Slowly, the access will worsen.

● (1320)

The Chair: Thank you.

Next we have Dr. Kitchen.

Go ahead, please, for five minutes.

Mr. Robert Kitchen: Thank you, Mr. Chair.

Thank you, everyone, again. It's been interesting to hear some of the responses we've had.

Ms. Silas, I'm just wondering if you understood my colleague's question.

You know, my wife was a nurse for 40 years. She did her first year as a neonatal intensive care nurse at the university hospital in Edmonton. She then went to SickKids in Toronto and was an ICU nurse. She went from there to Royal University Hospital in Saskatoon. She went from there to working in Crosby, North Dakota, and then back to St. Joseph's Hospital in Estevan, where we live today. Then she was basically a critical care long-term nurse.

In her conversations that I've watched and seen, she has been the best patient advocate in this world. I would put her above anybody with respect to that aspect and how she cares about her patients. Some of the things that you have said today shock me, because she's never said any of those things. I find it kind of interesting that this is the way the union sees the nurses versus the way the nurses on the ground see things.

You did, though, mention one thing that I thought was very important, which was that it's not up to politicians to be making these drug plans. I agree with you on that. It isn't up to politicians to be making these decisions; it is up to experts to be doing that. When the government comes out with a plan and it hasn't talked to the experts.... In this case we're talking about diabetes, and the question would be whether they have even discussed things with the diabetes association.

When we look at what the diabetes association has put out and this public plan compared to the NIHB plan and their clinical standards, we see totally different aspects. The public plan has significantly less than the private plans that are out there. I'm sure you're well aware of how Ontario came up with the OHIP+ plan. When they implemented that drug plan for people under the age of 25—and I'm not from Ontario; I'm from Saskatchewan—the reality was that it had a huge impact on young Canadians' being able to get their medications, because they weren't able to access those. That's what this piece of legislation is doing.

It's putting forward a public plan. As my colleague has indicated, we heard yesterday from many other places that said that the private plans would be cut. For you to then say you're going to negotiate, that's not something that's negotiable. It's in this piece of legislation.

What do we need to change in this legislation such that you would be able to negotiate your steps as you move forward?

Ms. Linda Silas: MP Kitchen, yes, any bill could be improved, but it has to start somewhere. This is a start based on 30 years of evidence.

I do commend your wife for her role, and I'm sure she's a great patient advocate. I'm probably the best nurse advocate there is in the country. I've been elected 11 times to do that over the last 22 years.

Mr. Robert Kitchen: I apologize for interrupting you. My question to you is this: What can we do? That's what we're here for—to come up with plans to improve this. This is the role of this committee here right now. How we can improve that? What can we do today that would make those improvements and put forward steps?

You're not offering any steps that would improve that part. You're saying that you're just fine with this. However, what I'm saying to you is that what is “fine with this” puts people's lives at risk. To step forward for the 10% of Canadians who don't have a plan, regardless of whether it's a good plan or not, the bottom line is to provide the funding to help those people. This is not going to help them, because it's going to provide only basic medications in the diabetes area, and it's not going to help others, who have plans, because this will take that away from them.

What do you see that we can do to change that?

● (1325)

The Chair: Ms. Silas, that's all the time for Dr. Kitchen, but take 20 seconds and do your best.

Ms. Linda Silas: Honestly, stop stalling on providing Canadians' access to medication. This is opening the door for equality in our health care system. I support this bill and will work on improving it in the years to come.

The Chair: Thank you, Ms. Silas.

The last person to pose questions to this panel is Mr. Naqvi for five minutes.

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

I'm going to start by reminding members of the committee that I had the great honour of serving at the provincial level in Ontario for 11 years. I was part of the government that actually brought in OHIP+, and I was quite involved in the creation and development of that program.

I can tell you—forget it from the government side—just from the perspective of a member of provincial Parliament and in talking to countless constituents of mine, I know that young people, parents of young people, were able to benefit from OHIP+, because all of a sudden they were able to get access to life-saving medications without any cost through just using their OHIP card. It was a game-changer in terms of providing the kind of support needed by people, especially for young people. Anybody who's a parent in this room or listening knows that there's nothing more important to a parent than making sure of the well-being of their children.

I met so many constituents of mine, so, with all due respect to Mr. Kitchen, I can share with you my personal experience being a member of the provincial Parliament at that time in Ontario in terms of the impact it made—and the lack of it once Doug Ford's government took away that option, that choice, and the suffering lots of people faced.

I'll go to Ms. Silas. It's good to see you again. Thank you for your hard work and advocacy.

“Choice” is coming up here often, and that somehow this legislation is going to undermine choice and take it away. I see it as the opposite. I see it as actually creating choice, creating more options for people who don't have pharmacare or who are uninsured or under-insured.

Can you, from your perspective and all the work and research that your organization has done, tell us what your thoughts are on choice and what this bill does in terms of the choices available to Canadians when it comes to access to life-saving medications? In this case, start with diabetes and contraceptives.

Ms. Linda Silas: First of all, I totally agree with you on OHIP+. We all celebrated when it was introduced. The only downfall was that we were hoping the federal government would be doing that, similarly as they did with the dental plan.

When you use the word “choice”, I see it again as an equal playing field for the essential medications that are prescribed across this country. The choice will be for those who can afford more. However, the equal playing field for diabetics across this country, for women across this country, will be putting them on equal footing with everyone else. The choice will be the extras.

Mr. Yasir Naqvi: Thank you. You've looked at this bill fairly closely and in detail. Did you find anywhere in this bill a mention of private insurance or how that will disappear, or that people will not have the option to access or rely on their private insurance?

● (1330)

Ms. Linda Silas: No. When you look at the principles in clause 4, it's, again, talking about working with indigenous peoples, provinces, territories and stakeholders on how to implement the funding aspect. Again, as we mentioned earlier, “rare diseases” are especially identified there. It continues with diabetes treatments and contraceptives.

It's important to look at the simplicity of this bill, which the experts will be able to work with.

Mr. Yasir Naqvi: Nowhere in this bill is there any reference to removing drugs or reducing the drugs covered by private insurance.

Ms. Linda Silas: No. There is not one union in this country that would agree to eliminating the private programs that exist everywhere.

Mr. Yasir Naqvi: Can I ask the same questions of Ms. Berg and Dr. Wong-Rieger in terms of private insurance?

In your analysis of this bill, do you see any reference to private insurance not being available for those who want to access it?

We'll start with Ms. Berg.

Ms. Angelique Berg: Thank you.

We're actually not familiar with the private and the public plans. It's business-to-business throughout the supply chain.

I would defer to Durhane. I know she's done tons of work on that.

Mr. Yasir Naqvi: Great.

Thank you.

Dr. Durhane Wong-Rieger: Thank you very much.

For us, the concern is to make sure that.... As you know, there are essential medicines, but in many cases, there are much more personalized medicines. There are much higher-level medicines that are especially for those people who have that need.

Therefore, I would agree very much with Ms. Silas. If you need an essential medicine, if you need a basic medicine, as you say, with OHIP+, that would be available. Quite frankly, we would love to have the bill make it so that everybody gets the medicine they need and so that nobody is actually reduced to a common medicine if, in fact, what they need is much more specialized.

Today we have private and public insurance for rare disease drugs. I have to say that the sad news is that we get, over and over again, patients who tell us that the first question they'll be asked is whether they have private insurance. If they don't have private insurance, then they won't even get prescribed the appropriate medicine because it's not going to be covered by the public plan.

If there's a plan that provides, as you say, the optimal choice for each and every patient so that they can get what is absolutely the best for them.... In many cases, people end up in hospital because they don't have the right drug.

Yes, we would love to have a plan that would allow everybody to get what they need regardless.

The Chair: Thank you, Dr. Wong-Rieger.

Thanks to all of our panellists for being with us here today. We very much appreciate your testimony and the professional manner in which you've delivered it.

Colleagues, we're going to suspend now until 1:45. We'd like you to come back right at 1:45 because we're actually going to have five witnesses on the next panel.

Thanks again to all of you for being with us.

The meeting is suspended.

● (1330)

(Pause)

● (1345)

The Chair: I call the meeting back to order.

I'd like to welcome our second panel of witnesses for today. We have a couple of witnesses participating remotely, so I will just inform the committee that, in accordance with our routine motion, all remote participants have completed the required connection tests in advance of the meeting.

For our remote participants, you will see on the bottom of your screen that you have the choice of floor, English or French. That's to be able to access the simultaneous translation, should you require it.

Here are the witnesses we have with us today. From JDRF Canada, we have Jessica Diniz, president and CEO.

Ms. Diniz, thank you for your patience as we worked through the technical issues. We're going to start with you.

[*Translation*]

From the Association québécoise des pharmaciens propriétaires, we have Benoit Morin, president, and Geneviève Pelletier, senior director, external and pharmaceutical affairs.

[*English*]

Representing the Canadian Association of Retired Persons, we have Bill VanGorder, chief policy officer, appearing by video conference. On behalf of Diabetes Canada, we have Glenn Thibeault, executive director, government affairs, advocacy and policy.

Welcome back, Mr. Thibeault. It's good to see you again.

We also have Russell Williams, senior vice-president, mission. Representing the Smart Health Benefits Coalition, we have Carolyne Eagan, principal representative.

We're going to begin with opening statements in the order listed on the notice of meeting. We're going to start with JDRF Canada.

Ms. Diniz, welcome to the committee. You have the floor.

Ms. Jessica Diniz (President and Chief Executive Officer, JDRF Canada): Thank you, Mr. Chair. I'm honoured to be here.

Good afternoon, members of the committee. My name is Jessica Diniz, and I'm the president and CEO of JDRF Canada.

JDRF is the world's largest charity focused on accelerating research to cure, prevent and treat type 1 diabetes and its complications, as well as helping to make life better every day for the people who live with it. We also advocate on behalf of the 300,000 Canadians living with type 1 diabetes, representing their voices on critical issues such as national pharmacare.

JDRF supports the goal of making access to medications and devices for treating and managing type 1 diabetes equitable and affordable for all Canadians. Patient choice needs to be a priority.

Type 1 diabetes is a lifelong autoimmune disease in which a person's immune system destroys insulin-producing cells in the pancreas, making them dependent on daily injections of insulin to survive. I just want to underscore that they require insulin to stay alive. I just want to make sure that is very clear.

Managing diabetes represents a significant financial burden for Canadians impacted by the disease, and many treatments and devices remain out of reach for some Canadians. We thank the government for bringing diabetes and the high cost to manage the disease into focus through coverage under Bill C-64.

While we align with the intention of Bill C-64 to provide fulsome, barrier-free access to treatments and devices for those living with diabetes, we'd like to raise a couple of recommendations to ensure that Bill C-64 meets the needs of all Canadians living with type 1 diabetes.

First, national pharmacare should not preclude anyone from using existing private and public insurance coverage to access insulin, whether they are listed on the national formulary or not. Bill C-64 should include a provision that clearly articulates this principle.

Second, based on consultations with health care providers and those living with type 1 diabetes, we'd like to see the list of insulins on the formulary be expanded to include more advanced insulins that help better treat the disease. It's a very limited list, including insulins that are rarely used and prescribed. It's important that physicians have therapeutic options to address the wide variation in individual patient responses to and tolerance of any particular drug, and that patients can access these, as one insulin may work well for one person and not for another. I think this is a very important point. By expanding the choice of medicines, you increase the number of treatment options available to help eliminate side effects, reduce complications and improve health outcomes.

We also have two areas of caution on how this program is implemented that we'd like to raise. Number one is changes in insurance coverage. The bill also creates a risk whereby the existence of the national formulary may motivate private insurers not to cover brand name insulins because some of the generic equivalents would now be available through the national pharmacare program. If this happens, the consequence could be the automatic substitution of a different insulin, which can impact health outcomes.

Another concern, number two, is stakeholder engagement and consultation. This will be critical to ensuring the implementation of a national pharmacare program that best meets the needs of Canadians living with type 1 diabetes.

JDRF is supportive of legislation that improves access to medications and devices for Canadians living with type 1 diabetes. We ask the government to provide clarity on this legislation to ensure it lives up to its intentions of equity and affordable access to medications and devices, and considers the input of various stakeholder groups that must have a voice now in how national pharmacare is rolled out.

It's critical to get the implementation of this legislation right to ensure it delivers on its promise, not only for those living with type 1 diabetes but for all Canadians who will benefit from this program in the future.

Thank you very much.

● (1350)

The Chair: Thank you, Ms. Diniz.

[*Translation*]

I now invite Benoit Morin, from the Association québécoise des pharmaciens propriétaires, to take the floor.

Mr. Benoit Morin (President, Association québécoise des pharmaciens propriétaires): Thank you, Mr. Chair.

Good afternoon and thank you for inviting me to appear before you in my capacity as president of the Association québécoise des pharmaciens propriétaires.

I am here today with Geneviève Pelletier, director of pharmaceutical affairs.

I represent the 2,050 proprietor pharmacists of the some 1,900 community pharmacies operating in all chains and under all banners across Quebec.

A significant characteristic of the Quebec industry is that only pharmacists may own a pharmacy, as a result of which professional independence and ethics take precedence over business decisions, and patient welfare is owners' main priority. We have a unique pharmacy network in Quebec.

From the outset, I would emphasize that our association supports the Canadian government's wish to improve access to and the affordability of prescription drugs for Canadians. However, we assert that the health minister's objectives can already be met under the system in place in Quebec.

Accessibility and the primary care they provide are distinguishing features of Quebec's community pharmacies. Our pharmacy teams offer a multitude of services that extend far beyond drug dispensing and monitoring, and the efficient provision of those services is largely responsible for our pharmacies' financial health and thus for the funding of those services.

However, we are very concerned about Bill C-64 in its present form. A national single-payer pharmacare program would jeopardize the pharmacy model to the detriment of patients.

The current funding of Quebec pharmacies relies mainly on professional fees associated with the dispensing and monitoring of prescription drugs. Variations in those fees can influence pharmacies' ability to provide services to patients. Under the mixed public-private system, pharmacies can provide their services in a stable, predictable manner for the plan manager, the Régie de l'assurance maladie du Québec.

Under the proposed public single-payer principle, pharmacists' fees for dispensing and refilling prescriptions for diabetes medications and contraceptives would be a single amount negotiated for covered drugs. In that scenario, the impact on Quebec proprietor pharmacists would be significant because those drugs are commonly used by patients who are covered by the private component of the general drug insurance plan. That accounted for nearly 7 million acts in 2023.

It is precisely the flexibility of the present mixed public-private model that enables Quebec pharmacies to develop, operate in all regions and provide a host of services to patients. The mixed nature of the system allows proprietor pharmacists to adjust to the specific needs of their local clientele and to react efficiently to market competition. Without that flexibility, the financial health of the pharmacy network would be undermined, and the impact would be even greater in remote regions. It is therefore essential that you maintain the mixed system, which will guarantee our network's survival and effectiveness.

The financial health of pharmacies both guarantees access to prescription drugs and protects pharmacists' clinical role in the provision of primary care and the management of chronic illnesses.

In the past 12 months alone, more than 7 million clinical acts have been performed in Quebec pharmacies in support of primary care. If that primary care, so essential to the health system, were undermined, even more patients would be left to their own devices.

I would remind you that, by promoting accessibility, affordability and optimum use of pharmaceutical products and by providing universal coverage for all residents, the Quebec model already meets the objectives that would be established under the proposed national program.

In some situations, particularly for low-income individuals covered by the Régie de l'assurance maladie du Québec, the insured's contribution declines to zero under the present system.

Consequently, Quebec's mixed system both meets the objectives set forth in the bill and enhances the public system currently in place.

In conclusion, a national single-payer plan in Quebec would be counterproductive and would run counter to the objective of improving drug access. It would also undermine Quebec's community pharmacy model, a system well established in the communities and the envy of the other Canadian provinces.

● (1355)

The Chair: Thank you, Mr. Morin.

[*English*]

Next, we're going to the Canadian Association of Retired Persons and Mr. VanGorder, who is online.

Welcome to the committee. You have the floor.

Mr. Bill VanGorder (Chief Policy Officer, Canadian Association of Retired Persons): Thank you very much.

Thank you to the committee for allowing me to appear on behalf of the Canadian Association of Retired Persons and our 225,000 paid members from across the country.

We applaud the government's intention to work with the provinces and the territories to sign the agreement that would provide what is called universal single-payer, first-dollar coverage. We applaud that, and the plan to allocate that funding to the provinces and territories is a goal in improving the cost of the coverage of medicines for a selection of drugs and diabetes drugs.

However, we're very concerned about the federal government's proposal of a single public-payer approach to deliver pharmacare, because we fear that this could crowd out the private payers that currently cover the majority of Canadians, including one in three seniors. CARP believes that this would not be of interest to older Canadians for a number of reasons.

First of all, a single public-payer system would make it harder to access many of the newest and most effective treatments. Public drug plans are notoriously slow in covering new drugs and much more limited in terms of what they offer than private plans. As well, a good example is the list of the diabetes medicines, as has been mentioned before, that the federal government is planning to cover. It's very limited and doesn't include the very latest treatments used by seniors with diabetes.

Second, off-loading all Canadians onto a single public plan could lead to serious disruptions. There were challenges a few years ago when Ontario moved all youth under age 25 to OHIP+, the government-administered plan. During that transition, many Ontario kids lost coverage for medicines that were previously available to them under private plans. A reform of the current drug insurance system could lead to similar challenges with potentially devastating consequences for many older Canadians who rely on their medications and can't afford any disruption in their access.

Third, most Canadians already have coverage for targeted diabetes and contraceptive medicines through private plans. The government's plan to invest $1.5 billion over five years to provide coverage to these Canadians would be a waste of public funds. There are many other areas where additional federal funding could be put to better use, including addressing the challenges of the current system such as the high out-of-pocket expense for medications due to insufficient spending and coverage of medicines by public drug plans. This can be a major financial burden, particularly for seniors, many of whom, of course, are on fixed incomes.

The Canadian Association of Retired Persons surveys our members on a regular basis, and they are telling us that they believe we could build a successful mix of public and private programs to achieve universal coverage through a targeted approach that focuses on those most in need, the uninsured, the under-insured and those facing affordability challenges. We've already seen this model successfully implemented with the federal government funding agreement with Prince Edward Island. The province provided the provincial funding to help expand the number of drugs it covers and to reduce out-of-pocket costs for island residents. This approach, which builds on existing pharmacare programs, will likely be easier and quicker to implement than significantly reforming the current system.

Canadian seniors want to see timely results that make a real, positive difference in how they access medicines and ultimately manage their health conditions in order to enjoy longer and better lives.

Thank you for this opportunity.

● (1400)

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

Next it's over to Diabetes Canada with Mr. Glenn Thibeault, executive director, and Russell Williams, senior vice-president, mission. I'm not sure how you plan to divide your time. As parliamentarians, you know the drill.

Mr. Williams, you have the floor.

Mr. Russell Williams (Senior Vice-President, Mission, Diabetes Canada): Thank you very much, Mr. Chair and members of the committee.

Diabetes Canada has long advocated at the federal, provincial and territorial levels for improved access to medications, devices and services for the over four million people with diabetes. The goal of Diabetes Canada is to improve the quality of life for people living with diabetes.

Diabetes Canada applauds the government's intention to include diabetes medications and devices in the initial scope of the pharmacare plan. In fact, we see this as another step in building from the diabetes framework that was tabled last year.

Thank you, MP Sidhu, for your leadership in that.

However, there is an urgent and pressing need for those who are uninsured and under-insured. With broad consultation and careful implementation, this could represent a significant step toward reducing barriers. Providing comprehensive coverage and patient choice, continued improvement of care and a robust consultation system are our three key recommendations.

We recognize that there are significant gaps in coverage for some people living with diabetes. Our belief is that any public coverage should focus on addressing those gaps. As a first principle, we believe that government should focus on the uninsured and under-insured individuals, but the approach to diabetes management must also be comprehensive and align with Diabetes Canada's clinical practice guidelines. These guidelines are created by the country's experts and are one of the foundations on which physicians make informed decisions about patient care.

Unfortunately, the formulary that was tabled along with the law by the government is not aligned with the clinical practice guidelines or the NIHB program. It is limited in scope, excluding several key newer treatments while including older and outdated treatments.

We have produced a comparison of the proposed formulary of the CPGs and NIHB program. This document demonstrates that for many uninsured and under-insured individuals living with diabetes in Canada, most of the commonly prescribed medications would not be covered by the proposed plan. This is why filling the gap to focus on the uninsured and under-insured individuals to start with is so critical.

We met with the minister yesterday and he confirmed, though, that this list will grow and will move forward in terms of greater coverage.

We have to remember what we're talking about here, too. Let me underline the human reality. I know you all feel this. We're talking about the most vulnerable.

On our 1-800 line, which is open to all Canadians, we get a number of calls regularly from senior citizens who are choosing between rationing their drugs or going without. We get calls from people who are not taking the right amount of their medication because they can't afford it. Recently, we were getting calls about people concerned about their private insurance and whether they'd lose it during the transition to this law.

Again, we were assured by the minister, when we met with him yesterday, that people would not be shifted off their private insurance. These are two of the fundamental questions we had.

A further recommendation was the adoption of our principle of continued improvement and access.

Our CPGs have shown and new data continually indicates improvements to services, care and products. A pharmacare system must incorporate the principle of ensuring that new techniques and products that are more effective get incorporated into that plan when they become available. The system should actually welcome diverse approaches and creativity, including private insurance, while seeking universal coverage. Every province and territory has a distinct approach to its public formularies and pharmacare should be no different.

We already heard that Quebec's hybrid model is an interesting example and a good example to consider.

● (1405)

[*Translation*]

It's a universal plan, but it's mixed, both public and private.

[*English*]

We must ensure that all individuals do not lose access to drugs that they already have covered by private plans and are not included in the formulary. Unfortunately, we've seen examples of that issue in the past. Therefore, we are calling for a “do no harm” inclusion in the law to safeguard existing access to medications and ensure that persons living with diabetes can continue to access the latest treatments in care.

With these recommendations in mind, we believe that Bill C-64 needs a process of evaluation and practical analysis to ensure we set up the most effective system and ensure it's not just a debate about ideas, but a practical analysis for the effective system to improve access to medicines for people with diabetes.

We call for a more robust and transparent consultation process in the next steps of this law with people, patients, people with lived experience, health care providers, drug plan managers, researchers, provinces, territories and the indigenous communities.

We encourage parliamentarians to carefully ensure that this emerging national pharmacare delivers on its promise of improving access and ensures that no one gets left behind.

We appreciate the opportunity to share our ideas and are certainly open to questions.

[*Translation*]

Thank you very much.

[*English*]

The Chair: Thank you, Mr. Williams.

Finally, we have Smart Health Benefits Coalition, represented by Carolyne Eagan.

Welcome to the committee, Ms. Eagan. You have the floor.

● (1410)

Ms. Carolyne Eagan (Principal Representative, Smart Health Benefits Coalition): Thank you to the committee for the opportunity to appear today.

The Smart Health Benefits Coalition is a united advocate for smart, innovative solutions that result in timely and positive change for Canadians. Through our seven member organizations, our on-the-ground advisers support and advise more than 65,000 plan sponsors with their employee drug plans, including over 4,800 union plans. Together, our thousands of advisers across Canada support robust benefit plans for 10 million Canadians and their families.

Let me summarize our top-line perspective on pharmacare.

We fully agree that it is unacceptable that Canadians are currently living with little or no coverage for essential medications, stuck in the gaps between public and workplace systems. Even though 97% have some drug coverage, nearly one in five Canadians still report having some difficulty affording out-of-pocket drug expenses. We recognize that this is an affordability and access challenge that needs smart solutions.

Canada can work with provinces to better solve these challenges faster and more cost-effectively by focusing net new public resources and policy energy on filling the gaps and by taking a progressive approach to affordability.

We believe that universal pharmacare can be done with less money spent, with better and quicker access to drugs, and with less disruption to Canadians' health care treatment plans if the government does it through a targeted, multi-payer system rather than on its own.

We believe that there are a few critical considerations that need attention.

A universal, single-payer, first-dollar coverage model will require taxpayers to carry the whole cost of drugs and fees. Currently, employer plans pay over $20 billion in drug claims, providing medications to Canadian families every year as a well-functioning part of our comprehensive health care system. When looking at the challenges facing Canadians, spending precious new health care dollars where workplace coverage already exists is an expensive, missed opportunity.

The biggest cost pressure and pain point for any Canadian, whether they have coverage or not, lies in high-cost therapies associated with conditions such as cancer, Crohn's disease, cystic fibrosis and many more chronic and rare health conditions that have innovative, life-changing drugs. These cost pressures are potentially devastating and deserve a higher priority within the pharmacare discussion.

We've recently been very concerned to see comments by the government stating that Canadians would retain their ability to choose a new public plan or their existing workplace plan. Like other stakeholders, we are seeking clarity on what universal, single-payer, first-dollar coverage means. This is important. From our industry perspective, this term means that if the public system pays for a certain list of drugs under the Canada Health Act, then employer plans are not permitted to pay for those drugs. The result would appear to have the unintended consequence of impacting the PBO's estimates, which currently assume continued employer coverage, resulting in a savings of $4 billion per year.

This is critical to resolve. If the intent is, in fact, to permit Canadians to choose where they get their coverage from, then we believe this part of the bill needs to be written with clarity and with no room for assumptions.

Let's go over some smart solutions we're proposing.

Let's use net new taxpayer funding in a way that gets coverage and cost relief to those in need, absolutely. Let's require a common, minimal formulary for all employer-sponsored and provincial drug plans to create predictability and a floor of coverage, work with provinces to create a coordinated national system of rare disease and high-cost drug coverage, update the Canada Health Act and work with provinces to include common out-of-hospital therapies, for example, cancer treatments.

Now, specifically, we have proposals to strengthen the bill and framework.

First, ensure that coverage is available to Canadians regardless of province. Without intervening in the core aims of the bill, we propose an amendment that would provide for the Minister of Health to enter into secondary negotiations with a province in the event that a province formally rejects the single-payer pharmacare. This should allow for Canada to negotiate and enter into an agreement with a province where universal, no-cost treatments are made available without the restriction of a single-payer, first-dollar model.

Second, examine opportunities to explore pricing reductions.

Third, provide Canadians with a cost-benefit analysis prior to further steps. We propose an amendment that would ensure that public accounting and cost-benefit analysis be prepared and released prior to any consideration of an expanded single-payer system. Canadians deserve to know the facts and costs before governments take further steps that may irrevocably impact their ability to access and afford the wider range of medications currently provided under workplace plans.

In closing, I want to thank the committee for the opportunity to appear today, and I'm happy to answer members' questions.

● (1415)

The Chair: Thank you, Ms. Eagan.

We're now going to proceed with rounds of questions, beginning with the Conservatives.

We'll go to Dr. Ellis for six minutes.

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

Thanks to everyone for being here on this important topic.

Ms. Eagan, I'll start with you.

We're going to be here for 15 hours to talk about this, not that I mind being here with my colleagues, but I guess my plea is that it's just not enough. When we see legislation like this that has the potential to impact the future of all Canadians in terms of accessibility to funding for medications, it would seem to me that this is a pittance of an amount of time to spend debating this and how it should be rolled out.

I wonder if you might have some comments around that and the consultations that you have had with respect to this bill.

Ms. Carolyne Eagan: Thank you for the question.

I would say that indeed this is time well spent. We look at what a great risk it would be to make decisions around people's health care and people's drug coverage. That impacts the lives and the productivity of our workforce, our seniors and those who are underserved. It's important to do this right.

That said, this is why the Smart Health Benefits Coalition has advisers who work in offices, in machine shops, in union shops and in every aspect of every business in Canada to help them design their benefits packages. Every day, we see the pain points and what works well as Canadians navigate between the public and employer systems.

We have great insights that we would love to spend time on to help us take the right path. We all agree on the destination, but the path of getting there is so important. To have communication and clarity around this is essential.

Mr. Stephen Ellis: Thank you very much, Ms. Eagan.

Through you, Chair, for Ms. Eagan, do you believe that there are people out there who are afraid they will lose their private coverage should this national universal single-payer system come into existence?

Ms. Carolyne Eagan: Absolutely. I think we can point even to recent examples with our national dental plan. There are some great things in place there where people had no coverage, so we did fill those gaps. However, thousands of our advisers have received thousands of phone calls and engaged in discussions with regard to the misperception that people can go ahead and cancel their plan and essentially replace it with the free plan, not knowing what is on that list of coverage and who it's intended for.

My own mother, who is turning 80 this year, got her letter. She was completely confused and figured that she would cancel her plan and have free coverage with everything included. Luckily, I'm in the business and could explain it to her.

It is a risk. There's a great risk to employers and Canadians. Thinking they would lose access to a longer list of medications when their health is stable on the treatment plan they have been prescribed.... Losing that access puts everything at risk. It puts the sustainability and health of Canadians and families and our workforce and productivity at great risk.

Mr. Stephen Ellis: Thank you very much.

[*Translation*]

Mr. Morin, thank you very much for your testimony.

Do people fear that rural pharmacies in Quebec may shut down?

Mr. Benoit Morin: Yes, there's a concern. Some 371 pharmacies shut down when a universal plan was introduced in New Zealand.

We're afraid that, if there's no mixed system in Quebec, pharmacies will find it hard to be profitable, which will result in closures and force them to set up in major centres rather than rural areas.

Mr. Stephen Ellis: Thank you very much.

Since my question involves some technical terms, I'm going to ask it in English. I apologize for that.

[*English*]

The issue is around expanded scope of practice for pharmacists. Obviously, as you mentioned in your opening remarks, that now has become an incredibly important part, sadly, of delivering primary care in Canada because of the crumbling health care system, which is on the brink of collapse. I don't think that's too much to say.

Obviously, in this bill there's no mention of funding for the expanded scope of practice, but maybe, on behalf of your members, you could explain to Canadians how important it is now to the delivery of care in Canada.

● (1420)

[*Translation*]

Mr. Benoit Morin: Thank you for your question.

On at least two occasions, Quebec has enacted various statutes that have expanded pharmacists' scope of practice. Last year, more than 7 million clinical acts were performed at pharmacies, including vaccinations and acts for the management of chronic illnesses. Pharmacists enjoy considerable independence and may prescribe many drugs for common minor ailments such as urinary tract infections in women, for example. We hope our scope of practice is expanded so we can do more.

However, these activities need to be funded. They're currently funded by prescription dispensing fees. This is what enables community pharmacies to be relevant and to have an available area where they can conduct those activities. It's essential for us that pharmacies maintain their financial health so they can continue playing that role.

I'd say that, for a few years now, we've had to do more and more with less and less in the way of resources. Needs are increasing and labour is scarce. Consequently, it's important that we maintain this stability so pharmacies can continue to play their role and meet the expectations of Quebec patients.

The Chair: Thank you both.

[*English*]

Ms. Sidhu, please go ahead for six minutes.

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

Thank you to all the witnesses for being with us. I really want to say thank you to everyone who's working on the ground, especially Diabetes Canada and JDRF. However, my first question is for Mr. Williams.

Mr. Williams, as we worked together for many years, especially on the framework for diabetes, thank you for the work you are doing on the ground for people living with diabetes, especially in Brampton. Even though I just wanted to acknowledge that, you're also sending reps from Diabetes Canada to educate people. Thank you so much from the bottom of my heart.

My first question is on the implementation of the national framework for diabetes. We know that coverage of diabetes medications and devices is an essential component of the framework. Can you give a brief update to this committee on the implementation of the framework? Also, what recommendations can you give to this committee about the best way the diabetic devices access fund can serve patients with diabetes?

Mr. Russell Williams: Thank you very much for the question.

The framework that I referred to actually has improved access for medications and devices as one of the six main components. Across the country the provinces are working, to their own levels, on implementation of the framework. I don't have time today to go into it, but I can certainly give details to the committee later on. There's a real engagement of provincial health bodies to take the six pillars of the framework and implement them, so I see this as part of the next step.

As to how we do it, still there are a lot of questions, and I think you talked about this in terms of education. A lot of people in this country don't know how the health care system works or how pharmaceuticals are delivered, and I think there probably is a need for greater clarity. I also very much encourage that, in the next phase of this law, we take the discussions of the framework that we're doing and add concrete discussions with the provinces on how pharmacare will work within that context.

Ms. Sonia Sidhu: However, as the minister said yesterday, the bill will not impact access to private insurance, and people with diabetes will continue to have access to the full range of medications that are provided through their current insurance plans. This will add to the existing plans and does not take away anything. What do you think about those comments from the minister?

Mr. Russell Williams: At our meeting with the minister, those words were very reassuring because, when you take a look at the bill, there are a number of interpretations, which we heard about today, that cause a great deal of concern—excitement in some areas and concern in other areas—so the clarity from the minister is important. We did also talk about how the list that the government tabled is certainly not all-inclusive and doesn't reflect the clinical practice guidelines that Diabetes Canada creates with experts, and he assured us that this is a minimum list and one they'll start to work on. We supplied the committee members with a comparison between the clinical practice guidelines and the Bill C-64 list, as well as the NIHB list, which is a list of the government.

Ultimately, the care and management of diabetes is not one-size-fits-all. It's very individually focused, as you know. We have to make sure we build a program that will, on one hand, not just seem that there's a certain level of coverage but will actually be effective coverage for people with diabetes.

● (1425)

Ms. Sonia Sidhu: Thank you.

It is important to acknowledge the need for education, but it's also important to acknowledge the leadership of some provinces in their work implementing the national framework for diabetes. Also, some provinces, like Quebec, which you already talked about in your testimony, have a good hybrid model for pharmacare.

Let's talk about the human cost for patients. It's clear that patients just want a system that works for them. However, from the meeting, we understand that we need to work with patients during the rollout. How would you like the Government of Canada to approach the outreach component to educate patients with diabetes on the rollout of the pharmacare program?

Mr. Russell Williams: This is fundamental. We have to have patients at the table and fully involved in the discussions. That hasn't happened too much up to this point. With the limited debate, as a former politician, I'm concerned about limited debates, but that's the decision that was made.

We have to get out in the community and we have to get concrete. We need to talk to patients, and I would say we should set up a large education program. We should start a full engagement discussion, and Diabetes Canada would be pleased to help. However, we should also sit down and—again, speaking as former provincial politician—talk to the provinces and say, here's the direction we want to go in. We want to try to fix this for vulnerable Canadians. How would you do it in your province?

I mentioned one in terms of Quebec, the province I come from, but we work with each and every province. That's why I mentioned, in my remarks, that we should build on the creativity and diversity of our health care systems across the country in both the provinces and the territories.

Ms. Sonia Sidhu: My next question is for JDRF.

Ms. Diniz, not so long ago you joined me in Brampton, where one in five Canadians live with diabetes, for the third annual World Diabetes Day flag-raising. It is great to see you again virtually.

This is my question for you. Investment into research allows innovative companies to provide new solutions and devices, such as pumps, continuous glucose monitors and other devices. The diabetic devices access fund is the key to unlocking access to the newest technologies for patients who have diabetes. How can this fund best serve Canadians?

Ms. Jessica Diniz: First, it's very nice to see you again, and thank you—

The Chair: Please give a brief response, if you could, please.

Ms. Jessica Diniz: I'm sorry. First, thank you for the question.

I agree about the special devices fund. It is critical that we get this right. Access to continuous glucose monitors for people with diabetes is so critical. It improves health outcomes, and it actually reduces complications. It will reduce our long-term health care costs if we can get better access to continuous glucose monitors for Canadians.

Therefore, we would propose an open engagement with the minister's office, as well as with the provinces, to see how we can get more Canadians having access to CGMs. It is critical, and we will have better long-term health outcomes.

Thank you.

[*Translation*]

The Chair: Mr. Blanchette-Joncas, you now have the floor for six minutes.

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

Greetings to the witnesses and thank you for being here.

My first question is for Mr. Morin, from the Association québécoise des pharmaciens propriétaires.

Mr. Morin, as you are on the front lines, you necessarily understand the observation that was made regarding the cost of certain medications. Like many others, I wonder whether people currently covered by a drug insurance plan will be able to continue using it. Yesterday the minister seemed to say yes. According to one credible witness, Stephen Frank, president and CEO of the Canadian Life and Health Insurance Association, there are some ambiguities and the bill doesn't necessarily afford any confirmation in that regard. You also say in your brief that imposing the program on Quebec would really jeopardize the viability of private insurance plans.

I'd like you to tell us a little more about that.

● (1430)

Mr. Benoit Morin: Thank you for your question, Mr. Blanchette-Joncas.

It's obviously nonsensical to think that private insurance plans could act as supplementary insurers. There's no viability there. I'm not an insurance expert, but based on what's done in Quebec, it wouldn't work. These are comprehensive plans that provide comprehensive drug coverage in most cases. This also gives SMEs access to private insurance plans, to group plans. SMEs aren't required to join those plans; they could decide not to join one and then get public insurance. However, for marketing reasons or reasons of their own, they can opt for a group plan. I think that's a good thing; it's a good arrangement to offer their employees. I think that should continue as is.

In addition, these plans frequently offer broader coverage than the public plan. The public plan in Quebec already offers broad coverage. If you compare Quebec's scope to what's offered in the national plan for diabetes, you can also see a major difference in molecule access.

Mr. Maxime Blanchette-Joncas: Thank you.

Realistically, if we lost the private plans, and even if we kept them, do you think it would be financially realistic for the government to operate with no deductible and to maintain the same drug formulary?

Mr. Benoit Morin: I don't think that's realistic.

Mr. Maxime Blanchette-Joncas: Why? I'd like to hear what you have to say about that.

Mr. Benoit Morin: It's because of the increase in drug costs. Choices will have to be made. If coverage is comprehensive, if it is 100% covered by the public plan, tough choices will have to be made regarding the technology, which is advancing quickly.

The new drugs are extremely costly. It's possible to treat rare diseases, and chronic diseases as well, with biological drugs, for example, which work miracles but are extremely expensive. I think it's problematic to consider a completely universal plan.

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

Going back to what you said in your remarks, I can tell you firsthand how important it is to have access to a pharmacy in a rural community. I proudly represent 39 municipalities in the Bas-Saint-Laurent region, and I can tell you it's essential to have a pharmacy when there's no hospital nearby.

You mentioned that the federal government's present program jeopardizes the pharmacy model, and even community pharmacies, and you cited the example of New Zealand, where 371 pharmacies shut down. I'm very concerned by your remarks. This makes no sense to my mind. We're talking about local services, individual welfare and keeping people in their communities, especially with an aging population as we have back home, the second fastest aging region in all of Quebec.

What should we do to prevent these closures, which would be a real problem?

Mr. Benoit Morin: First, you shouldn't put undue pressure on key actors, on front line actors like the community pharmacies. The Bas-Saint-Laurent example is a telling one. We had the front line single-window pilot project for orphan patients who had no family doctor and were given access to the services of pharmacists at pharmacies to which they were directed, where that was possible.

This is an excellent example of how pharmacists can provide those services, even though they're underpaid for the clinical acts they perform relative to needs. They can provide those services because they're in good financial condition, but undermining that condition would threaten the system and the presence and number of pharmacies in those regions.

Mr. Maxime Blanchette-Joncas: Thank you for your answer, Mr. Morin.

The drug formulary of the Régie de l'assurance maladie du Québec covers approximately 8,000 drugs. That isn't perfect, but I think we're doing all right. That's a lot of drugs. Do you think there's any risk that we may lose certain coverages under this new federal pharmacare program?

Mr. Benoit Morin: If you compare Quebec's formulary to the one being proposed, even though it's not final, you can see that several millions of diabetes-related prescriptions would be lost. A significant percentage of patients would have to switch drugs, which makes no sense. It's impossible. Quite honestly, we manage stock shortages every day in community pharmacies. Adding a draconian change in coverages to that could be disastrous for the health of Canadians and Quebeckers. We really need to ensure that this formulary at least covers Quebec's formulary, even though the Quebec one is generous.

Broad coverage is needed for diabetes, for reasons that my colleagues mentioned regarding the individual contribution of each drug to the treatment of that disease. This availability, this wide range of covered drugs, is essential in maintaining the health of Canadians.

● (1435)

The Chair: Thank you, Mr. Morin.

[*English*]

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

[*Translation*]

Mr. Peter Julian: Thank you, Mr. Chair.

Thanks to all the witnesses for being here.

Your remarks are interesting. You're giving us good information.

I'd like to go to you, Mr. Morin and Ms. Pelletier.

Pharmacists will definitely play a major role in the future of drug insurance.

Yesterday a large group of nearly two million Quebeckers, including members of the Centrale des syndicats démocratiques, the CSD, the Confédération des syndicats nationaux, the CSN, the Fédération des travailleurs et travailleuses du Québec, the FTQ, the Union des consommateurs, the Fédération interprofessionnelle de la santé du Québec and many other organizations, had this to say about the present situation in Quebec:

> …the current Quebec drug insurance program can in no way guarantee all Quebeckers reasonable and fair access to drugs…"The various fees charged to drug purchasers are in fact copayments that have a deterrent effect: People skip doses or deprive themselves of certain drugs because they can't afford to buy them"… Furthermore, rising drug costs also put increasing pressure on private plans, leading workplaces to abandon their insurance and thus lose all their coverage.

These groups are calling for parliamentarians to pass Bill C-64.

You've obviously raised the matter of the formulary of drugs that will be covered. That aspect will be negotiated with the Quebec government. Other countries are fortunate to have universal, public drug coverage without any pharmacy closures.

Do you think it's important to ensure universal access to drugs that keep people alive and in good health, while being careful to negotiate repayment and to pay attention to how pharmacists are affected by this universal public system?

Is that the message you want to send today?

Mr. Benoit Morin: Thank you for your question, Mr. Julian.

I think we have to guarantee coverage for everyone before considering the pharmacists. I think that's the first step.

Under a measure in Quebec, no one pays a deductible or copayment of more than $996 a year, regardless of whether the coverage is public or private. It's what's called "the ceiling."

For low-income individuals, the ceiling is zero. They therefore pay nothing. People who have incomes have a ceiling of $996 per year. The public program has a monthly ceiling, and private plans have an annual ceiling. I think it would be helpful to spread that amount out over 12 months because a single amount of $1,000 might be too much for certain individuals. It might cause them to question their decision to take their drugs. However, $90 or $100 a month might be possible.

I don't think the solution is necessarily to make drugs free for everyone. Instead we should educate people who have a certain income level, by which I mean people who can afford to pay for their drugs. They should be told that their drugs are essential and a priority, that they should attach to them the importance they deserve and that they shouldn't choose other products that might undermine their treatments. However, people in the public system who can't pay for their drugs should enjoy full coverage; there should be no barriers preventing them from taking their drugs.

Mr. Peter Julian: We agree that the status quo isn't acceptable.

Thank you for your answer.

[*English*]

I'd like to go to Ms. Diniz.

We had very compelling testimony yesterday from Mike Bleskie, who is a young person with type 1 diabetes. He talked about what happens if he loses contracts. He talked about going into his line of credit to keep paying for the medication that keeps him in health—in life. I asked him what happens if the contracts don't come in and he can't go into the line of credit. I thought he talked very movingly. He said that within 24 hours, he could find himself in the hospital. Within days, he could be facing amputation or worse.

I'd like you to tell us what happens when people can't afford to pay for their medication now. When it comes to diabetes, what are the impacts? When you can't afford to pay for medication, what happens to you?

● (1440)

Ms. Jessica Diniz: First, thank you very much for the question and for bringing this area into focus.

I agree. It is critical that patients have access to the medications and devices they need.

For type 1 diabetes, this is a matter of life or death. They don't have a choice. Think of insulin as being like air. They need insulin to stay alive, so to answer your question of what happens to the individual when they can't afford their medications anymore, they ration them. They don't take enough. That leads to worse health outcomes and more complications, and that actually costs our health care system more money later down the road.

It's important to think about the young person entering the workforce who no longer has coverage under their parents' plan and is choosing their profession based on the benefit programs that are being offered, which can cover their medications.

It's critical that Canadians living with type 1 diabetes have access to medications to control their diabetes, which will eventually prevent long-term complications.

Mr. Peter Julian: Mr. Thibeault, I'd like to ask you the same question. What are the impacts when people can't afford their medications?

Mr. Glenn Thibeault (Executive Director, Government Affairs, Advocacy and Policy, Diabetes Canada): Thank you for the question. It's very similar to what our colleagues at JDRF are talking about. Someone who lives with type 2 diabetes will also have serious complications if they can't access the medications they need.

I also live with type 2. I was diagnosed in 2016 when I was an elected official. Learning the process of what types of medications, you need to go through.... I went through three or four different types of metformin before I was able to get on the right one. That's why we've talked about choice and making sure it is available to everyone who lives with either type 1 or type 2 diabetes. It's important to make sure we can avoid all of the complications that we know can happen out there.

I know, Mr. Julian, you've talked about Amber in your riding, who spends $1,000 a month.

The Chair: Thank you, Mr. Thibeault.

Mr. Glenn Thibeault: Are we out of time?

The Chair: We are indeed.

Mr. Glenn Thibeault: We can talk about that next time.

The Chair: We now have Dr. Kitchen, please, for five minutes.

Mr. Robert Kitchen: Thank you, Chair.

Thank you to everybody for being here so quickly and on such short notice. To the many of you who provided us with briefs, I greatly appreciated seeing those in advance. I'd love to go over each one of them with every one of you individually. It is appreciated.

I'm trying to ask questions as quickly as I can.

Mr. Williams, you've indicated to us that you met with the minister yesterday. Did the government actually come to you at any time before they were setting up this plan, or was it purely an opportunity to speak with the minister yesterday?

Mr. Russell Williams: Thank you for the question. We talk with the governments regularly, mostly on the implementation of the framework. We did not talk before about the specifics of this bill.

Mr. Robert Kitchen: Thank you.

We've heard from many groups, yesterday in particular, that there has been a lot of concern about no one discussing it. That's from the provincial health ministries all the way up to individuals, whether it's diabetes, etc., and experts along those lines, so I appreciate those comments.

Part of what you talked about was your conversations with the minister. He was here yesterday, and he basically said, “Trust me; everything's going to be good.” Apparently, from what I'm hearing you say, that's what he said to you: “Trust me; it's going to be good.”

However, this is from the same government that said the carbon tax would never go above $50, which they campaigned on in the 2019 election, and now it's going to be up to $170.

How trustworthy do you see this being? Would it not be better to have something within the legislation that would support and provide protection from that?

Mr. Russell Williams: One of the things we talked about yesterday, which we've supplied to all the members, is a comparison between the list provided by the government and our clinical practice guidelines, to say that there's work to be done on this. We've also supplied all the lists of what's happening in each and every province.

I'd like to have all the answers, and we've been working at this for some time, but I'm leaning towards trying to move this forward for the most vulnerable people as soon as possible.

One of the things we have to do here is get answers to those questions, for sure. There are other stages of this law. There's going to be negotiations with the provinces. Should we move on with this? I'm not entirely comfortable with this. However, on the other hand, for the people we're trying to serve, is it worth trying to move forward on whether there are enough checks and balances on it? I understand your question. We put those questions to them, and we'll share any of the answers we get.

● (1445)

Mr. Robert Kitchen: I appreciate that comment, and you did mention the uninsured and the under-insured, and those are aspects of things. I do appreciate your document because I have it here.

It's interesting. I am a type 2 diabetic and to you, Mr. Thibeault, I too went through a number of aspects, and my wife as well, regarding what metformins would be there. I appreciate the comments in here where you've listed the differences and where you've indicated that, for the NIHB, basically the plan that they have is better than the plan that was proposed by the government. We got that information as well from first nations yesterday, who indicated that the avenue is there. Basically, the clinical guidelines are there, which are very appreciated too.

I see where, for example, under Quebec, the listings are either restricted—in other words they need to have permission to get them—or they're listed, and they're the most prevalent of all the provinces. In Saskatchewan...I'm on Jardiance and ultimately it indicates that it's restricted, and that's true. I need to get permission from my doctor in order to get that aspect of it.

Those are huge challenges that are there and where we don't have doctors available even to provide the ability to get that done.... The challenges we have as we move forward on that is that the plan that's being proposed basically is a very basic plan, but there's no avenue to indicate that it would change. There's no avenue to indicate—and that's what we heard from different people—that as medicines improve that list would be changed.

Do you not see that as an amendment that might be available and that we need to put into this legislation to make certain that it is complied with?

Mr. Russell Williams: That's why we put in our second recommendation the principle of continued improvement of care. Our clinical practice guidelines change from time to time as we get new evidence, and we have to make sure that, as new medications come up we have a system that allows for it. It shouldn't be just a system of older medications, but it should have that capability.

Our recommendation would be that this principle be built in, and again, in the discussions we had yesterday, we expressed that. We understand that there's an opportunity, and ultimately, it's discussions. I hope every province will also embrace that principle and that we'll build a stronger system, more than that base list that we saw tabled with the government, which the minister, once again, said will grow. We'd like to see how much it will grow in the discussions with those who know, and again, I really would like us to get to the next level so we can have discussions with the health care providers to understand some of those questions.

Thank you very much.

The Chair: Thank you, Mr. Williams.

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

Mr. Marcus Powlowski: Bill C-64, except for diabetes medication and contraception, does not create a single-payer system. We don't know what the national pharmacare system is going to look like at the moment. It won't necessarily by the sounds of it be a single-payer system.

However, Ms. Eagan, in response to the idea of a single-payer system, you said this was wasteful because all Canadians would have to pay for it with taxes—which is true—but that, right now, many Canadians get it as a benefit from their employer.

It's not like that's free. That's part of your pay. You get paid a certain amount of money, but you get some benefits. It's a cost to the employer, and if the employer doesn't have to pay that cost presumably you would get more in your salary. If the government can have a system that is cheaper to run—and there is some indication that with a government-run system, a non-profit system, because of economies of scale, government could provide that system more cheaply than the employer could—that would be a net benefit to Canadians.

Would that not be the case?

Ms. Carolyne Eagan: What I would like to highlight here is that today it's $15 billion. How much lower could that number be? That's what's being paid by employer plans.

Secondly, I would say that four out of five Canadians are enjoying that system without any reported incidents or challenges.

We agree. Let's get the coverage. Let's not take the money where it's working well. Let's leave that in place and allocate those dollars, those extra dollars, to those who have no coverage or those who struggle in any capacity, whether it's 20% of a $100 copay or 20% of a $10,000 copay. People are struggling at both ends of that spectrum. For the ones, the four out of five, that it's working for, let's leave those in place, leave what's working and get the dollars allocated.

● (1450)

Mr. Marcus Powlowski: Although you may get benefits as an employee, with those private plans, a certain amount of the money goes to the profit of the provider. Instead of that money going to the profit of the provider, perhaps that money could be used to provide better pharmacare for all Canadians, if there are efficiencies in having a government system.

Is that not the case?

Ms. Carolyne Eagan: I can tell you, from working in this business for 28 years and having done the analytics on renewals line by line, the profit margin would be surprisingly lower than what you're thinking. It's a lot lower.

Mr. Marcus Powlowski: The profit margin for...?

Ms. Carolyne Eagan: I mean the profit margins for running a benefits program. That money alone would not even be a drop in the bucket for what we need to achieve as a country. We need to work together in a multi-payer system to achieve.

If you could allow me a brief example here, I'm going to say there's a patient A with a $100 claim and no coverage. Let's get them that $100. Patient B has 80% coverage through their employer. The employer plan pays $80 and the patient pays $20. Now that patient is struggling. Let's figure out how to get them that $20. In the third example, if I may, there's an 80% coverage. The employer pays $80, the patient pays $20. For four out of five people, that's working great. Why disturb that?

The last one is a fourth scenario, where two spouses have 80% and they coordinate. They're zero out of pocket. It works great.

With scenario one, with a single-payer, the government pays $400. In scenario two, it's $140.

Mr. Marcus Powlowski: Can I interrupt, please?

I want to ask a question because pretty well everyone said a limitation of a single-payer system—and I would challenge this—is that those systems are all kind of limited in what they provide. What if you want a newer medication? How about if you want a brand product? That's not allowed in those kind of single-payer systems, but it could be. There's nothing to stop it.

There's nothing to prevent an employer, if there's a single-payer system, from offering additional benefits—kind of a top-up system. Just as now, if we go to the hospital, because we get Canada Life insurance, we can get a single room or a room with one other person or something. That's a benefit that you get from Canada Life that you would otherwise not get. That's what's offered.

Couldn't an employer offer a system that provides that kind of top-up coverage, so there would still be that choice if people wanted it? A number of people have said that this is the problem with the single-payer system.

Ms. Carolyne Eagan: Here's the challenge—

The Chair: Give a brief answer, please.

Ms. Carolyne Eagan: The challenge lies in confusion. Look at dental. How many people think that the coverage is the same? They go to cancel it, and then they're left with nothing.

This way, shifting that cost entirely to the public system, would be at great risk. We have a longer list of covered medications that get...faster under the employer system that we need to protect and have in place. We need that system to help people who can't afford both base medications and those high costs.

Let's keep innovation coming to Canada with those therapies for cancer and other conditions that are costing patients, who are struggling to afford them even a 10% copay, tens of thousands of dollars.

Thank you.

The Chair: Thank you.

[*Translation*]

Mr. Blanchette-Joncas, go ahead for two and a half minutes.

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

I'll stay with Mr. Morin.

Mr. Morin, according to some of my parliamentary colleagues, the status quo would be a disaster for Quebec, and I'd like to know what you think about that.

Wouldn't it be preferable to have a right to opt out with full compensation and, as we've done for 30 years now, to be able to improve our own public pharmacare program?

Mr. Benoit Morin: Absolutely. That's what the Association québécoise des pharmaciens propriétaires, the AQPP, is proposing.

Earlier I said I thought the system wasn't perfect. It's a mixed system; sometimes you have to pay out the full $1,000 ceiling amount if you're insured privately. There should be some protection against that.

Perhaps other, simpler measures should be adopted. We mentioned how hard it is to access exception status drugs, for example, where it's difficult because people don't have access to doctors. Sometimes it's an obstacle course for patients. The professions should be decompartmentalized so that other professions can provide access to those products. There are rumours that that's what's happening in Quebec.

Furthermore, Quebec's Institut national d'excellence en santé et en services sociaux, the INESSS, makes scientific decisions on what should and shouldn't be included in the formulary. As a pharmacist and scientist, I support those decisions in 99.9% of cases because they're based on effectiveness, efficiency and relevance rather than feelings of being deprived of a product or not having access to this or that.

We know the pharmaceutical industry works miracles, but is it always necessary to cover the thirtieth molecule, which costs more? The answer is no.

INESSS conducts those analyses, and I think that improves the quality of the Quebec system.

● (1455)

Mr. Maxime Blanchette-Joncas: Mr. Morin, according to a study conducted by the Canadian Pharmacists Association, 94% of Canadians agree that governments should expand and fund community-based care such as health services in pharmacies.

The federal government was supposed to pay 50% of health care costs through transfers, including to Quebec, but it now pays 22%. Is that really something that will help improve health care services in pharmacies and community-based health care?

Mr. Benoit Morin: We don't discuss clinical services in pharmacies in our proposal; we only discuss distribution. Diabetic patients and young women who use contraception methods, such as the morning-after pill, need more than just the drug.

These activities should be adequately funded so the drugs are properly and rationally used.

The Chair: Thank you, Mr. Morin.

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

Mr. Peter Julian: Thank you very much, Mr. Chair.

[*English*]

I come back to you, Mr. Thibeault. You just started to talk about Amber, who is a young woman with type 1 diabetes, and I want you to continue informing the committee about her situation.

Mr. Glenn Thibeault: Through you, Mr. Chair, thank you, Mr. Julian, for allowing me to continue because, for the story that you told about Amber, we could go into every single riding in every single constituency across this country and, unfortunately, we would have a similar story.

My colleague Mr. Williams talked about the calls that we are getting to our 1-800 line. Very similarly to what Ms. Eagan was saying, we receive calls from individuals who have no coverage, like Amber, and who are spending, in her case, like you said, $1,000 a month just to get the care that she needs, and that's devices and medications. We also have individuals who are living with either type 1 or type 2 diabetes who have private insurance. It's at, let's say the 80% level. However, the 20% level is still difficult for them to meet at the end of the month, so they're rationing, as my colleague Mr. Williams also outlined in his opening statement.

That's why we continue to talk about our three recommendations, because those are the key points that we think.... The debate about what is universal, first-dollar, single-payer—as Mr. Powlowski talked about—hasn't been defined yet. We keep talking about the under-insured and uninsured. We have an opportunity here—"we" being everyone at this table, diabetes organizations, contraception organizations—to actually look at making sure we can fill those gaps, and if that isn't the right term, let's figure out what the right term is to make sure that the choice and the opportunity to continue to move forward is still there while we're figuring out how we make this work in the negotiations that happen with the provinces.

We talk about that fulsome and robust consultation that we would like to see with persons with lived experience, like me, like Mr. Kitchen and everyone else across the country. Let's look at the comprehensiveness. In the bill it talks about section 4 and looks at how the Canada Health Act can be included, and some of our legal interpretation talks about making sure that we look at the comprehensiveness of that choice and then, of course, what we're calling "do no harm". We need to ensure that individuals who have wraparound care still have it, but let's not forget about Amber or about anybody else we could talk to, in any one of these constituencies across the country, who needs that support.

● (1500)

The Chair: Thank you, Mr. Thibeault.

Thank you, Mr. Julian.

Next we go to Mrs. Roberts, please, for five minutes.

Mrs. Anna Roberts (King—Vaughan, CPC): Thank you, Mr. Chair.

I have two questions for Mr. VanGorder and I would like some answers. Many seniors in my communities have concerns with the pharmacare plan, and I'll explain why. They're very disappointed in the dental plan, and they don't trust this current government to deliver any plan. They feel that it has failed them at every level.

In Ontario, seniors pay a flat fee and receive their drugs for the remainder of the year, so once a year they pay a flat fee and they receive their drugs. How is this plan going to impact the provinces and territories?

Mr. Bill VanGorder: Thank you for the question.

Through you, Mr. Chair, that's a key point, because they don't know. They're confused. The seniors who are watching today—and I know many of them are—are going to see that, if there are this many questions about the coverage for those with diabetes, what's it going to mean for the rest of us? What will it mean for those of us with heart and other conditions, and for people who need the coverage?

They're confused, they're worried and they're fearful. I'm not just assuming this. Our members write us weekly, if not daily, about their concerns. Why is this going so quickly? Why don't we know what's going to be covered?

I had a woman call me the other day to say that her husband had retired last fall and then he passed away. She still had his drug coverage, but couldn't afford her payment part and was told that she couldn't get rid of it and get onto the new program.

Whether or not this is going to be changed in the future, that's the kind of thing that's worrying seniors. When they hear a discussion like they're hearing today, whether they're in Ontario, in Nova Scotia where I am or in B.C., they're worried about what they see as an incomplete framework.

Mrs. Anna Roberts: Thank you for that.

You mentioned in your opening statement the Ontario plus plan and how it didn't have any benefits for young people. We know what happened in 2018—the provincial Liberals got killed.

What did you mean by that?

Mr. Bill VanGorder: I meant that there was confusion in its operation. When it first came into play, there were many people who fell between the cracks. Eventually, it seems, most of those were picked up; however, there were people who were without the ability to get their medications from the time the program was introduced until they got through the paperwork of getting it.

If seniors and older Canadians have to stop even for a month or two taking their medications, that's going to create very severe problems. We can't let that happen with this plan.

Mrs. Anna Roberts: I guess what we should do is put the patients back in patient care instead of the government. Would you agree with that statement?

Mr. Bill VanGorder: I would absolutely agree. What we have now—one of my colleagues pointed out—is like a kind of mismade quilt. It's a patchwork, with gaps in it, covering everybody.

What's being proposed now is more like a burlap sack. It's the lowest common denominator with holes in it. We need a tightly knit quilt. That's what seniors are looking for and want to have. Whether or not the future will allow us to see things better and changed, right now they're really wondering why we're rushing this through with no consultation—with our group and very few others.

Mrs. Anna Roberts: Thank you for that.

I have a question for Carolyne, if I can call you that. You've explained the plan to us. You said there's not a huge profit for companies.

Can you tell me the difference between what the government is offering on the pharmacare plan and what it eliminates for current plans that people have?

● (1505)

Ms. Carolyne Eagan: When it comes to that list of drugs—I think this is what you mean—it would be far less expensive. We've been talking about that a lot today.

Overall, province by province and employer plan by employer plan, it's a 40% to 50% difference in the drug list of what is covered. That's the main difference—there's a higher list of drugs and a longer list of drugs. If we spend the money with smart solutions, we can get that right coverage to people for more health conditions or a longer list within the fields of the conditions we're talking about today.

What I want to also add is that with our advisers on the ground—the thousands I mentioned across Canada, who look after the 65,000 employer plans—we see, province by province, the models of how they are built today. We see what's working, what's not working and what the pain points are. They look after not only the drug portion, but the dental, vision, disability, paramedical, and mental health and wellness aspects of plans.

This is a comprehensive package that, again, four out of five Canadians are enjoying and seeing work well. Let's pay attention to the one in five who are having affordability and access challenges.

The Chair: Thank you, Ms. Eagan.

Thank you, Mrs. Roberts.

Next up, we'll have Dr. Hanley for five minutes.

Mr. Brendan Hanley: Thanks very much for everyone's testimony and for the range of expertise and expert opinion we have today. It's really welcome.

I've heard some, maybe, disparaging comments on the dental program. I just want to point out, on that note, that 100,000 Canadians have been served so far by the Canadian dental program, many for the first time. To me, this is a model of success, early success, of a great program. I think there are some things we can emulate with the proposed Bill C-64.

Mr. VanGorder, I want to go back to you. Thanks for appearing. I'm mesmerized by your backdrop, I must say. You wrote an editorial about pharmacare, and you talked about the successful collaboration between the federal government and P.E.I. in 2021. I wonder if you want to just comment briefly on that, on how that was a successful federal-provincial collaboration.

Mr. Bill VanGorder: We think the agreement between the federal government and the provincial government in P.E.I. is a model that many other provinces could emulate, taking the money that is available, examining exactly where the gaps are and the needs of coverage, and then applying the money specifically to those areas rather than trying to spread the money like a burlap sack over the entire issue. It is a particularly focused and effective way of using the money. We think that, in the long run, it will prove very effective, especially for the seniors in that province.

Mr. Brendan Hanley: Thank you.

Ms. Eagan, I was intrigued by your comment in your opening remarks about updating the Canada Health Act. Then you mentioned the importance of, for instance, coverage for outpatient cancer therapies. We know how big of an issue that is. Have you done any analysis on what it would actually take to update it? Can you tell me a bit more about what your vision is?

I know that's outside of the scope of Bill C-64, but I am intrigued.

Ms. Carolyne Eagan: Definitely, I would agree to rewriting the Canada Health Act, but it would be quite a task.

What I can tell you is that what we see—

Mr. Robert Kitchen: I have a point of order, Mr. Chair.

Earlier, when my colleague was doing her presentation and making a comment about Ontario and what transpired, a member from across the floor, Mr. Naqvi, basically called my colleague “stupid”. I would ask that this be stricken and that he apologize.

The Chair: Mr. Naqvi, do you care to respond?

Mr. Yasir Naqvi: Mr. Chair, I would never call any member of this House or any individual by that term. I did not call the member that at all. If she feels that this was the case, I apologize. That was not my intention.

● (1510)

The Chair: Thank you.

Please continue, Ms. Eagan.

Ms. Carolyne Eagan: I think that this is an important part that we need to examine.

A brief example—again, a boots-on-the-ground example, I would say—is that we had a recent patient who was in the hospital for chemotherapy. They were prescribed a pill. Their prescription went outside of the hospital to be filled and came back in the hospital to be administered. Now what do we have? We have a $10,000 monthly bill where, according to the Canada Health Act, it was prescribed. The hospital went out to fill it, and now you have the public system and the employer system confused as to who should be responsible to pay.

The bottom line is that a therapy like this that is high cost is allowing this person to leave that hospital and be productive at work and healthy long term. This pipeline of drugs that is coming and available to Canada.... We want to make sure that we can work together to cost-effectively build a national strategy for high-cost and rare diseases.

Thank you for the question.

Mr. Brendan Hanley: Thank you.

I'm assuming I have preserved some time from that point of order.

The Chair: You have 40 seconds.

Mr. Brendan Hanley: I will quickly go to you, Mr. Williams.

You have a very interesting background from your experience with Innovation Canada, with Research Canada and with a political career.

I don't have time to go over the preamble but, in this bill, we talk about supporting modernization of the health care system with drug data and improving coordination. We talk about the national strategy for rare diseases.

Is there room for improving collaboration and innovation within the context of Bill C-64? Do you see that there is potential there?

Mr. Russell Williams: There has to be. We have to find the room to make sure that we continue to encourage innovation, research and development. As we're trying to make sure that, on one hand, we respond to the uninsured and the under-insured, on the other hand, we want to make sure that we continue to develop new treatments and new technologies that improve care. One of the challenges of what you're trying to do is that it's a balance that we're trying to work on.

One thing that I think we're trying to say is that we would like to be able to help people get answers to your questions so that we understand how we're going to do it, and I would encourage that we do that.

The Chair: Thank you, Mr. Williams.

We're almost at the hour, but not quite. We're going to shorten the last two rounds of questions, and then we'll thank and dismiss the panel. The next two rounds will be three minutes.

Dr. Ellis is next.

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

Thank you to the witnesses.

Before we finish, Mr. Morin, I'd just like to ask a question. Are you still a practising pharmacist?

Mr. Benoit Morin: Yes, I am a pharmacist. I am practising. I practised yesterday. I own a pharmacy in Montreal.

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

Do you hear patients? Has the issue around the cost of prescriptions become worse in the last several years, with people not being able to afford their medications?

Mr. Benoit Morin: I've been practising for 30 years.

I'm going to switch to French. It's going to be easier for me.

[*Translation*]

I don't think so.

Quebec's public pharmacare plan was initially free of charge. The deductible and copayment were introduced later, but that was a challenge at one point.

I often see social problems in my practice. I see that some people don't join the plan because they're unable to do so. People need help navigating the system. There are a lot more social needs than financial problems.

I believe we need innovative solutions to help people in difficulty. They're out there, and I think it can be done through social services.

[*English*]

Mr. Stephen Ellis: Thank you very much. I appreciate that.

Mr. Williams, you talked a bit about meeting with the minister. It's interesting that these lists exist. Did you have any conversation with the minister? It appears that they have no bearing on reality, so why did the government create them? Did that come up in your conversation?

Mr. Russell Williams: Rather, we chose to offer what we thought was a good list, and that's why the document that you all have in terms of the comparison of our clinical practice guidelines as well as the NIHB program—

● (1515)

Mr. Stephen Ellis: I'm going to interrupt you. I have only a couple of seconds.

Did you talk about the list or not?

Mr. Russell Williams: Yes, so—

Mr. Stephen Ellis: But you didn't ask why they created the list if it has no bearing in reality.

Mr. Russell Williams: What we said was that it was not adequate compared to our clinical practice guidelines.

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

Ms. Eagan, to you in the few final seconds we have left, we've talked a lot about public plans and private plans, etc. You have incredible experience with respect to this.

Have you ever come across a public plan that is better than a private plan and, if so, what is it?

Ms. Carolyne Eagan: Do you mean within Canada?

Mr. Stephen Ellis: Yes.

Ms. Carolyne Eagan: I have not heard of one that is better, but I would defer to doing further research, but to my knowledge, I have not been made aware of one. When you talk about lists of drugs and time to access, I have not heard of a better public fund.

The Chair: Thank you, Ms. Eagan.

Thank you, Dr. Ellis.

The last round of questions will go to Ms. Sidhu for three minutes.

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

My question goes to JDRF.

Yesterday we heard from Heart and Stroke that more than 600 people in Canada die every year from ischemic heart disease because they cannot afford their medication. We also heard testimony from a type 1 diabetes patient, Mr. Bleskie, who said that insulin is not a luxury; it's a necessity. We also heard that they have to pay $1,600 a year per patient, so there is a lot of savings from this legislation.

Ms. Diniz, from our work on the framework, we know how important this legislation in front of us is to all patients and their families.

What are you hearing from the young type 1 diabetes patients and their parents? What expectations do they have from the committee when it comes to Bill C-64? Can you explain that?

Ms. Jessica Diniz: Thank you very much for the question.

I agree that diabetes is a very expensive disease to manage. I think there are points in time, with respect to insurance coverage, when it can be more costly. This bill will help the uninsured and the under-insured significantly.

As I've stated, insulin is required to stay alive. It's not a luxury. It's not an add-on. It's something that's needed. I encourage the committee to make sure we're focused on first principles of providing better access to the medications and devices that are required and then look at the mechanism of how. That's how we're looking at this. What's our first principle here? It's to have better access for Canadians.

In terms of your question regarding what people are looking for, it's better access that's affordable and equitable. It shouldn't matter which province you live in or what age you are. All Canadians with diabetes should have access to the medications they require.

Ms. Sonia Sidhu: Thank you.

My next question is for Mr. Thibeault.

We know that education and awareness.... You know how important education is, living with type 2, especially.... In Brampton, you and I have talked about that and Diabetes Canada is helping with the awareness campaign.

What are you looking at for the diabetic devices and also the education campaign, when we roll it out? What are your thoughts on that?

Mr. Glenn Thibeault: Thank you for the question.

As an individual who is fortunate enough to wear a continuous glucose monitor, it has completely changed the way I can manage my diabetes. It's allowed me to stay in the green—for those of us who have it and understand what that's all about.

Therefore, making sure we can get access to devices—I know we're going to talk about the device fund at another time—is an absolute game-changer for people who live with type 1 or type 2 diabetes. I think that when we have the opportunity to start talking about the device fund in a more fulsome discussion—right now, it's pharmacare—we are going to be able to raise all boats.

Through the advocacy we have been doing over the last year within Diabetes Canada, we now have provinces and territories right across the country with some form of continuous glucose monitor or insulin pump coverage. That's great, but there are still gaps that need to be filled. Having the device fund, and then coming in with the education component that will be needed to teach people and ensure they understand how they can do this, will be key.

We're going to continue to advocate and do our job within Diabetes Canada to talk about the importance of devices, education and medications at the provincial and territorial level.

We work with NIDA as well, which was here yesterday on the indigenous component. We do a lot of work with JDRF. We met with the minister as a team yesterday to talk about some of the clarity we're looking for on choice and we were thankful to hear that.

As such, we'll continue to be a strong voice for the people who are living with diabetes in this country.

● (1520)

The Chair: Thank you, Mr. Thibeault, and thank you to all of our witnesses on this panel.

It's hard to get time with a panel that's so diverse and large. Ms. Diniz, we very much appreciate your sticking with us to get the technological issues resolved. We appreciate your participation and everyone's participation.

We're going to suspend now until 3:30 to allow these witnesses to take their leave and for the next ones to get in.

Thank you again, and have a good weekend, everyone.

We are suspended until 3:30.

● (1520)

_____(Pause)_____

● (1530)

The Chair: I call the meeting back to order and welcome our final panel of witnesses.

In accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

Joining us for this panel as individuals are Dr. Marc-André Gagnon, associate professor at the school of public policy and administration at Carleton University, and Dr. Steven Morgan, professor at the University of British Columbia, who is appearing by video conference. On behalf of Action Canada for Sexual Health and Rights is Dr. Wendy Norman, Public Health Agency of Canada chair of family planning and research. From the Best Medicines Coalition, John Adams is the board chair.

We're going to invite you to offer opening statements of five minutes in length.

Before we do, I will remind everyone that if they want to submit amendments for Bill C-64, the deadline is in 25 minutes, as was pointed out at the start of the meeting.

We're going to proceed now with opening statements in the order listed on the notice of meeting, so we're going to start with Dr. Gagnon for five minutes.

Welcome to the committee, Dr. Gagnon. You have the floor.

● (1535)

[*Translation*]

Mr. Marc-André Gagnon (Associate Professor, School of Public Policy and Administration, Carleton University, As an Individual): Thank you very much.

My name is Marc-André Gagnon, and I am a professor of public policy at Carleton University. I have been working on pharmaceutical policy issues for the past 20 years and have written more than 150 articles, chapters and technical reports on those same issues. I have no commercial conflicts of interest.

I am always astounded by the way our governments kowtow to the power of pharmaceutical companies and commercial lobbyists to the detriment of the Canadian public.

The evidence is clear: As recommended in the Final Report of the Advisory Council on the Implementation of National Pharmacare, the Hoskins report, a universal public pharmacare program would help to provide better access to drugs for all Canadians and to lower costs by approximately 20%.

However, the government still hesitates and has only announced coverage for contraceptives and diabetes drugs, while trying to maintain the present hybrid private-public system, which has become a model of inefficiency and waste all around the world.

The problem stems from the fact that drug coverage in Canada is a system of fragmented and disparate parts. It is an unfair and ineffective system lacking any consistency or overall objective. There are some who believe we can solve the problem by adding new parts, but the fundamental problem is that the system is fragmented.

Let's remember that Canada is the only country with a universal public health insurance system that doesn't include prescription drugs, as if the latter weren't an essential health care service. Canada ranks third, after the United States and Germany, among countries with the highest per capita drug costs in the world. Canada remains one of the countries with the biggest percentage of citizens who, for financial reasons, can't access the drugs they need. More than 10% of Canadians avoid filling their prescriptions for financial reasons.

Today I've heard many people with obvious conflicts of interest proposing that we introduce a mandatory private system such as the one in Quebec. By the way, Quebec is the only province in Canada where per capita drug costs exceed those of Germany. Thus, by following Quebec's example, Canada could become the country with the second-highest drug costs in the world after those of the United States. That would mean that we essentially want a publicly funded Quebec-style system with expensive drug coverage for high-risk patients receiving the highest-cost treatments.

A Quebec-style system would increase drug spending by $5 billion a year and would do very little to lower financial barriers for access to the drugs people need. We would be introducing a mandatory private plan that is incapable of providing coverage for the most costly patients, who constitute a bad risk and would be offloaded to the public plan for expensive drugs.

In short, we would be asked to pay more to create an inefficient system by making private plans mandatory and undermining our ability to negotiate lower prices, while demanding public funding to cover the risks of the private plans. We want a mandatory private insurance program that doesn't cover risks. It's quite fascinating. That's what we're demanding. That's what I've been hearing.

There's a dangerous barrier to the introduction of a universal public plan as the Hoskins report recommends, and that's the fact that too many stakeholders, including provincial and territorial governments, benefit from the present system of unclear prices and whisper discounts. The provinces' public plans don't know how to contain costs and merely shift them around within a fragmented system.

Take Repatha, for example, an anti-cholesterol drug. Its official price is $6,000 a year, and the whisper discount is an estimated 90%. So the actual cost of the drug is $600 a year, and the difference is a rebate that goes to the payer. In Quebec, patients insured under the public system pay a deductible of $23 a month, and their copayment is 33%. To buy Repatha, they will ultimately have to pay $1,200 a year out of their pocket for a drug that costs only $600 a year. In addition, to be guaranteed this kind of coverage, they are required to pay a premium of $731 a year. This isn't insurance; to a certain degree, it's a scam.

On the other hand, the private plans, innocent as doves, have to pay the full price of $6,000 a year without any whisper discounts, not the government-negotiated price of $600 a year.

● (1540)

The present system has become an opaque institutionalized scam, which is unacceptable. Too many actors are lining their pockets and have every interest in preventing anyone from eliminating waste.

We need an efficient universal public program to contain costs for Canadians; we can't just shift costs elsewhere in the system onto the shoulders of the patients and workers. We need a universal public plan with the necessary institutional capacity to ensure that we get value for our money and promote good prescription habits based on solid evidence, not the arguments of corporate marketing campaigns. We need a rational insurance plan, as proposed in the Hoskins report. I would remind you that the Trudeau government has committed to following that report's recommendations.

I will be pleased to answer the committee members' questions.

The Chair: Thank you, Mr. Gagnon.

[*English*]

Next up is Dr. Morgan, please, who is online.

Welcome to the committee, Dr. Morgan. You have the floor.

Dr. Steven Morgan (Professor, School of Population and Public Health, University of British Columbia, As an Individual): Thank you.

I'm an economist and professor of health care policy who has studied pharmacare systems for 30 years. I have published over 150 peer-reviewed research papers on related topics, and I serve on the World Health Organization's technical advisory group on pricing policies for medicines. I have no financial ties to commercial interests in this sector, and I have no have financial ties to health professionals, unions or other groups who also take an active interest in this file.

I am here simply because I wish to help Canada develop the institutional capacity necessary to fairly and efficiently provide access to necessary medicines in a very complex sector that involves some of the world's most powerful corporate interests and very serious, truly global challenges regarding the reasonableness and transparency of pricing.

I want to start by saying that we do not need another study of whether or how Canada should implement a national pharmacare program. These questions have been thoroughly investigated by four separate inquiries since the mid-1990s. All of these inquiries have recommended that carefully selected, medically necessary prescription drugs be included in Canada's universal single-payer public health insurance system.

The latest of these studies, the June 2019 report of the advisory council on the implementation of national pharmacare, was conducted by a council of experts from across the country and chaired by Ontario's former health minister, Dr. Eric Hoskins.

The Hoskins council, as it is known, consulted with provinces and territories. It consulted with first nations. It consulted with patients, health professionals and other stakeholders in the sector. It consulted with Canadians from coast to coast. It concluded with a detailed and feasible plan for implementing a universal single-payer public pharmacare program that would save Canadians billions of dollars every year while improving access to medicines from coast to coast and reducing strains on our health care system.

The foundations of Bill C-64 are backed by thorough discussion and analysis. I believe Bill C-64 can, if the government actually wishes to do so, move us toward the fair and efficient pharmacare system that has been recommended by commissions time and time again.

However, as it is written, Bill C-64 will not do this. This is because it does not make absolutely clear what type of pharmacare program the bill would establish. This ambiguity in Bill C-64 allowed the Parliamentary Budget Officer to conclude that the system that would be created would be a fill-the-gaps pharmacare system involving a patchwork of literally thousands of private and public drug plans. Indeed, even the Minister of Health testified yesterday that he would create such a program with the powers that Bill C-64 would give him.

This would be disastrous for Canada because patchwork pharmacare systems inject needless and costly inefficiencies into the system. They impose significant inequitable financial burdens on individual households and employers, they diminish a country's purchasing power on the global market for pharmaceuticals and they isolate the management of medicines from other key components of the health care system.

It would be especially problematic to have for-profit insurers involved in the core of a national pharmacare system. This is something that only the United States permits. It is problematic because insurers can actually profit from higher drug prices through higher administrative fees charged to plan sponsors. They can also profit by pocketing secret price rebates that they can and do negotiate with drug manufacturers and pharmacies.

If the first stage of national pharmacare is allowed to be a fill-the-gaps program involving a mix of private, public, for-profit and not-for-profit insurers, subsequent stages of national pharmacare will almost certainly be locked into that model too.

If, contrary to the recommendations of its own advisory council on the topic, the government wishes to implement a fill-the-gaps system, then it can leave Bill C-64 as it is, because that is what this legislation will deliver. In this case, the NDP should understand that their supply and confidence agreement has been broken.

If, on the other hand, the government does indeed wish to implement the recommendations of its own advisory council on this topic, then it must amend Bill C-64 to set out crystal clear standards for a national program that will prove that Canadians are, in fact, stronger together. That is what Canadians deserve, but as the bill is currently written, that is not what Bill C-64 will deliver.

Thank you.

● (1545)

The Chair: Thank you, Dr. Morgan.

Next, from Action Canada for Sexual Health and Rights, we have Dr. Wendy Norman.

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

Dr. Wendy Norman (Public Health Agency of Canada Chair, Family Planning Research, Action Canada for Sexual Health and Rights): Thank you, Honourable Mr. Chair and members of the committee. Thank you for the opportunity to speak today to your study of Bill C-64.

I am a family doctor and a UBC professor, and I have had the honour to serve for the past decade with the Public Health Agency of Canada as the chair for Canada for family planning research. I'm the co-chair on Statistics Canada's expert committee for sexual and reproductive health. I have worked with Health Canada to advance several of the programs within the sexual and reproductive health themes over these past several years, and as a long-time collaborator with Action Canada for Sexual Health and Rights.

There are two points I hope to bring expertise and experience to and highlight for you today. The first is that universal access to free contraception to prevent unintended pregnancy will support immediate, lifelong and intergenerational impacts for individuals and families, and society as a whole, that improve health and health equity throughout Canada.

Secondly, our modelling in Canada and examples in practice across the globe indicate that universal, comprehensive, single-payer, first-dollar coverage of contraception is required to address the needs of people at risk of unintended pregnancy. In Canada, 40% of pregnancies are unintended, and contrary to what you might expect, most unintended pregnancies result in unplanned births. The devastation of facing an unintended pregnancy and managing whatever outcome can have lifelong and intergenerational consequences not only for that pregnant person and their partner, but for the unplanned children and the children and other relatives already in the home.

The most comprehensive, most effective contraceptive methods have the highest upfront costs. The least expensive contraception has the highest rates of unintended pregnancy. In the case of longer-acting contraception, such as implants and intrauterine devices, which are our most effective methods, the cost can be over $400 up front. For many, this need for contraception conflicts with the money they need for rent or food. Due to their much higher effectiveness to prevent unintended pregnancy, however, those same “most expensive” methods have the lowest overall cost for government.

More effective contraceptive methods offer families a better and safer start for their planned and appropriately spaced children, while supporting family members to pursue advanced education, to better their opportunities, to contribute to the workforce and our economy, and to service their communities. In contrast, people unable to afford to manage their own fertility face lower educational achievements, lower household income and higher exposure to intimate partner violence. Their children, in turn, suffer lower rates of food safety, adequate shelter and graduation from high school.

Through a Canadian Institutes of Health Research-funded, UBC-led study from 2015 to 2019, the Government of B.C., Action Canada and a wide range of our collaborators modelled the cost effectiveness for prescription coverage in B.C. We found that among people who experienced unintended pregnancy and sought abortion, only about 30% had access to any form of subsidy for contraception, and the contraception cost was the factor most related to those subsequent unintended pregnancies.

For over two years, we worked with the B.C. government on variations of patchwork contraception coverage and compared them to comprehensive coverage through the modelling process. We looked at all kinds of models to address specific gaps. In every case, as soon as we moved from universal, comprehensive, first-dollar, single-payer systems, the rates of unintended pregnancy went up and the overall health system costs went up.

With a model of universal coverage, the B.C. government most effectively reduces unintended pregnancy while lowering overall health system costs by over five dollars for each resident of the province each year.

Evidence from health systems around the world indicate that a universal, first-payer prescription subsidy, rather than partial, fill-the-gap coverage is required to support health equity. Analysis after the institution of the U.S. Affordable Care Act determined a savings of over seven dollars for each dollar invested in contraception and contraception counselling. Similarly, Public Health England has found it's saving nine pounds for each pound it spends on universal prescription contraception.

● (1550)

An important factor here is that contraception is a stigmatized prescription. This is particularly true among equity-deserving populations and those in our society who face the most intersectional barriers. Our study found that reproductive-aged people, and particularly women at the ages of highest fertility, are the least likely to have stable, full-time jobs providing prescription benefits.

In fact, in analyzing the impact of the new B.C. policy for free contraception, we found that prior to its institution, 40% of those who bought contraception had to pay out of pocket completely, and another 20% had private coverage that required copayments. This isn't even looking at all of the people who weren't able to access contraception at all because of cost. Once B.C. implemented their policy, these out-of-pocket costs decreased to less than 10% of those accessing contraception.

We know that among those—

The Chair: Dr. Norman, I'll get you to wrap up. You'll have lots of time to elaborate in the questions and answers.

Thank you.

Dr. Wendy Norman: Thank you.

I'll just say, then, that adolescents and people whose insurance is held by a parent or a coercive partner are in a particularly difficult situation and much less likely to access coverage if they need it.

There are few investments in health that have the potential to offer both health system savings and improved equity and health equity for children and families. Bill C-64 would support improved health for people throughout Canada.

I apologize, Mr. Chair, for going over the time.

The Chair: Thank you, Dr. Norman.

Next is Mr. John Adams on behalf of the Best Medicines Coalition.

Welcome, Mr. Adams. I know you've been in the room. You know the drill. You have the floor.

Mr. John Adams (Board Chair, Best Medicines Coalition): Mr. Chair and health committee members, thank you for the invitation to be a witness at these historic hearings regarding pharmacare for Canadians.

Our Best Medicines Coalition represents 30 patient organizations, from Parkinson's, arthritis, hemophilia and blindness to cancers and other complicated and rare diseases. Together, we represent the interests of millions of patients and their caregivers.

I'm happy to have moral support from JK Harris of the Canadian Breast Cancer Network and one of our member organizations, who's here today. Thank you very much, JK, for being here.

BMC's aims are simple.

Number one is to fix the postal code lottery by ensuring all patients have access to the medically necessary medicines they need and ensure patients are meaningful participants in the development and oversight of pharmacare policies.

We at BMC recognize that Canada is the only developed nation with a universal health insurance system that does not include universal coverage for prescription drugs used outside of hospitals. This gap results in disparities within and among provinces, territories and indigenous jurisdictions where individual programs provide varying levels of drug coverage. This is what we call the postal code lottery.

As a result, one in 10 Canadians reportedly do not take their prescribed medications due to out-of-pocket costs. This highlights significant inequities in access to necessary medications. Up to 7.5 million citizens—one in five Canadians—don't have prescription drug insurance, have inadequate insurance to cover their medication needs or do not enrol when eligible.

Cost and coverage aren't the only problems.

Here's the bad news for anyone in the Ottawa bubble: Sixty-four per cent of Canadians believe that the federal government is not transparent enough about its health care policies. This lack of transparency erodes public trust and hinders the effective implementation and uptake of health initiatives.

Then there's data. Inconsistent reporting and lack of transparency in health data hinder the measurement of performance and outcomes, decrease opportunities for identifying gaps in data and services, and impede the capacity of the health system to integrate patient voices.

There's also a lack of representation of patient voices within governments and government-funded organizations in generating and implementing drug policy. One result is a health care system that is less responsive to patient needs. This can potentially compromise the quality of care and lead to a disconnect between patient expectations and the care provided.

In addition, existing complicated patient pathways cause significant stress and anxiety for patients and their caregivers, potentially exacerbating health conditions and leading to worse health outcomes. Thirty per cent of Canadians experience difficulties in navigating the existing health care system, leading to significant delays in receiving necessary medical attention. Changes in pharmacare must not create new barriers to innovations to address the unmet needs of patients.

The involvement of patients should be done with more than an expedited and truncated consultation on such a foundational expansion of the social safety net of Canadians. Patients should be built into the programs and the structure, not just with an occasional consultation. For example, patients—and that's plural—should be on the board of the Canadian drug agency.

We have eight friendly recommendations for amendments to the bill. I'm right at the clock, so if somebody could do us a courtesy, we'd love to have those eight submitted. They're in our written submission.

I want to highlight two key points of patient interests.

First, create a chief patient officer at Health Canada. Second, create a patient ombudsman who reports directly to Parliament. Only MPs and senators can make this ombudsman role come to life.

The chief patient officer at Health Canada would work within the organization. It should be someone with lived experience whose role gives them authority to ensure that the patient experience and expertise is recognized and used to drive reform and improve patient outcomes. This person should further be supported by an advisory committee with diverse patient representation, which this legislation doesn't quite contemplate yet.

The patient ombudsman would work outside the organization and report independently to Parliament. Besides reporting on any failures to uphold the act and regulations, this ombudsman would also assess barriers and concerns as expressed by patients when it comes to accessing medications and would recommend changes.

● (1555)

These amendments to Bill C-64 would enable and reinforce transparency and accountability. It's not enough for any government to say that they want universal access to medications. Bill C-64 should speak to the role patients must take in improving equitable access to medications.

With your questions, I'd be pleased to go into detail on all eight of the proposed amendments we suggest to better support patients.

The Best Medicines Coalition calls on Parliament to do its best for Canada's patients. On behalf of all patients, nothing about us without us.

Thank you.

The Chair: Thank you, Mr. Adams.

We'll now begin with rounds of questions starting with Dr. Ellis for six minutes.

● (1600)

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

Thank you to everyone for being here.

It's certainly with interest that we'll pursue this next round of questioning.

I don't want to start a fight between Dr. Gagnon and Dr. Morgan, because your bios both say that you're Canada's leading expert in pharmacare systems. It's a good thing you're not both in the room. It might be interesting.

That being said, I'll start with you, Dr. Morgan.

You've written 150 papers about pharmacare and how to implement it. I'm interested to know how much consultative time you spent with the government on this Bill C-64.

Dr. Steven Morgan: I was not directly involved in developing this piece of legislation or the bill at all.

I've worked with government and advised different people within the bureaucracy and government over many years, but I was not involved in drafting Bill C-64.

Mr. Stephen Ellis: Thank you for that.

Through you, Chair, to Dr. Gagnon, were you involved in the drafting of Bill C-64?

Mr. Marc-André Gagnon: Absolutely not.

Mr. Stephen Ellis: I have two Canadian experts who had nothing to do with this. This scares me.

That being said, Dr. Gagnon, you talked about the universal health care system and a universal pharmacare system. I was a family doctor for a long time. The Canadian Medical Association president from a couple of years ago, Dr. Katharine Smart, said that the universal health care system was on the brink of collapse. Clearly we have a system that, for a whole host of reasons, is not working. It's not managing well, and it's not being managed well.

Why would we want to enter into a universal pharmacare system? I'll even put myself in the same boat. It wouldn't matter if it was a Conservative government or a Liberal government. Why should we trust the federal government to make another system that, in my mind, is probably just going to fail Canadians?

Mr. Marc-André Gagnon: When it comes to implementing universal pharmacare, it doesn't have to be the federal government that does this. It can be done at the provincial level. It can be done through specific agencies that are being put in place for this through different types of social insurance systems. You can have an independent agency taking care of this.

With the current fragmented system, there are no common objectives, and there's massive waste. Right now we have 100 different public drug programs, and we have more than 100,000 private drug programs going in every direction. You end up with a system that, if you want to navigate and play the game, basically, doors are very much open for abuse, and we're seeing this a lot.

When it comes to cleaning up what's happening, a universal single-payer public system remains the best thing to do. Then you can have all the other players adding on with supplementary coverage. Be they provinces or private payers, it's not an issue, but we need a solid foundation that works well, is efficient, works rationally, gets us value for money and also promotes a more appropriate use of medicine.

If we have these building blocks, then we can see in terms of.... In French, we say *la finition*. We basically see what adds up, and we can build different things. However, we need the solid foundation, and it's not there right now. For example, we are not prepared for all these new, superexpensive drugs coming to the market. We are not prepared to face the music. Canadians are not prepared, because we don't have these foundations now.

Mr. Stephen Ellis: Thank you very much.

Dr. Morgan, I'll turn to you. The other thing is that often we've heard in the last couple of days testimony related to the length of time it takes a medication to get on formularies on behalf of Canadians, often thousands of days. We have Health Canada, PMPRB, CDA, CADTH and pCPA, etc. It would appear to me that it would also have been a good idea in this Bill C-64 to add some oversight of those agencies, specifically the newly formed CDA.

Do you think that would be of benefit here, or do you have some other ideas around the necessity to get drugs to market on behalf of Canadians?

● (1605)

Dr. Steven Morgan: I have a couple of points. I'm glad you raised the issue around timeliness in terms of drug approvals and coverage decisions. Some of the evidence that's been cited in testimony in these hearings comes from reports that start the clock, so to speak, when a medicine is first approved in any country internationally. It doesn't take into account the fact that manufacturers themselves choose to delay the introduction of a drug into some markets for strategic purposes, but also often they'll trial drugs in markets like the United States, Germany or Japan and then choose whether ever to even launch in other markets. Nearly half of all drugs that are trialled in that way don't make it to other markets. That's important to know.

With regard to delays in approval times, I think there are concerns about making sure that Health Canada is adequately staffed and resourced to make its timelines. There are also concerns about the fact that the fragmented system we have right now, with CADTH and the pCPA and then the provincial decision-making that follows it, is one that does beget long delays in coverage decision-making. In fact, it is one of these processes where no means no in terms of the recommendations from the advisory bodies, but yes only means “maybe”, because provinces are not bound to complete the coverage equation.

A truly national program, managed by an agency such as the Canadian drug agency or something like that, which was given the budget to manage and the task of making sure there was timely access, would be a system that would make sure we don't have those kinds of delays. It should be reasonably independent, but it should be accountable for performance.

The Chair: Thank you, Dr. Morgan.

Next we have Mr. Naqvi, please, for six minutes.

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

I'll start my line of questioning with Dr. Morgan and Dr. Gagnon.

You both are experts in pharmacare. You've studied this. Can you talk about the impact of the lack of a pharmacare plan on the general health of a population? We can talk about Canada. What's the impact? I'm assuming it's negative. If it is negative, in what ways does that manifest itself?

Dr. Gagnon, perhaps we can start with you first.

Mr. Marc-André Gagnon: That's an excellent question. Basically, lack of access is a very important issue, and low-income workers are normally the most impacted by this. For racialized communities, in particular, based on surveys that were made looking at barriers to access, looking at issues of race, it was a big problem.

What the PBO did not include in all the costing was how much money we would be saving in hospitals, in emergency rooms, if people could have the right access to the drugs they need.

Keep in mind, the PBO report showed that we would be saving more than $2 billion a year, but also by extending it by 13.5%, we will be increasing, basically, the number of prescriptions by 13.5%. This is 13.5% of the people who need prescriptions right now and are not getting them. They are the people who end up in emergency rooms, and then this is for hospitals...because if they go there, then it's not the same budget. Their drugs are being paid for by the hospital. We see this a lot, and it is something super important when we do all the budget and costing and stuff.

There are other issues that for me are also very important. When it comes to social security, if I'm in Quebec, on social security, I will be getting something like more or less $15,000 a year. If I try to start working, let's say, 15 hours a week, because that's all I can do, I get access to my drugs with no premiums. There's nothing to pay. Everything is for free as long as I'm on social assistance. However, as soon as I want to get out of this, basically, then I need to pay huge premiums in Quebec. I need to pay my full premiums even if I'm only working part time. If I'm working only 15 hours a week, basically, I end up with maybe $20,000 in terms of revenues, but then something like maybe $2,000 a year in premiums for my prescription drugs.

In terms of creating poverty traps, Sheikh Munir met with people and wrote this report about the reform of social assistance in Ontario. That was one of the huge barriers, the huge poverty traps. Basically, people end up trying to stay in programs where they can have access to their drugs, because if they switch to a different status they might lose access and that has an impact on their health—morbidity and mortality.

Maybe I have one last point on diabetes. There was a study 10 years ago, basically showing if, in Ontario only, we had universal, single-payer, first-dollar coverage for people with diabetes, that would save 700 lives a year. This is amazing. We're not doing anything about this, because it's not two planes that are falling onto the street and everybody is dying. It's just, “Oh, well, these are statistics somewhere. It's 700 people, and they were sick anyway. This is not important.” This is freaking important.

Yes, these are some of the issues.

● (1610)

Mr. Yasir Naqvi: Thank you, and I appreciate your passion.

Dr. Morgan, do you have any points to add to Dr. Gagnon's?

Dr. Steven Morgan: No, other than to say that this has been thoroughly studied, and the business case for making sure we have universal access to appropriately prescribed medications is unequivocal. It is good for the country's health. It's good for the health care system.

Mr. Yasir Naqvi: I want to come to Dr. Norman. Thank you for being here and bringing the perspective of Action Canada to this conversation.

On the same theme of cost savings in the health care system, can you talk about what kind of impact we can see from having universal access to contraceptives, which is contemplated in Bill C-64?

Dr. Wendy Norman: Absolutely.

As a family doctor who's been working in family planning for most of my professional life, I regularly see people coming in for recurrent unintended pregnancies. They do not want to be pregnant, they hadn't wanted to be pregnant and they have no access to the ability to manage their lives so that they can continue in their education, get out of a toxic relationship or be able to undertake the job training to move into a profession they would like. They're saddled again with an unintended pregnancy. Some of them will go on to ensure that they aren't pregnant through to delivery. However, most will end up having to look after other children and then have child care and other actions in their homes that take time of their lives that they could have used to advance the care of the children they already have and for themselves and their lives.

When we talk about cost savings, we can show—and all over the world systems have shown—that single-payer, first-dollar, universal contraception coverage will be able to have better health outcomes and lower pregnancy-care costs.

I think we have to look, as well, at the costs to our next generation and to the fact that they will have lower achievements throughout their lives due to the inability of their parents to have accessed universal contraception, so then it becomes intergenerational in—

The Chair: Thank you, Dr. Norman.

[*Translation*]

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

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

Greetings to the witnesses who are with us on this third panel.

My first question is for Mr. Adams, from the Best Medicines Coalition.

Mr. Adams, in recommendation 6 in your brief, which I have here in my hand, you say that the Minister of Health is required to establish a special pathway so that, in certain conditions, patients may be prescribed a drug or treatment that doesn't appear in the formulary.

As you know, under the Quebec plan, patients who require drugs that constitute a treatment of last resort may be reimbursed for the cost of those exception drugs.

The proposed plan provides no guarantees regarding those drugs.

What would you recommend if we found support for that concern?

Mr. John Adams: Pardon me, but I'm going to answer in English.

[*English*]

We've heard a lot about Quebec today in the conversation. Thank you very much for the question because it highlights one distinct aspect of Quebec that the rest of Canada should emulate.

The other thing we heard a lot about is that not every patient responds in the same way to the same drug. We need some variety and some choice. Quebec has a mechanism where a doctor can apply to a truly independent scientific review committee that is outside of the health bureaucracy for a drug that the doctor knows the patient needs, whether or not it's been approved by Health Canada and whether or not it's being funded through the existing system.

I come from a rare disease community. PKU, phenylketonuria, is not life-threatening; it's only brain-threatening. I have a son with it who is a responder to the first pharmaceutical, a true and full responder. Every patient with PKU who has received access to that first drug for PKU has been approved through Quebec's unique exception patient program. There will always be outliers.

What we need to achieve and work towards is precision medicine, a molecule that works for the individual given that individual's genetics and biochemistry. We're not all the same. One size does not fit all. It would be a great improvement for national pharmacare, as a concept, to always have that safety valve for the exceptional patient. There are decades of working experience in the province of Quebec that we can all learn valuable lessons from.

● (1615)

[*Translation*]

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

I'm glad you acknowledged that distinction, which, as you know, goes beyond pharmacare. We could definitely conduct another study on that subject alone, but I'm not sure it would be in the Standing Committee on Health. But we'll have that discussion at a later date.

Mr. Adams, you say in your brief that no patients in Canada should lose the drug coverage they currently have with a private plan as a result of the reforms and programs under Bill C-64 and that the changes made must not leave patients in a worse situation than before the reforms were introduced.

Would you please explain your concerns to us?

[*English*]

Mr. John Adams: We hear many concerns and criticisms of the version of the model proposed in Bill C-64, and I've heard additional criticisms from my fellow panellists today. We're hearing mixed messages about whether this is such a good idea or not, as proposed.

As the parent of two sons and two daughters, I care about sexual reproduction and sexual health all the way around. Also, as I used to be prediabetic and am no longer, I care about medicines for diabetes. The drug that turned me from a prediabetic into a non-diabetic is not on the list as proposed by the Minister of Health at the moment. Those are specific examples. There's a great deal of uncertainty.

Also, in previous government initiatives at the federal, provincial, territorial and indigenous levels, there have been unanticipated or unintended consequences. Therefore, you should make haste slowly. I think the bill is a useful start, but this legislation is in need of improvement and has many opportunities to be improved.

[*Translation*]

Mr. Maxime Blanchette-Joncas: Mr. Adams, again in your brief, you make a very important point:

> All governments—federal, provincial, territorial and indigenous—must work together and consult stakeholders, including patients and the organizations that represent them. The emphasis must be on establishing an effective and simplified infrastructure designed to improve patient care and guarantee a high degree of fairness, with a full range of drugs available to all based on medical needs and provided in a timely manner.

I completely agree with you that everyone should get the best care. With that in mind, don't you think the federal government should increase health transfers to enable Quebec and the provinces to improve their health systems and thus the care given to patients?

● (1620)

[*English*]

The Chair: Please give a brief response if you can, Mr. Adams.

Mr. John Adams: I'm old enough to remember when medicare was sold to Canadians and to provinces and territories on the general concept of fifty-fifty cost sharing. We should take a look at that.

The Chair: Thank you, sir.

Ms. Zarrillo, you have six minutes, please.

Ms. Bonita Zarrillo: Thank you so much, Mr. Chair.

I want to get some clarity from you before I begin my questioning. You mentioned that the time for amendments was a while ago, so any input that comes today will not be able to inform an amendment. Is that correct?

The Chair: That's correct.

Ms. Bonita Zarrillo: Okay.

I want to say what an amazing and informative panel this has been. Because we cannot have a technical influence on the bill at this time, I do have some questions around equity and fairness. I want to focus on gender equity, because I think that, if there had been more women in the government at the federal level, we would be a lot further along, certainly, on contraceptives.

Dr. Norman, I want to ask you specifically about getting results. We know that B.C., as you mentioned, has free contraceptives now. Could you share some of the arguments or factors that got the B.C. government to implement free contraceptives? Obviously, it's something that I, along with many people right across the country, would like to see.

Dr. Wendy Norman: Thank you very much, Member Zarrillo, through the chair, for your question.

We were funded by CIHR to conduct a study in which the Government of B.C.'s Ministry of Health was one of the partners in setting the main research question and how to analyze the results so that we would be able to support it in what the impact of a subsidy system for contraception would be on health and equity in B.C.

First, our study undertook a province-wide sexual and reproductive health survey. In 2021, this government was able to use the basis that we made for that sexual and reproductive health survey to implement a sexual and reproductive health survey across Canada, which we'll be fielding later this year. It will be run by Statistics Canada.

I think this is key moving forward, as we implement precontraception through this bill, in my hopeful way, to be able to measure the impact. This is because this was what B.C. used to measure the need, and it was how we determined where there were inequities and how those inequities could be addressed through universal contraception.

Undertaking surveys of people and being able to look at health systems and health administrative data in comparison with the survey data.... StatsCan's new survey that will go out will also be linked with a personal health number to health administrative data so that we'll get specific, disaggregated equity data on the gaps for people in achieving their sexual and reproductive health.

The baseline in 2024, of course, will be before any impact of this bill, but I think it will be very important, moving forward, for the government to continue to have, as one of Statistics Canada's core surveys, a sexual and reproductive health survey that allows us to disaggregate and understand those equity barriers across Canada.

I don't know if I've answered your question in the way you wanted.

Ms. Bonita Zarrillo: You have, and it's spurred another question.

You've been working in reproductive health for a very long time, so I'm sure you have some indication of how those surveys are going to come back. However, my question is about what factors you think contribute to the difference in prescription insurance coverage described for the population overall and for those at risk of unintended pregnancy. I'm quite sure you're going to get information about the disaggregated groups that have unintended pregnancies.

Dr. Wendy Norman: Yes, absolutely.

As you have heard from other panels here today, I'm hearing that experts in the insurance industry say 97% of people have some form of coverage. Well, we are certainly not seeing that in sexual and reproductive health. When our studies have looked at those presenting with unintended pregnancies, we find that up to 70% have no coverage at all.

When we've been able to look overall at the prescriptions accessed in B.C. through the pharmacy, for people who have already accessed and purchased a contraceptive, 40% had complete out-of-pocket payment with no insurance whatsoever, and another 20% were required to copay. This copay and not having insurance for that 60% of those accessing contraception don't even illuminate for us the wide range of people who weren't able to access contraception at all because of that inequity of cost.

The people who need contraception tend to be those in the reproductive age range. The age range of the highest fertility among women and people of any gender who are pregnancy-capable has one of the lowest rates of permanent, full-time jobs that offer coverage. There's a gig economy. People are still in school.

The coverage that people in this sector of highest fertility have—where they might have it—is often through a primary plan holder for coverage, who has power over this person. The need to disclose their use of contraception is a barrier for people in coercive relationships or for adolescents on parents' plans—

● (1625)

Ms. Bonita Zarrillo: I'm going to interrupt you there because I want you to go on with that one a bit.

I'm a female. Like many people, by the time you're 16, you're having conversations about contraceptives and needing contraceptives. I made note of your comments about parents or coercive partners. Maybe you could share the risk that presents to teens and very young females.

Dr. Wendy Norman: Yes. As many of you are aware, the highest fertility rates are at the time closest to your teens and decline after the late twenties. In this age range, people are often still living at home, or if they are away from home, they're often in relationships, sometimes with a partner who is the person controlling their access to contraceptives or to funds.

These individuals face so many intersecting barriers to achieving their own gender equality. They have to choose between buying a contraceptive or paying their tuition, rent or food. Clearly, the other three aspects are their first priorities so that they can continue on in their lives, and they'll use no contraception or a much less expensive method that has high pregnancy rates and then present with an unintended pregnancy that may stop their education altogether and prevent them from going into the workforce.

The Chair: Thank you, Dr. Norman.

I have Dr. Kitchen, please, for five minutes.

Mr. Robert Kitchen: Thank you, Mr. Chair.

Thank you to all for being here. It's greatly appreciated, given that it's late on a Friday. Our windows are closed, so I have no idea what the weather is like outside, but I appreciate your all being here at this point in time with your presentations and comments.

As you all understand, ultimately, we're looking at the legislation. To me and to you, I believe, this is about what we can do to make this piece of legislation better. What steps and suggestions can you put forward that we should be able to utilize so that we can make amendments, if needed, to this? That's a huge challenge because, as we've heard, those amendments have to be in by four o'clock today, so there are concerns as to whether they will be put forward and whether they even be passed or not. Time will tell along those lines.

One thing that I think is being alluded to but not really hit on is that health care is provincial. It's been touched on by a number of you that it is a provincial issue, and it comes to that aspect of the provinces being able to do what they need to do.

Dr. Gagnon, you made some comments on looking at steps that could be done, and you did indicate or suggest, at least what I thought I heard you say, that it could be done at the provincial level.

Are you suggesting that we as the federal government should be putting in legislation to tell all the provinces that they should be putting in a universal health care plan?

● (1630)

Mr. Marc-André Gagnon: Certainly having some help from the federal government to implement this would be something that would make things way easier, I think, for provinces.

You say that health care is a provincial jurisdiction. I don't want to get into legal stuff, but constitutionally, health care establishments are of provincial jurisdiction. When it comes to prescription drugs, it is more complicated, because this is outside health care establishments. That's one thing.

When it comes to drug approval, this is criminal law in terms of determining which substance is illegal versus legal, and if it's legal, there are ways to have some access to it with pharmacies and everything. This is why we have Health Canada, basically, approving the drugs. And at the same time, when it comes to the pricing of these drugs, this is based on the Patent Act, which is also at the federal level.

Like it or not, when it comes to prescription drugs, the federal government already has two feet, basically, in this field. It doesn't mean that the provinces shouldn't have anything to say about this. I mean, I'm a proud Québécois. When we put in place our pharmacare system in 1997, at the time, basically, it was perceived as a first step towards universal pharmacare, but when we put in place a hybrid system, we kind of locked in all these commercial interests, basically, that can abuse the system in different ways. It is not normal that, in Quebec, we are the second place on this planet with the highest cost per capita when it comes to prescription drugs. Nothing is being done about it. Instead of containing cost, we'll just shift the cost elsewhere in the system.

Mr. Robert Kitchen: I appreciate it. I apologize for having to intervene. It's because I have such limited time.

I appreciate that comment, but ultimately it still comes down to the provinces needing to make those decisions on what they believe—as Quebec has done, and every other province should be doing—is best for them.

Mr. Adams, I appreciate what you presented and the eight recommendations you put forward. I think there are some good things about them. Ultimately, when we look at the legislation and the amendments we're dealing with in this little piece that we have right now. The scary part is whether that will grow over time. I think in some ways one of your recommendations relates to what's talked about with the national formulary, when we talk about the Canadian drug agency.

I'll just read one of your recommendations to you. It says, “The Canadian Drug Agency must be established in legislation rather than at the direction of the Minister of Health, subject to Parliamentary oversight, the Access to Information Act, Auditor General scrutiny and interventions by a Patient Ombudsman.”

Those are recommendations that are suggesting in many ways, in particular for this agency...but we've also seen this in the legislation where we talk about building a committee but we have no idea who those people will be in those roles. I'm just wondering if you could comment on that.

The Chair: Answer briefly, please, Mr. Adams.

Mr. John Adams: Thank you.

I don't know if there's procedurally any way to get an extension to five o'clock for those amendment guidelines. I toss that out there for what it's worth.

This bill gives the minister substantial new powers. It could be improved by building in various forms of transparency and accountability, as I've said. Those are some of the things.

With all due respect, I think it defers too much to the black box called the Canadian drug agency and doesn't put transparency or accountability mechanisms around what could become a very important role in system reform. That's the plea.

You're members of Parliament. Don't cut yourselves out of accountability and transparency. Build it into this legislation by amendment.

Thank you very much.

The Chair: Thank you very much.

Ms. Sidhu, go ahead, please, for five minutes.

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

Thank you to all of the witnesses for being with us. Thank you for your amendments and submissions to the committee. Thank you for your work.

My question is for Dr. Norman. It's mostly a question for you.

First of all, are you able to speak about the B.C. program? It's a successful program. Do you have any data to share with us? I know it's a successful program. Can you share the data?

● (1635)

Dr. Wendy Norman: Thank you, Member Sidhu, for a great question. I'm very proud of the work we've been doing with the Government of B.C. over the last 10 years to build toward this program. I am working within the ministry under a non-disclosure agreement to assist the ministry in evaluating the implementation of the program. I have access as well to independent research we've been conducting at UBC on health administrative data. I can share with you things that we've found on our own but not the wonderful, amazing things that we're finding within the government in our own evaluation.

What we can see from the health administrative data access that we have through the university is that we have thousands of people requesting these new contraceptives and the most highly effective contraceptives since the policy was put in place about a year ago in B.C. There are thousands every month. In fact, we had such a surge, such sustained requests for these most effective contraceptive methods, which have been out of reach for people in their personal and household economies before this, that the B.C. media has been reporting on the wait-lists in the health system and the service factors that are now being addressed to be able to meet this unmet need. When you see that even the media notices there was such a high degree of unmet need in the province that the rush of people to access intrauterine devices and contraceptive implants....

This matchstick-sized device that people can put in their arm has a lower rate of pregnancy than tubal sterilization, yet it can be removed at any time. It can last for up to three years. People are rushing to be able to get these more effective methods rather than what we've had before. The rates for birth control pills might have nearly 100 times as many people pregnant each year.

Yes, B.C. has been a success story. We are superexcited about the numbers we're seeing from the comprehensive data within the government and even from the data available in media reports and through the publicly accessible data we can access through UBC. It's an out-and-out success story. This is a way that people are now meeting their needs to be able to stay in school, to contribute to the workforce and to realize their own dreams for whether and when to have children and how to space them.

Ms. Sonia Sidhu: Dr. Norman, what recommendation can you give to this committee on the education component during the implementation? How can we work with the provinces, territories and indigenous groups in working with young women and girls, their families and potentially schools on raising awareness about the program? You talked about contraceptive stigmatization. Yesterday we heard about teen pregnancy.

Can you talk about that?

Dr. Wendy Norman: Thank you. This is a wonderful question. I think it's a piece of the puzzle that we all need to pay attention to.

I would come back to the need across Canada for a comprehensive national sexual health survey that's iteratively and regularly administered so that we can disaggregate and understand where we can target education programs and where we can target outreach health systems that can get to those populations that inequitably aren't able to understand the knowledge, the methods and the services they require to achieve their own reproductive health goals.

To have the ability to address a problem, we first need to understand it. To understand it, we need to measure it. I think the baseline sexual health survey that will go out this year will provide a lot of data for the government on where we could be going, but it won't help us understand how this bill and other future efforts by the government in terms of the amazing work the government's been doing to advance sexual and reproductive health through Health Canada.... These impacts need to be measured as we go forward.

● (1640)

The Chair: Thank you.

[*Translation*]

Mr. Blanchette-Joncas, the floor is yours for two and a half minutes.

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

I'm going to continue my questions with Mr. Adams.

Mr. Adams, earlier today, a group of witnesses told us it was important to ensure that the expert committee that is struck isn't a pro forma group, by which I mean one that has no actual responsibility or that has an advisory role. Those witnesses asked that the pharmacare advisory and national strategy implementation groups be given the information they need to provide genuine advice rather than serve as a sounding board or merely provide tacit approval of decisions made in camera. Do you agree with that? What you have to say to us about that?

[*English*]

Mr. John Adams: We had many lessons recently from a little thing called a pandemic.

Some of us took the time to observe the advisory processes in another jurisdiction south of Canada. The CDC and the FDA advisory committees, whether they were dealing with vaccines, therapeutics or other things, I could watch those on Zoom. I could read the background materials and I could come to my own informed view. Did they get it or did they miss it?

When those advisory processes take place inside a black box and you can't see.... I welcome this opportunity. We're in public. People can make their own evaluations on whether I get it or not. I can make my evaluation on whether you get it or not. It's open, it's transparent and we can be accountable.

Too much of the process at the federal, provincial and territorial levels takes place behind closed doors, in black boxes. I would appeal to this committee to move amendments to start opening doors, opening windows and letting the sunshine in.

[*Translation*]

The Chair: You have 28 seconds left.

Mr. Maxime Blanchette-Joncas: Mr. Adams, what essential measure would you add to ensure that things are well done?

[*English*]

Mr. John Adams: There are specific things in our written submission.

I think you need to try to do your best to ensure that freedom of information and access to information rules apply to the new model that this bill is trying to build for pharmacare. Ensure that there's accountability, so the Auditor General of Canada can go in and do value-for-money audits.

There should be a new function of an ombudsman, so that people who think the system has not responded to them in a fair and reasonable way have an ability to access, without going to court, a review and oversight function. Those officers and the health minister should be required to report back to Parliament on a regular basis on steps, progress, problems and alternatives.

The Chair: Thank you, Mr. Adams.

Ms. Zarrillo, you have two and a half minutes, please.

Ms. Bonita Zarrillo: Thank you.

I just wanted to ask a question each of Dr. Morgan, Dr. Gagnon and Mr. Adams. I only have about 30 seconds for each answer. Each of you said something that I'm interested to know, outside of this bill.

Dr. Gagnon, you referred to an institutional rip-off. What can we do to fix that, outside of this bill?

Mr. Adams, you said “postal code lottery”. What can we do to fix that?

Dr. Morgan, you talked about fairness and efficiency.

Maybe I could start with Dr. Gagnon.

Mr. Marc-André Gagnon: One example is Trintellix, which is an SSRI antidepressant. It came to the market and CADTH, at the time, basically did the evaluation. There was no clinical evidence that this new drug was bringing anything more as compared to existing drugs. The recommendation was to not pay a penny more for this drug than the lowest-priced drug of this category. Trintellix still entered the market with a price 10 times what it was for other drugs in the same category.

I was reading an annual report from the company Lundbeck that said that in Canada, Trintellix—this drug that doesn't have any clinical evidence that shows any advantage as compared to other drugs—managed to capture 24% of the antidepressant market in Canada.

In terms of rip-off, if we have a system that says that you can make a commercial blockbuster with a drug that doesn't bring anything new, basically the message we're sending, in terms of incentives for innovation, is don't innovate. We have a crappy system that will take in anything at any price. In terms of institutional rip-off, this is what is missing in terms of getting value for money.

● (1645)

Ms. Bonita Zarrillo: Thank you.

Mr. Adams, go ahead, and then Dr. Morgan.

Mr. John Adams: For the "postal code lottery" line, I have to give credit where credit is due. It's not my line; it's the line used by the immediate past federal minister of health, Mr. Duclos, in March of 2023 when he announced the go-forward of the plan for drugs for rare disorders. I was there. It was ad libbed by the minister. It wasn't in his prepared text.

It captures the essence of some of the inequities in the lists of drugs that are or aren't covered in various jurisdictions.

I think there is a compelling role for the Government of Canada and the Parliament of Canada to make financial contributions, so that access gets not to the lowest common denominator but to a much higher common denominator for all patients, no matter where they live and no matter what postal code in Canada they're in.

Ms. Bonita Zarrillo: Thank you.

Dr. Morgan, I hope you have time there.

The Chair: You don't, but if you can answer very briefly, we'll allow that.

Dr. Steven Morgan: I think what you do is build national capacity to procure, with ironclad contracts with manufacturers, medicines of proven safety, efficacy and value. Essentially, we need to implement the recommendations of the Hoskins council.

The Chair: Thank you very much, Dr. Morgan.

Next, we have Mrs. Roberts, please, for five minutes.

Mrs. Anna Roberts: Thank you, Mr. Chair.

I'm going to ask yes-or-no questions of everyone, starting with Dr. Gagnon.

Do you think family doctors are crucial?

Mr. Marc-André Gagnon: Are they crucial?

Mrs. Anna Roberts: Are they important to society?

Mr. Marc-André Gagnon: Yes.

Mrs. Anna Roberts: Dr. Norman, what is your answer?

Dr. Wendy Norman: As a family doctor, I think I have to declare my conflict of interest, but my answer is a resounding yes.

Mrs. Anna Roberts: Okay.

Dr. Adams, please go ahead.

Mr. John Adams: Yes, and thank you for the promotion.

Mrs. Anna Roberts: Dr. Morgan, how about you?

Dr. Steven Morgan: Yes, alongside other primary care providers.

Mrs. Anna Roberts: I'll tell you why I'm asking this question. In Ontario, the province I'm from, we have a shortage of 2,500 doctors. Over two million people don't have a doctor, and by 2026, there will be 4.4 million people without a doctor. In Ontario alone, 1.7 million people have a family doctor who is over the age of 65. In Canada, six million Canadians don't have a family doctor.

The reason I bring this up is that a couple in B.C., Jane and Steve Williams, have been on the waiting list for a family doctor for three years. He recently went in for emergency surgery, and he has no family doctor who will be able to help him.

Here we are talking about pharmacare and taking care of our patients. How can somebody get the required medical attention and have the drugs prescribed to them that they will need?

I'm going to go back to Dr. Morgan because I want to make sure I get this right. You made a statement earlier that this is a "patchwork system," and I have to agree with you. I don't think this system was well thought out.

If I understand correctly, Dr. Norman, you said you were part of the panel. Is that correct? Were you part of the pharmacare investigation on the panel with the government?

Mr. Marc-André Gagnon: I am Mr. Gagnon. Dr. Norman is....

Mrs. Anna Roberts: I'm sorry.

Mr. Marc-André Gagnon: No, I wasn't part of the pharmacare panel.

Mrs. Anna Roberts: Were you, Dr. Norman?

Dr. Wendy Norman: Was I part of the panel to...?

Mrs. Anna Roberts: Were you part of the panel to develop the pharmacare plan?

Dr. Wendy Norman: I worked with the B.C. government to provide evidence that supported their development of their plan for contraception. At the request—

Mrs. Anna Roberts: Were you part of the plan federally?

Dr. Wendy Norman: —of the Minister of Health in B.C., I was able to present to the Minister of Health federally and to other federal departments.

Mrs. Anna Roberts: All right.

Dr. Wendy Norman: I provided evidence. I wasn't part of their internal process to develop the bill.

Mrs. Anna Roberts: Okay. We have experts here who were eliminated from that. I'm a little confused about it.

Dr. Morgan, with this patchwork system that you mentioned earlier, how is it that this pharmacare plan will benefit Canadians?

● (1650)

Dr. Steven Morgan: One of the things is that if we move to a system that is truly national, universal and single-payer, Canadians will have increased access to medicines from coast to coast. We can use national procurement contracts to get better prices for medicines. We can use those same contracts to make sure manufacturers guarantee the supply of medicines when Canadians need them and when we know shortages are all too common internationally.

It's true that if the federal government were to fund these first stages of contraception and diabetes treatments and leverage the purchasing power nationally to get the average price we find in comparative countries, that system might actually cost more than the PBO has estimated, but it would deliver savings to the provinces and territories on the order of about $1.3 billion per year—

Mrs. Anna Roberts: Okay. I—

Dr. Steven Morgan: —and it would deliver savings to the private sector of $1.7 billion per year and net savings to the country of $700 million.

Mrs. Anna Roberts: I'm sorry to cut you off, but I do have limited time.

My concern is that Bill C-64, in its current state, does not give specific enough information to ensure that this plan will benefit Canadians. Unless I misunderstood you, that's what I took from your statement.

Dr. Steven Morgan: This plan will provide some new coverage, but it will cost significantly more than it should and will continue to impose inequitable financial burdens on individual households and employers.

Mrs. Anna Roberts: Would you agree that individuals with private health care and private plans are better off than they would be with the current plan the government is offering?

Dr. Steven Morgan: They're not better. There's no change. That's what the minister basically said yesterday in testimony. They'll just have the same coverage through their private insurance under this new plan.

What we want to see is a change where they can actually see their medicines being procured nationally through a public program that takes the financial burden off their households and their employers.

Mrs. Anna Roberts: Right now, that doesn't happen.

Dr. Steven Morgan: That's not what this bill will achieve.

Mrs. Anna Roberts: Exactly.

The Chair: Thank you, Dr. Morgan.

Thank you, Mrs. Roberts.

The last round of questions for our examination of Bill C-64 will come from Mr. Jowhari for the next five minutes.

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

I thank all the witnesses for joining us today.

We're well into Friday afternoon. I know that it's past four o'clock, and most of the amendments have probably already been written down and passed on, but I want to emphasize the fact that this bill will go through clause-by-clause on Monday. It will be sent back to the House. We will have the opportunity to debate it, and then it will go to the Senate. That will present more opportunities for us to highlight areas where we could strengthen it.

I'm going to focus most of my questions on Dr. Morgan. I noticed that you were patiently waiting and that a number of times, you wanted to intervene. You were not given the opportunity, so I'm going to dedicate all my five minutes to you.

You were very complimentary about the Hoskins report. You also said that if certain elements are considered in the design, then this bill, Bill C-64, would be a good starting base for us to introduce pharmacare.

If I get up next week in the House and debate those areas on third reading, using Hoskins as a base and saying, “Hey, look, this is the reality of Bill C-64; this is the base in Hoskins, and these are the three areas I want to focus on to make sure this bill is strong”, what would those three areas be?

You have all the time you want before the chair stops you.

Dr. Steven Morgan: Yes, I'll be quick.

There are minor amendments to clauses 4 and 6 of Bill C-64 that would probably suffice to make sure that even though this is just like baby steps, the pilot project for implementing Hoskins' recommendations, if you make a couple of key amendments, you can genuinely say that this legislation is actually going to do what Hoskins said.

For instance, clause 4 of Bill C-64 reads, “The Minister is to consider the following principles”. I think the Conservative members of this committee pointed out that this is unusual language. It should say, “The Minister shall apply the following principles”. That's important language.

In proposed paragraph 4(d), it reads, “provide universal coverage of pharmaceutical”, but the Hoskins council was very clear that it should be universal single-payer, first-dollar public coverage. There's language there that could be improved and clarified.

As was discussed yesterday at this committee, this bill should define what is meant by “single-payer”, “first-dollar” and “public coverage”. Those are terms that are very clearly defined in the Canada Health Act, which would be the analogous act to Bill C-64 in terms of establishing principles that all provinces and territories should aspire to in delivering these things. There are a few changes there.

Similarly, in clause 6, where it talks about the kind of coverage that should be implemented, it should be very clear what we're talking about. As the Hoskins council recommended and as many other commissions have recommended, the program should be universal, single-payer, first-dollar and public. That word needs to be there.

● (1655)

Mr. Majid Jowhari: Thank you.

I want to go back to another topic, and I want your input. As it relates to, let's say, diabetes, and as it relates to the different types of diabetes medications, the minister has said that this is basically our floor. We will negotiate with different jurisdictions, provinces, territories, indigenous groups and others. We'll look at their needs, and then we'll expand that.

What are your thoughts on that?

Dr. Steven Morgan: If I were to design a program like this, I would start with the most compelling evidence-based basket of medicines that should be provided.

You've heard witnesses testify that some of those compelling medicines, including GLP-1 drugs, such as Ozempic, are outside of the current proposed basket, so you might go back and think carefully about what would be included.

I want to be clear that if you do this as a truly universal plan, as a truly single-payer plan, buying medicines on behalf of 40 million Canadians, you would have such purchasing power that you could include a comprehensive basket of treatments for contraception and diabetes and save considerable funding while doing so. It can be done in a very prudent way, and it should be evidence-based but also sufficiently well funded so that it does meet the needs Canadians have.

The Chair: Thank you, Mr. Jowhari.

Thank you to all of our witnesses. This was an absolutely fascinating panel and a really good one for us to finish on.

We are coming up to the time that has been designated by the House for adjournment. Before we adjourn, separate and apart from thanking the panel, we've been very well supported by the clerks, the analysts, the technology people, the IT folks and the interpreters throughout this process. On behalf of the committee, I express my gratitude to them.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: We're adjourned.