HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

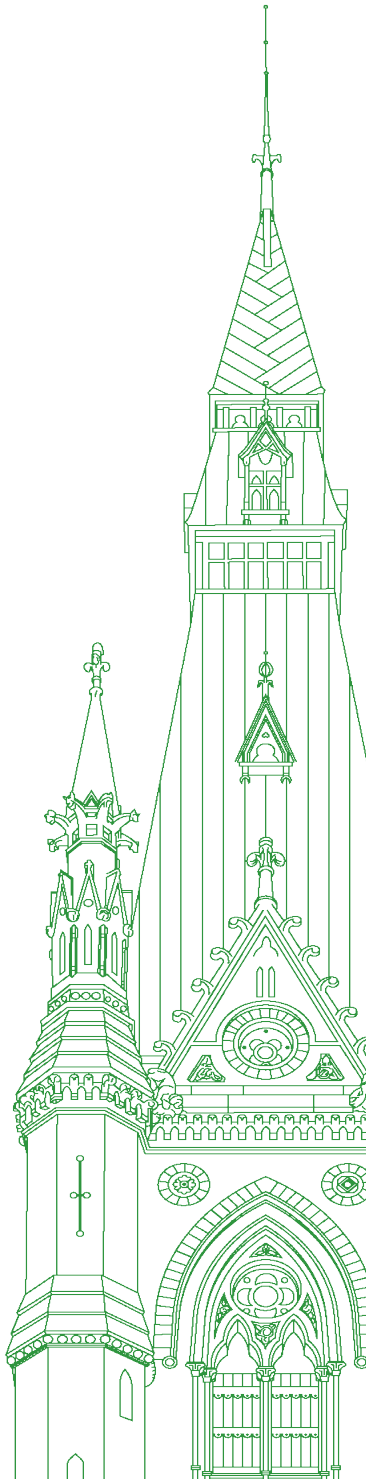
44th PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 129

Tuesday, October 1, 2024



Chair: Mr. Sean Casey

Standing Committee on Health

Tuesday, October 1, 2024

● (1105)

[*English*]

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

Welcome to meeting number 129 of the House of Commons Standing Committee on Health.

Before we begin, I would like to ask all in-person participants to read the guidelines written on the cards on the table. These measures are in place to prevent audio and feedback incidents and to protect the health and safety of all participants, including the interpreters.

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

Pursuant to Standing Order 108(2) and the motion adopted on November 8, 2023, the committee is resuming its study of the opioid epidemic and toxic drug crisis in Canada.

I'd like to welcome our panel of witnesses. Online, appearing as an individual all the way from Somalia, we have Dr. Sumantra Monty Ghosh. In person, we have with us Dr. Rakesh Patel, associate professor and medical director.

Thank you both for being with us. We normally have a larger panel, but this is to our benefit and to yours because we'll have more time for a conversation with each of you.

We're going to begin with you, Dr. Ghosh. Welcome to the committee. Thanks for making the effort to be hooked up from so far away. We have five minutes for opening statements.

You now have the floor, Doctor.

Dr. Sumantra Monty Ghosh (Assistant Professor, As an Individual): Thank you so much.

For introductory purposes, my name is Sumantra Monty Ghosh, but I go by Monty. I'm an assistant professor at both the University of Calgary and the University of Alberta, as well as a frontline physician who works with people who use substances.

I have a strong area of focus around research. Specifically, my research areas include the national overdose response service, which is a phone line that people can call after using substances alone. Seventy per cent of individuals using drugs and dying of overdoses are dying alone. This line helps provide them with support. They just call the line if they're using drugs alone, and they're paired up with a person with lived experience who monitors them. If they have an overdose event or drug poisoning event, EMS will be dispatched to their place.

I also do studies on waste-water testing, specifically in Calgary and the surrounding regions. With waste water in particular, we're looking at monitoring and quantifying substances within waste water, over 48 substances, including carfentanil, fentanyl and methamphetamines. We're also looking qualitatively to see if there are new compounds entering the drug supply. We've had a lot of success with monitoring this. Using this data, we've had an early detection warning system put in place to tell other practitioners that there could be concerns with the waste water. This has also helped us predict and determine why potential spikes and overdoses might happen. As an example of this, back in July 2023, we had a large spike in overdoses in Calgary, and we noticed at the same time that there was a large spike in carfentanil and xylazine within the waste water itself.

Last but not least, a large study was done that we just completed—although not published as of yet—looking at the community's perceptions around supervised consumption services. It included over 2,500 individuals who live in communities across Canada and are not health care providers or people with lived experience to see what their perceptions of supervised consumption services are and what the impacts of them are on their communities. This data is not published as of yet, but we're moving towards publishing it reasonably soon.

I'm glad to talk about any of these topics with the committee. I'm glad to talk about decriminalization as well, which is another area that I'm very much focused on. Last but not least, because I work within the recovery systems of care in Alberta and have a lot of experience with that, I can also share some of those experiences, how things are going within Alberta and the successes that Alberta has been demonstrating.

I'll leave it at that. Thank you so much.

The Chair: Thank you, Dr. Ghosh.

Next we have Dr. Patel.

Thank you for agreeing to appear. I understand that happened fairly recently. We appreciate your being here.

You have the floor, Doctor. Please go ahead.

● (1110)

Dr. Rakesh Patel (Ottawa Inner City Health): Thank you, Mr. Chair and ladies and gentlemen of the committee.

I'll be honest. I'm not quite sure what exactly my role is, or what you'd like from me. Things unravelled very quickly yesterday afternoon. I apologize for being late. There's absolutely no parking in downtown Ottawa, apparently.

I'll tell you what I do. Maybe that will help guide the questions you may have for me.

I am predominantly an ICU doctor. I work here in the city at the Ottawa Hospital. I'm also a general internist. In 2018, I started volunteering at what is known as Ottawa Inner City Health, predominantly because I had a lot of experience in a previous life when I was a pharmacist—before I joined the dark side. I used to work in downtown, inner-city Detroit. I saw the problems that different social systems and a lack of health care can cause. The emergency department was essentially the primary deliverer of health care for the population of inner-city Detroit.

When I wrote my medical school essay, I foolishly said that one day I was going to open up a downtown clinic and look after people who don't have equitable access to health care. When I came to Ottawa, one of my colleagues, Dr. Jeff Turnbull, had already started this. I called Jeff up one day and said that I had to start walking the walk and not living a lie, because I said this is what I was going to do when I applied to med school. It was about time I got off my butt and started walking the walk. That's how I joined Ottawa Inner City Health. I took over from Jeff as the medical director of Ottawa Inner City Health in 2022, just as we were nearing the end of the pandemic.

I work downtown as a frontline physician looking after the homeless and the vulnerably housed in Lowertown and across a variety of different supportive housing and community shelters across the city. I'm responsible for the programs we develop, implement and monitor. Predominantly, those programs are run by frontline nurses, which demonstrates that you don't need a physician at the front line to provide health care. This can be done by people who are kind, compassionate and interested in delivering the care they currently do.

I'll stop there.

The Chair: Thank you, Dr. Patel.

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

Mrs. Goodridge, go ahead, please, for six minutes.

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

I want to thank both witnesses for being here today. It's always a great day when we have more people from Alberta around this table.

Dr. Ghosh, I'm going to start off with some questions for you.

I find the conversation on waste water quite interesting. You talked about how in July 2023, there was a spike in overdose deaths, and the waste water also had spikes.

How are you and the Province of Alberta working to analyze waste water in ways we could potentially catch this before it results in overdose deaths?

Dr. Sumantra Monty Ghosh: Thank you so much, honourable member Goodridge.

That was one of many examples in which we were able to utilize waste water for benefits on a population level. While I share this information with the government as necessary, we're not necessarily working with each other. This is more a research project within the University of Calgary.

Essentially, we're just keeping track of what's going on in the waste water, both from a qualitative perspective, meaning if there's anything new coming in, and from a quantitative perspective, sharing if there are spikes. As mentioned, in 2023 we saw a spike in both carfentanil and xylazine—much higher than we've ever seen before—that coincided with this.

The way this translated was that we alerted the government to it. We alerted our frontline colleagues to the situation as well. In fact, the chief of staff for Premier Smith called us in to talk about the data. Again, one of the things we were able to do was alert the community at large about the situation and people who were using substances.

There were a couple of other instances in which this was beneficial. We were testing drugs at the same time as we were testing waste water, and what we noticed is that for a time, there was a lack of fentanyl in the drug supply, which is very dangerous. The police service in Calgary does their own direct testing and noticed that there were some concerns with the drug supply and there was missing fentanyl. They asked me if I had noticed the same thing. We did some tests and noticed it as well. The reason this is so concerning is that if all of a sudden within the drug supply there are missing drugs, people lose their tolerance towards opioids, and if they use opioids again, they might overdose.

This was a concern. We were able to triangulate the data with the police service and other services. For example, we have colleagues in Atlantic Canada from both the police force and the provider community. We shared this information with them, and they noticed a similar trend. However, what we couldn't figure out was why these two trends were isolated to Atlantic Canada and Alberta. The common thought was that maybe there was some sort of link between the organizational drug crime rings that operate in both areas.

I can share more examples of why it's useful, but I'll leave it at that.

● (1115)

Mrs. Laila Goodridge: That's incredible.

I know you are part of the VODP and some virtual RAAM programs. I was just wondering if you could explain to us why the virtual programs that Alberta has been using are so successful and how you think we could possibly move them to a more national scale.

Dr. Sumantra Monty Ghosh: Just for clarification, I don't work at the VODP, although I did do some virtual stuff for a while with Grande Prairie. It's using a similar platform.

The VODP has been a phenomenal program. They're currently in the process of launching the virtual RAAM—rapid access addiction medicine—program. The difference between the two is that the VODP focuses just on opioids, whereas the RAAM program will focus on everything but opioids. This includes alcohol, methamphetamines, GHB and other substances.

What's remarkable about the program is that it's open almost 24-7. It's open seven days a week from nine to nine. I know they're thinking of expanding to 24-7.

The benefit of this program is that it's what we call a "low-threshold intervention", meaning that anybody who has a substance use concern or anybody who works with someone who has a substance use concern can call their number and seek help. For example, people in rural communities can call the VODP number and seek help right away to get off their illicit substances and onto buprenorphine or methadone. If you are someone experiencing homelessness and don't have a phone, you can get someone to call the number for you, whether it's a social worker, a peer or a police officer.

The VODP has permeated multiple different systems and services. They include the homelessness sector—shelters specifically—and our corrections systems to a certain extent. They include our arrest processing units across the province as well. The reason the arrest processing units are particularly important, in my view, is that I've seen first-hand how some people can go through bad withdrawal within these facilities. From a humane perspective, the most appropriate thing to do is provide them with buprenorphine, which will take away the withdrawal symptoms so they're not in agony.

These are all benefits that we've seen with the VODP.

The virtual RAAM program has not yet launched, but it is going to be launching soon, hopefully. It was supposed to launch on October 1, so we'll see if it launches today.

This whole concept of low-threshold intervention is key. In terms of how this can be expanded across Canada, I there's a place for this in every jurisdiction. I know that Ontario has some programs. I know that B.C. is looking at expanding their programs as well. It has been a hugely successful program, and again, it's because anybody can access it provided they have a phone. If they don't have a phone, they just need to get someone to help and call the number. It's been incredibly helpful in that regard.

I'll leave it at that.

The Chair: Thank you, Dr. Ghosh.

Next we're going to Dr. Powlowski for six minutes, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Dr. Patel, I thought I would ask you a few questions.

It seems we're on a similar life trajectory. I was a long-time emergency room doctor, and now I have taken a job where I'm forced to look at the bigger picture. It sounds like when you're working at Ottawa Inner City Health, you have the same kind of perspective: You're seeing a lot of people with homelessness, mental health problems and poverty.

I've been in Ottawa for only five years, but it seems to me that in the five years that I've been here, things in the downtown core have gotten worse. There seems to be a lot more homelessness. There are a lot more people openly using drugs. There are people overdosing on the street. There seems to be a lot of people with mental health issues. For us to walk into the core to the mall, our chance of being accosted by somebody who's either high or has mental health problems is about 50%.

Maybe I'm wrong, but do you think things have gotten worse among people in the downtown core with addictions and mental health-related problems? Is that the case? If that's the case and you agree, what are we doing wrong, or what do we have to do differently to better address this issue?

● (1120)

Dr. Rakesh Patel: To answer the question directly, before I try to come up with some solutions, yes, the situation on the streets has definitely gotten worse. There's no doubt about it. If you've driven across Ottawa, whether it's the downtown core or outside the downtown core, you will have noticed there are a lot more people panning. I recognize many of the people on the streets who are panning because they are patients of mine. The reason for it is fundamentally because of the drugs that are non-regulated and non-prescribed and available on the street.

I think at least some of the people around this room are old enough to remember *The French Connection*, the movie with Gene Hackman. The drug was heroin. That's how it all started. The problem with heroin is that you can only inject it, and it comes in big quantities. As the drug trade has evolved because of a variety of different policies, both social and medical, what you find is that people become a lot more inventive, and they make a lot more varied and potent products.

Fentanyl, crystal meth, xylazine and things like them that you have heard about are all very potent. A milligram of heroin is equivalent to about a microgram of fentanyl. It's one one-thousandth of the quality to give you the same euphoria, the same tranquility or the same peace that you might have felt with the heroin.

As those policies have been promulgated across the years, essentially they are prohibitionist policies. The fundamental conceit about it is that we can stop human desire, which is clearly wrong. Humans have desires, and we are risk-takers, which is why we got to where we are.

You can't legislate away or policy away human desire, so the approach of using supply-side economics has led to far more potent drugs that are manufacturable in much smaller quantities. They are therefore a lot more concealable and are easily transported onto the street. That supply is now fundamentally on the street.

The issue with the drugs on the street is their pharmacokinetics. It's a fancy medical word that says if you take a Tylenol for your headache, how does your body get rid of it? Why don't you have Tylenol in your bloodstream for the rest of your life? The reason is that it's considered a foreign substance, so your liver and your kidneys do everything they can to get rid of it. The problem with crystal meth and fentanyl is that they have such a rapid onset, even faster in some cases than the nicotine that people who smoke cigarettes take in. The onset time is about 30 seconds to a minute or so. It's a rapid rush. It's a rapid hit, but unfortunately, it doesn't last very long, and because of that, we now see people on the streets who are panning for money.

There's an increased number of people on the streets and more people using drugs on the streets, and I will tell you why that is. You're seeing that because they no longer have time to engage with us to help them get to the social determinants of their health: the lack of housing, the lack of food security, poverty and the lack of life skills. They are so busy trying to get the next hit that they don't have time for anything else.

Mr. Marcus Powlowski: I'm sorry, Dr. Patel, but can I interrupt you? There are only two witnesses, so you'd think I have a lot of time, but I probably have only one chance to ask questions.

You seem like a supporter of safe supply. I know the Swiss model of safe supply is heroin-assisted treatment. There's a lot of evidence on that and directly observed treatment, which I have no problem with. However, someone have described safe supply in most of Canada as the poor man's version of that—giving people a bunch of pills because it's easier to give them a bunch of Dilaudid than it is to observe them injecting it.

The concern is diversion. One psychiatrist in Vancouver told me that he has a lot of kids on Dilaudid and a lot of them move on to fentanyl. I asked him why, and he said that when he asked his kids why, they said you can now buy one dilly on the street for a dollar in places. It used to cost $20, but because of diversion, the price has come down. A dilly costs one dollar. A joint costs five dollars. It's just simple economics. Do you want a buzz? Try—

● (1125)

The Chair: Dr. Powlowski....

Mr. Marcus Powlowski: Do you not see that as a problem, the Dilaudid safe supply model or the Canadian way of doing that?

The Chair: Dr. Powlowski, you talked right through the time.

Dr. Patel, give a very brief answer, please. Dr. Powlowski took all of the time.

Dr. Rakesh Patel: Yes, I'm concerned about diversion, but the majority of diversion doesn't happen in the way you described it. Much of the diversion happens from regulated prescription medication that you find in your medical cabinet.

[*Translation*]

The Chair: Mr. Thériault, you have the floor for six minutes.

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

I'd like to pick up on that. People often tell us that it's easy to circumvent safe supply in places like schoolyards. Some people have pointed out that the safe supply program requires people to go somewhere to see a doctor. In Quebec, these substances are available with a prescription. It's much more controlled than people who are in favour of abolishing safe supply would have us believe.

What are your thoughts on that? We're in the middle of a toxic drug crisis. The black market is pumping out massive quantities of products and substances. Anarchy reigns. We have a deadly drug problem on the streets. What other solution is there if safe supply is abolished?

Without safe supply, how are we going to achieve our objectives?

[*English*]

Dr. Rakesh Patel: Thank you for the question. I appreciate it.

The fundamental concern that people have about safe supply is what you guys have all alluded to, which is diversion, but the reality is that kids at school—high school students and university students—do not buy dillies from the people I look after downtown. Those people are scary. They look unkempt. They look threatening. Those are not the people the school kids are buying their dillies from. Their dillies are coming from the drug dealers who know how to manufacture them very cheaply and can get them to someone who looks like them and will act as their proxy. That's where the predominant number of drugs that are so-called diverted from safe supply are going.

Safe supply prescriptions are actually well regulated. I write those prescriptions. There are many times when we observe patients take those medications because we don't trust them enough to take them away. We trust some people. That maintains their autonomy. It helps build trust and allows us to engage with the other physical and mental health care disorders they have.

The number of people we have at Ottawa Inner City Health on safe supply is 50. There are far more prescriptions written for morphine and hydromorphone in an acute care hospital on any given day than those 50 people are getting.

Yes, there's an observation that school kids are using dillies. The inference that they're from safe supply is incorrect. You cannot connect those dots easily, reliably or consistently.

[*Translation*]

Mr. Luc Thériault: You said earlier that, if there's no way to reach these people, that means work at the community level needs to be done. For example, people on the front lines who are dedicated to harm reduction seek out contact with addicts to address their social determinants.

When we did a tour, we noticed that the good stories, the ones with happy endings, always started with supervised housing, among other things. Individuals are given a roof over their head and the right to supervised consumption. Gradually, these individuals were able to control their addiction. Having a fixed address enabled them to find a job and, over time, break the addiction.

That path seems much more difficult, and it can take a long time. Do you think it's better than something like forced detox?

● (1130)

[*English*]

Dr. Rakesh Patel: Yes. The problem with forced treatment.... First of all, we don't do it for diabetes, hypertension, rheumatoid arthritis or pneumonia. That's because we want to preserve your autonomy over health care. The underlying hypothesis of forced treatment is that it's one and done. I treat you, you're better and you go home. That's not the case.

When you're working on the sharp end of the stick like I am, you recognize that addiction or substance use disorders are a complex and wicked problem that involve not only health care but the social determinants of health. A simple, single approach for all patients is never going to work. It's a chronic disorder; it's not an acute disorder.

It's no different from managing diabetes. We know what the problem in diabetes is, for example, which is insulin. We still can't cure diabetes, and we've known about insulin since 1922. If we can't cure diabetes, how can we hope that a single addiction treatment is going to solve a complex and wicked problem like addiction?

You have to start somewhere. As an ICU doctor, my fundamental job is to keep you alive. It's to buy you time and, in the meantime, figure out what is actually going on and come up with a comprehensive plan to look after you. It's no different on Murray Street and King Edward Avenue. When somebody is addicted, my job is to keep them alive using a harm reduction approach.

We use harm reduction in all aspects of our life. This committee just used a harm reduction approach when it made me go through security. You don't know who I am. You might be afraid that I might hurt you, so you have a harm reduction process that prevents me from doing that. Most of you probably drove here today, or you had somebody drive you. Your car has harm reductions: seat belts, anti-lock brakes and airbags. You put your seat belt on. Why did you do that? There are traffic signs and traffic laws we all have to follow, yet people still die from traffic accidents. I know this because I look after them in the ICU, but we don't ban driving.

The Chair: Thank you, Dr. Patel.

That's our time for Monsieur Thériault.

Next we have Mr. Johns online for six minutes.

Mr. Gord Johns (Courtenay—Alberni, NDP): Thank you, Mr. Chair.

It's an honour to be joining you on the unceded lands of the Tseshaht and Hupacasath nations.

I'm sorry I can't be joining you in person. I was home for the National Day for Truth and Reconciliation and I couldn't get back to Ottawa in time.

Dr. Patel, in December 2023, you signed a letter, along with more than 130 experts in substance use, calling on the federal government to continue to support and scale up safer supply programs. The beginning of the letter reads:

> As researchers and clinicians across Canada, we are writing out of concern regarding the increased politicization surrounding the response to the drug toxicity overdose crisis that is taking the lives of 21 Canadians every day. We are particularly concerned about the spread of misinformation and the denial of the evidence-base on harm reduction interventions, such as prescribed safer supply programs.

Can you please share with this committee your knowledge regarding the outcomes of prescribed safer supply programs?

Dr. Rakesh Patel: Are you asking me or Dr. Ghosh?

Mr. Gord Johns: I'm asking you, Dr. Patel.

Dr. Rakesh Patel: The entire goal of safer supply is to have a harm reduction framework to try to get you into health care, which includes mental health care and the social determinants of health. There's not one outcome. It depends on what outcome you want to look at and in what way safer supply is helping.

If you want to look at mortality, there's a lot of evidence that safer supply reduces mortality. If you want to look at housing, do people who get safer supply get housed? Yes, they do. Do they get housed as much as we'd like? No, they don't. Do people who get into safer supply ever come off their drugs? Some people do—just like some people quit caffeine, some people quit cigarettes and some people quit alcohol. Do the majority stop? No. It's because they don't want to stop. Why don't they want to stop? The trauma and all the other things they've experienced in their life journey have not been dealt with, so it remains a coping skill for them. The tranquility, euphoria and peace they get from that override everything they're not getting to help them manage the influences that lead them to continue taking that drug.

If you're asking me, as I think you are, whether safer supply is a perfect program, of course it isn't. Is it a program that actually works? Yes. Does it work all the time for all people in every circumstance? No. Neither does insulin, but that doesn't mean we stop giving you insulin.

● (1135)

Mr. Gord Johns: I appreciate your response, Dr. Patel.

Do you remain concerned about the politicization of this crisis? You're saying that a multi-faceted approach needs to be applied. I think I'm hearing that from you. It's not one size fits all, but prescribed safer supply is one of the tools a physician can use to help support their patient. Are you concerned about the politicization of it?

You don't see politicians getting involved in heart disease or diabetes. Every party is saying that this is a health issue. Do you see that being applied given what you're hearing from politicians?

Dr. Rakesh Patel: Yes, I do. It's unfortunate, because substance use disorders, as you've alluded to, transcend political ideology and partisanship. The patients don't ask me what my political affiliation is before they let me examine them on the street. I don't ask them.

It very definitely has become a political issue. Can I share why I think it's become more of a political issue? It's because you are now seeing more people on the street using drugs, whereas before they were in safe consumption sites. That's because the way drugs are used, the availability of drugs and the types of drugs that are available mean that they can no longer take one injection of heroin, get on with their day, get a health card, find a house and get money from the bank like the rest of us do on a day-to-day basis. They now have to spend all their time doing that every hour, and because of that, it's become a visible problem.

That's the issue. That's what is driving politicians to make it a political issue. Just as you very clearly said, I've yet to hear a politician come down to the ICU and tell me how to manage a critically ill patient, yet all politicians, from a variety of different partisanships, have no issue telling me how to do my job at the corner of Murray Street and King Edward Avenue. It's visible. The reason it's visible is that the types of drugs people use have fundamentally changed. They are so rapid-onset and short-acting that patients have to get the next hit.

Let me explain it to you in a very quick way. Patients who inject drugs or smoke drugs, however they choose to do it, know that what they bought on the street they have no idea about. They have no idea, really, what they bought on the street. They may have bought fentanyl, or at least have been told that there's fentanyl in there. You heard from the other physician that there are a lot of contaminants. They know that when they smoke or inject that drug, they may very well die. However, they've experienced withdrawal, and withdrawal for them is a fate worse than death. Basically, they're taking a handgun with a single bullet and spinning the chamber. They're doing whatever they need to do to avoid withdrawal. They would rather die than go through withdrawal.

That is part of the problem. That's how potent and sinister the drugs on the street are. Therefore, one single approach will not solve this problem for us. It just can't.

The Chair: Thank you, Dr. Patel and Mr. Johns.

Dr. Ellis, you have five minutes, please.

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

Thanks, Dr. Patel, for being here.

One thing that I object to and find difficult is.... When you talk about treating diabetics, as a physician you're talking about treating one patient. What we're talking about here is how a population responded to some measures put in place by this coalition government that have allowed more and more people to access the short-acting narcotics that you find so objectionable and, I believe, should.

Maybe you could comment on that. Our job here is not to look after one patient at a time, as yours is. Our job is to try to help an entire country, which is in a terrible crisis.

Dr. Rakesh Patel: I take objection to the idea that I only look after one patient. It's true that I look after one patient at a time, but there is a cohort of patients I manage collectively at Inner City Health. It's not just one patient, and all of their well-being is important to me.

The treatment approach that I use is really not that different from the infrastructure of diabetes. There is a community of patients who have diabetes, have home care, have foot care and have regular clinic visits. There's an entire infrastructure that we as a society have collectively put in place to help manage them, because we view that as an important problem.

I think we should take the same approach to substance and drug use, because it is not a single patient issue, it's not a single entity and it's not an acute problem. It's a chronic problem.

● (1140)

Mr. Stephen Ellis: Thanks for that, Dr. Patel.

On this side, that's not something we're arguing. Realistically, if all we're going to do is give you the substance you're seeking, we're talking about palliative care, because there's no other treatment for you as someone who uses drugs.

Over here, what we suggest is that people absolutely do need comprehensive care—housing, withdrawal management, all those things. However, we're also talking about supporting them while they're doing it. I guess the question is this: Why would we use the so-called safer supply method when we have other alternatives like Suboxone? How could you argue against using it? I don't know if you are arguing against it, but that's my question.

Dr. Rakesh Patel: I do use Suboxone for some of the patients I look after downtown, but that's a patient autonomy issue. Lots of people don't want to be on Suboxone because they don't necessarily want to stop their drug use entirely. I don't want to stop taking a single shot of whisky on a Saturday night, but I want to use it responsibly. As long as they have capacity and turn down Suboxone, I can't force that treatment on them.

I understand the value of Suboxone because there are some patients who take it and do well on it. If the goal is to get them completely off any opioid, whatever substance they're using, and the patient wants to do that, then I agree with you that we should look at alternatives other than safe supply. However, often the only way to get the patients to trust us, as an infrastructure of people at the front lines looking after patients, is to start them off on Dilaudid and get them into the fold. You have to remember—and as a physician, you know that building trust is crucial—that lots of the patients who end up on the street have substance use disorders and have gone through horrible life journeys where the people they wanted to trust let them down, so for us to develop trust takes time.

I wish I could start everybody on Suboxone and see how they do, but the reality is I can't because of an individual's situation.

Mr. Stephen Ellis: The only other argument, Dr. Patel, is related to the fact that, as you and I both know, the opioid crisis was largely fuelled by OxyContin prescribed by physicians. Just for the record, you nodded in the affirmative to that statement. How can we suggest that flooding the market with more and more opioids for people to use at their will is going to be of benefit? To me, that's counterintuitive. It really becomes nonsensical to say that we got into this problem—which we agree on—based on an oversupply of readily available, highly potent short- and long-acting opioids, and now we're going to get out of it by giving people more and more opioids. That seems counterintuitive to me.

I agree with you that we need to create spaces where we have relationships with people, but just saying, "Take whatever you want" doesn't seem sensible to me.

Dr. Rakesh Patel: I would disagree with the statement you're making—"Take whatever you want." That's not the case; that's a gross oversimplification. I think you know that.

The reason to have safer supply is to try to build trust while keeping a patient alive. If they're dead, who cares? Why use Suboxone? Why worry about Billy? He's dead. The problem is gone.

However, we're human. We try not to kill people if we can actually avoid it through a variety of different societal policies. This is no different than that policy. The goal of safer supply—I'll say it again—is to keep people alive so that we can get them the help they actually need. There's no other way around it. If we take away safer supply, people will die. You're going to have a bigger problem on your hands, and that's the issue.

The Chair: Thank you, Doctor.

Ms. Sidhu, go ahead, please, for five minutes.

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

Thank you, Dr. Ghosh and Dr. Patel, for the work you are doing on the ground.

My first question is for Dr. Ghosh.

Dr. Ghosh, you talked about waste-water testing, and you also talked about two programs that are working very successfully. You're co-chair of the Canadian Network for the Health and Housing of People Experiencing Homelessness. Can you talk about the link between homelessness and substance use? Can you elaborate on that first?

● (1145)

Dr. Sumantra Monty Ghosh: Thank you so much, honourable member Sidhu. I can definitely talk about the link there.

First and foremost, in homelessness, the population itself is not ubiquitous; they're very diverse in who they are. As Dr. Patel mentioned, while one treatment might work for one population in one group, it might not work for another.

It's a difficult thing to manage because you have different levels of acuity in that circumstance as well. What I mean by this is that you have new people entering homelessness who are not chronically homeless yet. They are traditionally easier to get back into the housing system than others. These are people escaping domestic violence issues or who had their house burn down, for instance—situations like that. There are also youth experiencing homelessness, which is a different category or group.

In terms of chronic homelessness, one of the big things we see within this particular population is a large number of mental health concerns and a large amount of substance use, as Dr. Patel mentioned. However, there's also a large amount of brain injury. For that population in particular, this is one of the main concerns we have. We see this within various downtown cores throughout the country.

I'm an internist as well. At the University of Alberta Hospital, for instance, I often manage individuals who have a traumatic brain injury from a motor vehicle accident. I sometimes have patients with frontal temporal lobe dementia, and the behaviours they enact are no different from those of individuals I saw and took care of in the shelter at the Calgary Drop-In Centre when I was working there, or in our opioid dependency program, which is above our supervised consumption site. It's a very similar population. The only difference is that within the acute hospital setting, people with frontal temporal lobe dementia have families that are very supportive of them. We get them into long-term care facilities or housing, whereas with this particular population, we don't.

I want to highlight that systematic reviews have been done demonstrating that among the population experiencing homelessness, nearly 50% have moderate to severe brain injuries or moderate to severe cognition concerns. That is huge, yet we don't provide proper support for them.

Ms. Sonia Sidhu: Thank you.

My next question is for Dr. Patel.

Dr. Patel, you're running an Ottawa Inner City Health pilot project. In terms of the patients who received help and changed their lives for the better through your work with that pilot project, what recommendation can you give this committee for what led to their recovery?

Dr. Rakesh Patel: Thank you for the question. I appreciate it.

The fundamental thing that I would request the committee remember is that substance use disorder is a complex, chronic and wicked problem. Lots of different things have to be in place for us to manage it. You had a question about homelessness, which is a crucially important thing, along with the other social determinants of health. The medical and mental health we provide at Ottawa Inner City Health is one very small piece of the puzzle. All of the other things are crucially important.

If you have a home, the reason you benefit from it, whether it's a small apartment or a house, is that you have personhood. When you have personhood, you have a purpose. When you have a purpose, you're motivated to change. I don't know how my patients feel. I can only imagine how they feel. However, if I were living on the street, I would feel like I don't count and that nobody cares. If they did, why would they let me live on the street?

The social determinants of health, I would argue, are going to be far more important in how we manage this problem going forward than safer supply, Suboxone or whatever you want to put out there as a medical treatment. It is going to pale in comparison to what we do about the social determinants of health.

● (1150)

The Chair: Thank you, Dr. Patel.

[*Translation*]

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

Mr. Luc Thériault: Since I only have two and a half minutes, I'll try to be brief so you have time to answer my question, Dr. Patel.

Earlier, you talked about how people are politicizing the fact that this problem has become visible. There are problems with coexistence in cities. I'm sure you're seeing that downtown. Can you speak to that?

Do you think something can be done to address this issue?

[*English*]

Dr. Rakesh Patel: I'm not quite sure I understand the question about cohabitation. Are you referring to—

[*Translation*]

Mr. Luc Thériault: There are the people who live downtown and walk around there, and then there are the addicts who live on the street. You said earlier that this problem had become visible, so people are making it an issue, but that's a red herring.

How can we solve the fundamental problem? That's what you've been trying to tell us this whole time. If not for that red herring, we might not be having this discussion. Still, we need to take action. That's why I want you to tell us what else needs to be done, in your opinion. What are your thoughts on people who complain about the very real problems associated with coexistence?

[*English*]

Dr. Rakesh Patel: I'll start with the end of the question, which is about visibility. That problem is an issue for folks who live around it.

In the market here in Ottawa, for example, there are lots of new condos going up. It's a big issue for people who live there. It's not that the people living in those condos in the market are inhumane; it's that they're worried about their physical safety. That's what it really comes down to.

One way to get that visibility problem off the street is not to shut down safe consumption sites. It's to help support safe injection sites so that people can come out of the cold and into a site where not only are they allowed to use their drugs safely, but we can provide them with food, clothing and water. We can get them to trust us so they come to us when they want to use their drugs, not doing them on the street corner. The street corner, as everybody in this room knows, is going to be a very unsafe place, not only for them, but also for the people who live in the buildings around where that's happening.

There are a lot of different projects that people are doing. One example here in Ottawa is the block leaders program. People who use drugs and have lived experience are looking after those who are new to the problem. They're trying to show them the ropes, basically, as we would do in any other profession, so that they are safe.

My argument is that taking away centres like that—safe consumption sites and the clinic space I have downtown—is not the way, because you're going to push people outside. Part of that is based on the fact that the drug supply is not the same. It's not heroin anymore. Because it's so quick on and so quick off, they spend so much time with it that they don't even have time to come into the safe injection site. They have to do it outside because they don't want to be dope sick. In other words, they don't want to go into withdrawal because that to them, as I said, is a fate worse than death.

If you close down the places where they were going before, where else are they going to go? They have to go to the streets. The dealers aren't going away. They make money. The dealers are always going to be around. If you think pushing away all of the infrastructure we have now, either because you don't understand it or because you're ideologically opposed to it, I would just ask you to step back and think about the alternative.

The Chair: Thank you, Dr. Patel.

Next is Mr. Johns, please, for two and a half minutes.

Mr. Gord Johns: Thank you both for your incredible insight.

Dr. Ghosh, I have a couple of questions. Do you believe there's an urgent need for national standards on substance use treatment programs? Also, can you please share any thoughts or concerns you have about the role of for-profit treatment facilities in responding to the toxic drug crisis? For example, are standards of care consistent between facilities?

Dr. Sumantra Monty Ghosh: Thank you, Mr. Johns.

One concern I have is that there is no standardization around treatment programs across our country, let alone across our province or our own jurisdictions. Some of them are medically supported and medically assisted. This includes sites that provide buprenorphine and methadone, which are evidence-based medicines. There are others that do not provide this and sometimes do forced detox, for example, for opioid use disorder and don't provide opioid agonist treatments. This can lead to a loss of tolerance and risk of relapse once they get discharged from these facilities.

I think there is a need to standardize this across the country. We need to make sure it's evidence-based and evidence-focused. It needs to have a combination of medically assisted treatments, which includes medications such as buprenorphine and methadone. For alcohol, there's naltrexone, for instance, or acamprosate.

There's also a need for an evidence-based system around mental health supports, as well as cognitive behavioural therapy, for example. These are other added layers that we need to have to support this.

It doesn't just end there. We need to also address the social determinants of health, as Dr. Patel alluded to.

Again, there are no standards around this. There's a lack of competency at times with some of these facilities. They vary. Some of them are excellent and some of them are not so great. Some of them are private for-profit and some of them are public. I've seen great private for-profit ones and poor private for-profit ones and vice versa for the public system.

● (1155)

Mr. Gord Johns: We're hearing about for-profit mental health in the United States and that it's skyrocketing.

Can you talk about the dangers that we could be heading towards when we go to for-profit care?

Dr. Sumantra Monty Ghosh: This is something that I struggle with because in terms of the for-profit substance-use care, provided that it's evidence-based and evidence-focused, it does provide an easy route for individuals to access it, provided they have the means to access those services. I don't necessarily think it's a bad thing, but from an equity perspective it does not provide equity to the greater population.

One thing that Alberta has done, if I may, is that it has increased capacity for treatment supports. They're moving towards standardizing it. I haven't seen that yet, but many of them do provide medication-assisted treatments.

Last, but not least, it is providing a bit more rigour around the programming. That is something it is doing, but it's not necessarily ubiquitous. It needs to be better mandated and better standardized, in my opinion.

The Chair: Thank you, Dr. Ghosh.

We'll go to Mr. Doherty, please, for five minutes.

Mr. Todd Doherty (Cariboo—Prince George, CPC): Dr. Patel, do you have evidence that safe supply isn't being trafficked or diverted to schoolyards?

Dr. Rakesh Patel: I don't know how you would actually do that study because safe supply drugs are not tagged. There's no way for anybody to know that a dilly bought by a school kid would come from—

Mr. Todd Doherty: Would you support traceability measures on so-called safe supply?

Dr. Rakesh Patel: No.

Mr. Todd Doherty: Why is that?

Dr. Rakesh Patel: It's because it's a sinister entity. You're basically trying to govern somebody's autonomy. We don't do that for anything else, so why would we do it here?

Mr. Todd Doherty: Dr. Patel, has your program received federal funding through SUAP annually?

Dr. Rakesh Patel: I think it's a three-year program right now. It's renewed on a three-year basis.

Mr. Todd Doherty: I take offence to Mr. Johns' comment to you regarding the politicization of safe supply and the opioid crisis.

I do agree with you that we are seeing more of it. It is more evident. It is out in the open. Our communities look like war zones. I thank you for telling this committee what the high is like for those who are addicted to these drugs, and that they're chasing it all the time—continually chasing that high. It's why first responders say that if they attend somebody who has overdosed and they administer naloxone or what have you, the person who comes out of that or is rescued is very angry. Oftentimes they come up swinging.

I would offer to you this: Why politicians...and why it's become such a hot-button topic is that, since 2016, over 47,000 Canadians have lost their lives to overdoses. We continue to spend a lot of money on programs, but we're failing Canadians. That is why it is a hot-button topic.

We don't disagree with you in that more services should be there. At least on this side, we're saying we should do everything in our power to get people the help they need. I think that is part of the testimony that you provided earlier on.

Dr. Patel, what does *primum non nocere* mean in the Hippocratic oath?

● (1200)

Dr. Rakesh Patel: First, do no harm.

Mr. Todd Doherty: First, do no harm—is that correct?

Dr. Rakesh Patel: That is correct.

Mr. Todd Doherty: How do you square that, as a physician, providing safe supply to those who are addicted to drugs rather than trying to get them help?

Dr. Rakesh Patel: If I don't give them safe supply, they're going to die and it's game over.

Mr. Todd Doherty: Have you ever asked somebody on the street how they feel about living on the street? You said earlier on that you haven't asked that.

Dr. Rakesh Patel: I have asked. Nobody actually aspires to live on the street. Nobody actually aspires to use drugs. It's a coping strategy.

Mr. Todd Doherty: It's a coping strategy for what?

Dr. Rakesh Patel: All of the trauma they've gone through in their lives.

For some people, they've lost their homes because of interest rates and inflation. Other people have lost jobs. They end up on the street, because there's no other place to go.

Mr. Todd Doherty: They may be struggling with PTSD or a moral injury. Dr. Monty mentioned brain injuries as well. We see many people who are struggling with traumatic brain injuries who end up on the street, or what have you.

In my province, overdose is the leading cause of death for children aged 10 to 18. Were you aware of that?

Dr. Rakesh Patel: I'm sure the statistics are correct, but no, I'm not.

Mr. Todd Doherty: One of the families had a daughter who recently lost her life. The daughter was 13 years old. She just turned 13, living in a homeless encampment. You mentioned patient autonomy. This family tried, repeatedly, to get their daughter, who was struggling with addiction, who was suicidal, into treatment. The family was told by the health authority, and those who were there, that if she wanted to kill herself, that was her choice. She just turned 13.

How do you feel about that?

Dr. Rakesh Patel: I think the experience that she and her family went through was absolutely horrible and unbecoming of a health care system.

The Chair: Thank you, Dr. Patel, and thank you, Mr. Doherty.

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

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much, and thanks for the incredible testimony from both of you.

Dr. Patel, I would like to pick up on some of those themes from my colleague. *Primum non nocere*, or first, do no harm, do you think that would be an appropriate module for politicians as well?

Dr. Rakesh Patel: Yes, it should be.

Mr. Brendan Hanley: Thank you.

First of all, I have two follow-up questions for you, but—

The Chair: Dr. Hanley, I'm sorry to interrupt.

I see Dr. Ghosh pointing to his headset. I think that means he has a technical problem, and we just lost him. He does, indeed, have a technical problem.

Mr. Brendan Hanley: Should I continue, Mr. Chair?

The Chair: Hold on one second, and we'll see. If he's not back within a minute, we'll need to call him, so just stand down for the moment, please.

Dr. Ghosh, can you hear us?

Dr. Sumantra Monty Ghosh: I sure can. You have my apologies for that. I had to log out and log back in.

The Chair: Dr. Hanley, please continue.

Mr. Brendan Hanley: Thank you, Mr. Chair.

Dr. Patel, I have two, hopefully, fairly brief questions, because I also have a couple of questions for Dr. Ghosh.

You talked about the conundrum of supervised consumption really being designed around longer-acting drugs, principally heroin. You mentioned that people often don't even have time to get into the facility, because of the use of short-acting drugs.

Can you talk a bit about that mismatch, and what we need to do? Should we be actually putting more resources into safe consumption to make it that much more accessible, or is there a bit of a mismatch between the short-acting drugs and supervised consumption facilities?

● (1205)

Dr. Rakesh Patel: That's an excellent question, given that the actual drugs on the street are no longer the classic French Connection heroin.

First of all, I would argue that we need either extended hours for safe consumption sites or more, so that we can get people off the street to where they can use safely and where we can have eyes on them to tend to all the other health care problems they actually need....

Also, it's the way people are using drugs now on the street. As people who use drugs age, they have fewer and fewer veins in which to inject, so they're doing different things with the drugs they have. They either take them orally, which doesn't give them the same high, so they have to take more, or they're smoking or inhaling them, which makes them extremely rapid in onset. That avoids going into a safe consumption site to find a vein to inject.

As people are growing older in their lives and using drugs because of all the other things that are influencing them, they're losing veins, so they're changing the way they actually use drugs. That is actually problematic because they're smoking their fentanyl, their crystal meth and their crack on the street. I can't bring them into a safe consumption site because of the law around where you can and can't smoke, particularly indoors. It's just like smokers at a bar. You can't smoke at a bar in a restaurant, so you go outside. Well, that's exactly what's happening.

Mr. Brendan Hanley: Will closing supervised consumption sites actually lead to higher visibility of drug use and more encounters on the street?

Dr. Rakesh Patel: My short answer is yes because of the types of drugs and the ways people are using them now.

Mr. Brendan Hanley: Dr. Ghosh, I'll move to you.

I'm encouraged, perhaps, or curious that you, as an Alberta-based physician, actually mentioned decriminalization. I wonder where you think we can, perhaps, take up that conversation, given the whole politicization of that discourse at the moment. What do you see as the next step in approaching decriminalization? What are your thoughts?

Dr. Sumantra Monty Ghosh: Thank you so much for this opportunity, Mr. Hanley.

I see us moving forward towards the Portugal model of decriminalization. The Portugal model of decriminalization has accountability as its cornerstone. It was established by a conservative government in Portugal back in 2006. While there isn't published evidence on this, there's plenty of program-based evidence around this and years of data around the outcomes of this particular program.

Essentially what happens is that, if anybody is caught with less than two-weeks' worth of substance on their body, they are given a citation and they're taking that citation over to a dissuasion commission that—

Mr. Brendan Hanley: Dr. Ghosh, I'm going to interrupt you because I think the committee is familiar with the Portugal model. I'm glad to see you endorsing that, but can you briefly reflect on how that model would apply when fentanyl analogs are the primary drugs of use?

Dr. Sumantra Monty Ghosh: I think it gives an opportunity for individuals to access care, and it moves the conversation away from criminalization, which we don't do for any other health diagnosis, orienting them towards a health system. What I mean by that is that we don't criminalize diabetes or hypertension if someone goes and grabs a Slurpee. If they have poor blood glucose, we don't throw them in jail.

The Portugal model, I think, benefits us in that sense because it really does orient the person who is using the substance towards the health care side of things as opposed to the corrections and justice side of things, and it does—

● (1210)

The Chair: Thank you, Dr. Ghosh.

We're going to go to—

Mr. Brendan Hanley: Mr. Chair, the time when I was interrupted, was that included?

The Chair: It was indeed, yes.

Mr. Brendan Hanley: Thank you.

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

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

Dr. Patel, you don't have studies that prove that there isn't diversion, but you're saying that diversion isn't a problem. How can both statements be true at the same time?

Dr. Rakesh Patel: Fundamentally, it goes down to why people divert. People will divert predominantly because they don't have a place to stay. If they need a place to stay, they'll divert their drugs. They don't have food; they don't have shelter; they don't have hygiene—those are fundamental reasons for diversion. The people I look after are not going to Lisgar high school and Rideau high school and selling drugs to high school kids. That's not of value to them.

Mrs. Laila Goodridge: That's not the only diversion. This is one of the big pieces we've been hearing. There are countless articles that have been written on Ottawa proper and the Ottawa inner-city health of those blocks surrounding the so-called safe supply programs, where drug dealers go. They exchange fentanyl for these drugs. Then those drug dealers take them to the high school students, flooding the streets with dillies. Allowing people to have these to take home is creating chaos.

Sandy Hill is not a safe place to walk. I'm very curious about how you can say that your clinic and diversion have nothing to do with the lack of safety in that community.

Dr. Rakesh Patel: I fundamentally disagree with your inference that safe supply is the primary driver of “chaos”, as you call it, on the street. The fundamental drivers of chaos on the street are the types of drugs available on the street. Treating a fentanyl and crystal meth problem with Dilaudid is like treating my arm that's been chopped off in a car accident with pediatric Tylenol. It's a fundamental mismatch.

If we want to improve what we're doing, there are different ways to do it. Providing fentanyl to the kinds of people I see would be one alternative.

Mrs. Laila Goodridge: Therefore, you—

Dr. Rakesh Patel: If you have that, you're going to see what you call “chaos”.

Mrs. Laila Goodridge: Dr. Patel, are you an advocate of having fentanyl available in a so-called safe supply program?

Dr. Rakesh Patel: I am an advocate of doing that, because it will save lives.

Mrs. Laila Goodridge: My next question is this: I saw yesterday, in fact, that you guys got an extension to your clinic for an additional three years, per Health Canada.

What consultation and communication did you have with the surrounding community regarding the clinic's operation?

Dr. Rakesh Patel: I'm not understanding the question. Forgive me.

Mrs. Laila Goodridge: Oftentimes, there's communication with your neighbours when you're operating something. There are tons of reports of increased crime.

Have you had any conversations? Was there any requirement from Health Canada to have community consultation in order to make sure public safety is being maintained?

Dr. Rakesh Patel: There's no requirement from Health Canada, but we fundamentally, as an operating infrastructure, consult with all of our community partners in Lowertown and the different shelters we have across the city.

Mrs. Laila Goodridge: Okay. Health Canada does not require you to have any consultation with community or to take into account the larger public safety risks when operating.

Dr. Rakesh Patel: It doesn't. On a formal basis, I and my CEO are not required to do any particular reporting back to Health Canada.

Mrs. Laila Goodridge: It's incredibly troubling—as we see so much crime happening in the very few blocks around your clinic—to know that Health Canada gave you another rubber stamp to continue operating for another three years, without putting any additional measures in place to ensure diversion isn't happening and that public safety is being put front and centre so kids aren't being put at risk. I really do not understand how Health Canada is doing its job and not doing those kinds of things.

My last question is for Dr. Ghosh.

Are you familiar with recovery-oriented housing solutions like Oxford House?

Dr. Sumantra Monty Ghosh: I am, yes.

Mrs. Laila Goodridge: Do you believe that recovery-oriented housing solutions similar to Oxford House are good models to get people housed and break the cycle of addiction?

● (1215)

Dr. Sumantra Monty Ghosh: I do.

Oxford House is, essentially, high-level supportive housing. It is an equity-based supportive housing facility as well, meaning that it is public and paid for by the Government of Alberta. One of the points I wanted to make earlier was that the Government of Alberta has provided access to these services for free.

The key to Oxford House is that it helps build community. They are long-term treatment facilities in the sense that it's not just three weeks that people spend there. It's not just six weeks that people spend there. They can spend a long time in these facilities. We know that the longer they spend in these treatment facilities the better their overall outcomes will be post-discharge from these services.

The other benefit of Oxford House is that they also provide transition services back to the community, which, as you know, is another key, evidence-based idea. It provides increased support for clients and has better outcomes as well in terms of recovery, cessation of substance use and decreased relapse.

Oxford House is a—

The Chair: Thank you, Dr. Ghosh.

Next, we have Madame Brière for five minutes, please.

[*Translation*]

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you, Mr. Chair.

I would also like to thank the two witnesses for their testimony, which has been very useful and very interesting.

Dr. Patel, based on their questions, it's easy to see where our colleagues across the way stand. Would you please reiterate your observations about the importance of an approach that takes into account the four internationally recognized components: prevention, law enforcement, risk reduction and treatment?

Also, Dr. Ghosh, this is related to the question you were just asked, so I'd like you to answer it after Dr. Patel comments. We obviously need services to house people, but that's not the only option.

[*English*]

Dr. Rakesh Patel: Thank you for the question.

I hope I've understood your question. I will try to answer it.

I think the approach to the social determinants, as I think you're alluding to, is going to be the most important way out of this crisis. I'm not convinced that we're never going to have a drug crisis. The reason is as I said: At the very beginning, humans have desires, and we're risk-takers, so a supply-side approach is never going to work. We've demonstrated that for the last 60 years. Unless we get rid of our fundamental biases in this, we're not going to overcome the situation.

Why housing is really important, as I've alluded to, is that it gives you personhood, and without that, there is no motivation for you to change. I can't change somebody. I can only help them try to change, but if they don't want to change or cannot find it in them to change with everything around them, I can't change that. That's a fundamental truth that I have to accept. As a physician, I can't fix everything. I can do my best, but I can't fix everything.

Mrs. Élisabeth Brière: Thank you.

Dr. Rakesh Patel: I don't know if I've answered your question appropriately.

Mrs. Élisabeth Brière: Dr. Ghosh, do you have something to add?

Dr. Sumantra Monty Ghosh: Thank you so much.

I do agree with Dr. Patel that housing is probably one of the key ways that we can get out of this crisis, especially around public consumption of substances, but it has to be in conjunction with other services as well.

Yes, for me, again, housing is crucial. I think it is the key piece that we don't have enough of in the system, and it's something that we need to be focused on. It's not just housing as well. It's supportive housing at a level of intensity that is congruent with the concerns of the individual. Some of these clients have severe mental health concerns. Some of them have severe brain trauma, brain injury or cognitive concerns. We need to have adequate support at a level similar to what their needs are. This includes addiction supports as well.

[*Translation*]

Mrs. Élisabeth Brière: Thank you, Dr. Ghosh.

Dr. Patel, you also worked as a pharmacist.

Is that correct?

[*English*]

Dr. Rakesh Patel: I did, in inner-city Detroit, in emerg and in the ICU there. Yes.

[*Translation*]

Mrs. Élisabeth Brière: Okay, so I'd like to ask you a question about traceability.

Whether one is for or against the principle, how would that work in practice? Wouldn't we need two production lines and two distribution chains?

Also, wouldn't organized crime be able to copy the product very quickly?

● (1220)

[*English*]

Dr. Rakesh Patel: The question is fundamentally around traceability, and you're right. From a compounding perspective, I don't see how a manufacturer would agree to that.

The medications we get from a safe supply program are from manufacturers. They're not compounded by us and they're not compounded by a community health centre. They come directly from the manufacturer. If you wanted to trace those, you would have to add a second step in order to trace them. That tracer would have to be detected. It would have to be easily detected and it would have to be detected consistently to demonstrate that it came from a particular batch from a manufacturer that led to a concern over diversion.

Anybody in organized crime who makes a tremendous amount of money could easily copy that, because they're far more inventive than traditional manufacturers are. They are far more inventive not because they're smarter, but because they don't play by the rules. There are no rules. They can do whatever they want. All they have to do is get a traced fentanyl analog, a Dilaudid analog or a crystal meth analog, find the tracer and use exactly the same tracer. Then they're off in the clear.

There's no regulatory burden on your average drug dealer. There's a huge regulatory burden on a pharmaceutical manufacturer: again, harm reduction.

The Chair: Thank you, Dr. Patel.

[*Translation*]

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

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

Dr. Patel, Alberta's health minister told the committee that addiction can go one of two ways: suffering, misery and death; or treatment. Alberta is currently making massive investments in more beds and more treatments. Safe supply is not in the picture there, and I don't get the impression that harm reduction is either. British Columbia has also pivoted to mandatory treatment.

What are your thoughts on those two models? Of course, we need more beds and more treatments. When relapse is part of the treatment, but there's no safe supply, isn't that condemning people, in a way?

[*English*]

Dr. Rakesh Patel: The fundamental path, I guess, as you've spoken about in Alberta, is suffering and death. Sure, that's cheap. Everybody in every ministry of health in every province would like that because it doesn't cost them any money.

The treatment plan has a fundamental flaw in it. That fundamental flaw is that there's only one treatment and it works for everybody, and there's no recidivism, meaning that when you have substance use disorder, you get your treatment and you go home. That's the end of the story. You become a part of society, and you contribute like everybody else. This is a false argument. There is no such thing.

How many people do you know who can quit caffeine, cigarettes or alcohol on the first try and never go back? For sure, there are some people who do it, but the overwhelming majority relapse and then they go through treatment again. If that's your approach, you're building a foundation that's fundamentally flawed.

The second problem with that approach is that we currently have trouble staffing acute care hospitals with enough health care workers. Where are you going to get people to staff these addiction centres? Is there some magical vending machine that I'm not aware of that has the doctors, nurses, social workers and pharmacists who are going to man these addiction centres and follow patients when they fall off the wagon? There isn't one that I can see.

If that's your fundamental approach, you're doomed to fail and you'll fail miserably.

The Chair: Thank you, Dr. Patel.

Our last person to pose questions to this panel will be Mr. Johns for two and a half minutes.

● (1225)

Mr. Gord Johns: I'm going to stay on that thread.

Dr. Ghosh, you've been involved in the conversations around involuntary treatment. You were on *Cross Country Checkup* yesterday. Do you think it's premature to have this conversation when so many people don't even have access to voluntary treatment on demand, like Dr. Patel just talked about?

Because I have only two and a half minutes, I'll ask these questions quickly.

We heard Dr. Goulão from Portugal say they don't support mandatory treatment. They say it doesn't work.

You've also talked about incentivization and paying people to get treatment.

Lastly, you're a member of the coalition called Doctors for Decriminalization. Do you continue to believe that the criminalization of people who use drugs causes more harm and creates more barriers to recovery?

You have the remainder of the minute and a half left of my time, so I'll let you speak to those.

Dr. Sumantra Monty Ghosh: For Doctors for Decriminalization, first up, yes, I believe decriminalization is the way to go. The models of decriminalization we've seen have varied. We just need to find the right model that works, so we shouldn't give up on it yet. That's number one.

Number two, in terms of involuntary treatment, I am a huge proponent of incentivized treatment in the sense that we know it works from a medical evidence perspective. We know that ideas such as contingency management have worked really well for methamphetamine use. There's a ton of evidence around this. We know that, around vaccines, incentivization has worked as well to get people to get their vaccine. I think we can create a system in which we can get people into treatment, provided that there is incentivization. We've heard this from people who use substances themselves.

The whole mandatory treatment piece is very complicated, but we still need more space for people who want to seek voluntary treatment, and we need to build a system up for that first and foremost. That is crucial, and I don't think we're there yet. We have to have standardization around treatment services as well.

There was one last part to your question, and I've forgotten it now. I'm sorry.

Mr. Gord Johns: It is to speak about the involuntary treatment being premature, given that people don't have access to voluntary treatment on demand.

Dr. Sumantra Monty Ghosh: Yes, that's the key thing.

The one last point that I want to say is that, outside of there being a lack of access, I think there's a portion of the population who will not benefit. They are people who are moderately or severely brain injured or have moderate or severe cognitive concerns. It just will not work for that population group. I think that's where we're looking when we're looking at people who have substance concerns on the streets who are talking to themselves and acting incoherently. Part of that is the substance, but part of that is also concerns around their cognition.

I do not think that forced, mandated treatment would work on that population group. We need to have alternatives such as housing for that population group.

The Chair: Thank you, Mr. Johns.

Thank you, Dr. Ghosh.

That concludes the rounds of questions for this panel. I want to sincerely thank you both for being with us. This has been extremely interesting and will undoubtedly be very valuable to us in our study. Thank you for being with us and sharing your expertise. You're welcome to stay, but you are free to go.

Colleagues, please don't run away. There's one update I have for you with regard to the calendar going forward.

Mr. Johns, I think, is going to seek to resume a motion that had been adjourned.

In terms of updates, this Thursday we'll commence the study of Bill C-277. That's a private member's bill from Alistair MacGregor. We will have a panel of witnesses that has been confirmed for Thursday. The sponsor of the bill will appear on October 10. Unless the direction of the committee has changed, we would propose to do clause-by-clause at a subsequent meeting, likely October 24.

With respect to the opioid study, we'll resume the opioid study on Tuesday of next week. We've gone with the work plan and invited the third panel. That's by way of update.

Now I recognize Mr. Johns, and then Mr. Doherty.

Mr. Gord Johns: Thank you, Mr. Chair.

I would like to return to the motion that we tabled.

Do I need to read the motion again, Mr. Chair?

The Chair: No. What you need to do is move to resume debate on the motion.

Mr. Gord Johns: I move to resume debate on the motion on the table.

The Chair: Okay. That's a non-debatable motion.

Is it the will of the committee to resume the debate on the motion and the amendment that was adjourned at a previous meeting?

An hon. member: No.

● (1230)

The Chair: Do we need a recorded vote on that? Could we have a show of hands?

(Motion agreed to)

The Chair: The debate is now resumed.

The motion has been circulated to the committee. When the debate was adjourned on the motion, an amendment had been proposed by Dr. Hanley. The debate was on the amendment.

To refresh your memory, this is the question before the committee. The original motion from Mr. Johns was:

> That, pursuant to Standing Order 108(2), given the increasing prevalence of privatized health care across the country and the difficulty Canadians face in getting the health care they need, the committee undertake a study of at least four meetings on protecting Canada's public health care system against for-profit corporations, and that the committee invite the Chief Executive Officer of for-profit health care providers like Loblaw Companies Limited to testify.

The amendment before the committee now is to add, after the words, "at least four meetings on", the following: "the role of the private sector in Canada's public health care system, including". The debate is on the amendment.

Mr. Doherty has the floor, and then Dr. Ellis.

Mr. Todd Doherty: Mr. Chair, if I can I'd like to cede my time on the floor to Dr. Ellis. I think I'll have something to say after.

The Chair: I'll put you back on the speakers list.

Dr. Ellis, you have the floor.

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

Here we are, nine years into a coalition government that has really done nothing but allow this public health care system that we all hold so dear, and one that I worked in for many years, to decay.

How do we know that? In this committee we've often talked about data, so the question then becomes this: What evidence is there to say that there is decay in the public health care system at the hands of the NDP-Liberal coalition? Where to begin, Chair, is probably the bigger question.

The most obvious difficulty that Canadians have is access to the system. When you begin to look at access to the system that we have, of course everybody around this table would clearly realize that it is predicated upon the fact of having access to primary care. Primary care providers, whether they be nurse practitioners or family physicians, allow folks to have that requisition for blood work or an X-ray or a referral to see a specialist.

In spite of the fact that we want to return to this grandstanding motion, which was tabled and interrupted our important witnesses related to the opioid study, what we know very clearly and very simply is that, when Canadians don't have access via a primary care provider, it doesn't matter if we have the best-formed health care system in the galaxy. I say that not to be hyperbolic or to sound foolish, but to outline the fact that without access, regardless of the system, there is nothing. There is nothing for those 6.5 million Canadians who do not have access to the health care system that has been held so dear by Canada for an incredibly long time.

I would suggest to you, Chair, that certainly would be the first metric that we want to look at. We know it has deteriorated over time. We know that 20 to 25 years ago people would have had their pick of a family doctor. Family doctors made house calls, etc. What have we seen happen to the system under the NDP-Liberal coalition is this incredible degradation of access. As I said previously, it certainly doesn't matter what system you have if you can't access it.

I think there are a few other things that we need to outline. There's a horrific story of a gentleman in Quebec who had a long history of paralysis. The sad thing is that he waited so long for care in an emergency room that he developed horrific bedsores. I'm sure that many folks here are not quite aware that bedsores are incredibly difficult to heal. They are often open wounds, let's put it that way, that persist for a very long time. That can require significant nursing care, significant off-loading of the area to allow them to heal, which becomes very difficult if you have a problem with paralysis.

When you think of that, this gentleman developed these bedsores because he had to wait in an emergency room on a stretcher for days, in an inappropriate setting for someone with his care needs. I'm going to come back to that story in a second.

I wish I could tell folks around this table that it was the only story we heard of system failure in the emergency room.

● (1235)

As I return to Nova Scotia every weekend, as many of my colleagues do, I would challenge anyone around this table to tell me they have not heard a story from a constituent about how long they waited in the emergency room. Sadly, it has almost become an abhorrent badge of honour to say, “Wow, you know, I waited in the emergency room for 16 hours.” We hear these stories. As a former physician providing care, I find that unacceptable.

Even in the days when I practised in the emergency room, which wasn't that long ago, often if I worked a Friday night till 11 o'clock, midnight or one in the morning and someone was coming on the next shift, I always thought it was my goal to basically have the waiting room empty when the overnight physician came on. That way, he had an opportunity to look after the most seriously ill patients who were inside the emergency room, perhaps waiting to go to intensive care or for test results to come back, who had been in a traumatic accident or who had suffered a stroke or a heart attack, etc. That was always my goal: to have that waiting room emptied so that the person coming on overnight could have that very fresh start.

As I said, when all of us around this table go home every weekend, I would challenge you to say how many of the people who are voters in your community have come up to you and said, “I have had to wait innumerable hours in the waiting room.” I would love to do a straw poll around the room, but I know that's perhaps not something that people would like to answer. We know it affects Newfoundland. We know it affects Quebec. We know it affects Ontario, both urban and rural. We know it affects P.E.I. I know that, Chair, because people from P.E.I., when I've been there, have come and told me that it affects P.E.I. I know it affects B.C. and Alberta. Even Saskatchewan is affected by this.

As we begin to understand the difficult nature of this, this is what has happened under this coalition. It's beyond the eleventh hour of a struggling government. It's the 23rd hour of a struggling government that now wants to bring forward these motions to say Canadians should entrust them to fix health care. Are you kidding me? What credibility does the Liberal-NDP coalition have to say they can fix health care when it has done nothing but spiral negatively in the last nine years? They have no credibility.

That is not to mention a fact that somebody, who will remain nameless, told me. I had the good fortune of being home this weekend at the first annual Nova Scotia Stampede. We had a charity hockey game while I was there, and one of the hockey players, who was notable—and I will not name him, because I didn't ask his permission, although he told a great story—had been to the emergency room with his children. He said they were there with a child who perhaps wasn't that unwell, but he saw another child with a broken arm. He said, “I know I'm not a physician, but I could tell this child's arm was broken,” and that child waited 14 hours in a waiting room with a broken arm.

I realize that, yes, there's a triage system, and we could argue that everybody knew the arm was broken, etc., but as Canadians, doesn't that pull at your heartstrings? This was a child waiting with an obviously disfigured arm who didn't get the service they required for 14 hours.

● (1240)

I wish it was, as we say, a “once in a blue moon” occurrence, but it's not. I know people who have waited so long with a laceration that by the time they had an opportunity to see a treating physician, they didn't even require stitches anymore. Their wound had healed, basically, and I'm not talking about some miraculous healing. What we're talking about is a wound that was held appropriately and tightly, and after the terrible amount of time that had elapsed, again, the wound did not need suturing, which appears fantastical, I know. However, these are stories that everyone around this table has already heard.

If I might return to my story of metrics related to the gentleman who had paralysis and ended up with severe bedsores after waiting many days—not hours; we're talking about days—in the emergency room on an inappropriate surface, who then.... I can barely even say this out loud, but again, it was reported in the news. I'm not making something up here, but it's hard to speak the words. That gentleman chose MAID because of the bedsores that happened to him at the hands of a health care system in the greatest country in the world. Again, that happened under the NDP-Liberal coalition's watch. That's when it happened.

We also know that things have gotten worse over time. The system has, perhaps, been struggling for a long time, but we know that, at the current time, wait times to have treatment, from after you see a family physician to seeing a specialist, has increased to the worst it has been in 30 years. That's three-zero, not 13. The average wait in this country, after seeing a family doctor—because, of course, as we all know, you need a referral from a family physician to see a specialist—has ballooned to 27 weeks, which, of course, is half of a year.

Again, I know we have physician colleagues here, and I appreciate that. I would suggest that, in most cases, when a family physician has exhausted all of their knowledge, their training and their experience, when the tests they have ordered and when the information has been assimilated, the expectation, and I know my expectation as a former family doctor, would be that I have done all the work that's required, but now you have to wait six more months to have the opinion of a specialist whose extra training and extra experience is required to either make a diagnosis or to confirm treatment. That has now ballooned to more than six months. That's not acceptable. That just isn't. That's not the expectation of Canadians, and it is certainly not the expectation of family physicians who serve the patients inside the system.

We know that, in many communities, the wait time for getting an appointment to have blood work done is more than a month. As we begin to look at these metrics.... I think that's where our focus needs to be, as we begin to talk about allowing a motion to happen on another study from the very group of people—the NDP-Liberal coalition—who allowed the system to fall apart. It seems rather sanctimonious and frivolous to me.

● (1245)

What other metrics do we have to say that the NDP-Liberal coalition has failed health care in this country?

If there's anybody who would like to.... Unlike some of my Liberal colleagues, I don't have dealings with this company. I don't have a financial interest in that company. That's not how I work. That being said, there's a great website called SecondStreet.org. When you begin to look at that, some of the work it has done is based around how many people have died in this country on a waiting list, which is absolutely shocking. Does that mean you're waiting for a CT scan? Are you waiting for an MRI? Are you waiting six months, as I already spoke about, to see a specialist? Are you simply waiting for a blood test? Are you waiting for something perhaps more invasive like a bone marrow transplant, etc.?

As you begin to look at those numbers, they are absolutely shocking. The estimate is that between 17,000 to 30,000 Canadians die every year on a waiting list. I'll say that again, 17,000 to 30,000 Canadians die every year on a waiting list.

As you begin to fathom that number, remember that these are Canadians. They are not some anonymous person you don't know. These are your mothers, your sisters, your aunts, your uncles, your fathers, your brothers, all of those people. All of those people are people who can die on a waiting list.

I spoke to a gentleman just yesterday. Again, it's another unfathomable story. He has a known cancer in his tonsil. He knows he has it. It's been biopsied; it's been diagnosed. There is a robotic surgery available to him to have this cancer treated. You can well imagine you're going to treat tonsillar cancer. The hope would be that you will have a successful surgery. Perhaps you might be able to avoid the terrible radiation, the dry mouth that comes after that and disfigurement as well. His surgeon only has access to the robotic surgical assist one Thursday every two weeks.

As we begin to look at the failing system that exists before us at the hands of the NDP-Liberal coalition, as I said, it becomes a bit rich as to movement of this debate, because what have the NDP-Liberals done over the last nine years with respect to health care besides destroy it? Nothing.

We have also heard the Prime Minister stand in the House of Commons, and say—I remember it happened when I first came here a little better than three years ago—that he was going to provide Canadians with 7,500 doctors, nurses and nurse practitioners to this system to make it better. When you look, objectively, at the metrics, you have to understand that the system has gotten worse and worse, and the number of physicians continues to decline over time.

Of course, those out there watching will ask, “What are you going to do about it? What would a Conservative government...?” We've already announced a program for international medical graduates. We know there are at least 20,000 physicians who are here in this country. They have practised medicine, trained in medicine abroad and have come to this country, but are not able to practise their trade. It is an incredibly sad indictment on the system run by the NDP-Liberal coalition. This is a terrible joke. I'll preface my remarks with that.

● (1250)

Do you know what? Everybody has heard this: In Toronto, don't call an ambulance. Call a taxi, because your taxi driver will be a physician who was trained elsewhere. It's a terrible joke. Sadly, we know, as I said, that 20,000 physicians who trained outside of this country and have experience are living here but cannot access the system. As I go around the country and talk to Canadians, I say, “Conservatives have a plan.” To a person, Canadians say, “That is a very common-sense idea. Why would you not do that if someone is trained elsewhere and has experience?” As everyone says to me, the body is the same in country X as it is in Canada. I'm sure it's exactly the same. I'm sure it functions the same way. I'm sure the liver is still on the right side of the body. Yes, it is. Broken bones, lacerations and high blood pressure exist in every part of this world. We know diabetes exists in every part of this world.

Therefore, regarding folks who received their training and experience elsewhere, everybody says that, if they have that ability to practically prove their abilities, of course they should have a licence to practice in Canada and help treat Canadians. We know this is a win for the 6.5 million Canadians who need access to primary care. We also know it is a win for the physician who is here doing some other type of work and not able to practise.

I met a group of internationally trained physicians. One gentleman in particular told me a terrible story. He has not been able to practise as a physician. He was working as a security guard. Again, these are heartbreaking stories. His son said to this gentleman, “Dad, if you're a doctor, why do you go to work dressed as a security guard every day?” How do you explain that to your young child? “Well, I came to this country for an opportunity, and because of the barriers that exist here, I'm not able to work as a physician.”

Look at how Canada historically built this country. Many people came from elsewhere with training in medicine, nursing, pharmacy, dentistry, veterinary skills, bricklaying, pipefitting, etc. They were electricians or carpenters. How did we welcome those folks back when the country was being built up? We welcomed them by saying, “Hey, let's see what you can do. Show us what you can do.” It was “Oh, here, watch me build this. Watch me do this. Watch me apply my trade.” Everybody agreed. “Wow, you know what you're doing.” Surprisingly, the body is not different in country X compared with here in Canada.

That's one example of a practical solution Canadians can receive from a common-sense Conservative government, one that says, “When you can prove your skills, we will have you going to work and providing services on behalf of Canadians.”

Chair, the other metric we need to look at is the failing health care system, which happened at the hands of the NDP-Liberal coalition and is related to services for veterans. On this side of the House, we know that mental health is health. My great friend Todd Doherty, champion of the 988 suicide prevention hotline, pushed and pushed, such that, in my mind, it never would have happened without him.

● (1255)

When we understand that and we understand that veterans are calling Veterans Affairs for help.... They're saying that they need to access mental health supports. They've struggled, they've served their country and they've signed on the dotted line. The answer, of course, in these terrible.... I wish someone would accuse me of hyperbole in making up these stories, but everybody knows they're true.

Everybody knows that there are veterans in this country who were reaching out for mental health help and who were offered medical assistance in dying—MAID. That was the offer. I don't know what they said—that they can't access it, it's too long to access it, their case is too difficult or whatever, so have they considered MAID?

This is not only a sad testimony as it relates to the failing health care system under this NDP-Liberal coalition, but it also relates to how we treat our veterans. I'm a proud veteran.

Mr. Todd Doherty: Thank you for your service.

Mr. Stephen Ellis: You're very welcome, Todd.

I'm grateful to have had the opportunity to serve. It taught me a lot of things.

Here we are not offering veterans help. We're not saying, "Here's a hand, grab hold. I don't want you to die.” Not us.

The NDP-Liberal coalition government is offering medical assistance in dying to veterans who need incredible amounts of mental health support because of what we as a country have asked them to do. We have asked, "Will you sign on the dotted line? Will you serve? Are you willing to give the ultimate sacrifice for doing what we believe as a country is right?" They answered that call. They said yes. The NDP-Liberal coalition government failed them.

Chair, if it were only one veteran who was failed, maybe someone could call it a mistake, but it was not only one veteran. There were multiple veterans. This was a pattern of behaviour that, to me, could only come from where all the decisions come from in the NDP-Liberal coalition, and that is straight from the Prime Minister's Office. That is where it would appear all the decisions come from. That is a sad state of affairs.

We've been debating opioid therapy. I found it very rich today that nine years have passed and the only argument that the NDP-Liberal coalition has come up with is so-called safe supply. Let's give out free drugs. I find it absolutely fascinating that suddenly colleagues on the opposite side are now saying that we need comprehensive treatment.

We've been talking on the Conservative side of a common-sense solution of comprehensive treatment for years now, ever since I came to this place three years ago. Those are the things that we have been talking about on this side of the House. We do not believe that giving out an endless supply of high-powered opioids is what is going to enable this crisis to end.

We do believe that there is a possibility for rehabilitation and treatment for every person that is affected by the opioid crisis. We do not believe in just giving them opioids, which is palliative care. That is saying to them, "Guess what. You are never going to get better. Just take these drugs." I believe that the costly coalition wants them to take drugs and be quiet, because then they're not a problem to them. That, of course, is an absolutely ridiculous thing to do.

As we begin to understand what the NDP-Liberal coalition has done to destroy health care in this country, it is an incredibly rich and—and perhaps unparliamentary for me to say—ridiculous argument to say that they want to talk about the health care system as it suddenly becomes a ballot-box issue. We begin to see what's important to Canadians.

First of all, for the people I visit whose doors I knock on, it's the cost of living. That's the important thing. They say, "I cannot put gas in my car. I cannot put food on my table. I cannot put a roof over my head." Those things are what we hear every single day. If all of you who sit around this table are not hearing that, I suggest you have your hearing checked.

Then, suddenly, health care becomes a ballot-box issue. We should address health care.

Why don't you get rid of the carbon tax and address the cost of living? We know that one of the determinants of health is the ability to go ahead and put good food on the table so that you can have a healthy life. Those are things that are incredibly important. Those are the changes, the blue seal program, getting rid of the carbon tax, fixing the budget, building houses and stopping crime. Those are things that those of us on this side of the House are seized with.

● (1300)

We're not seized with fanciful notions of suddenly having a wake-up call to now treat people with opioid addiction properly. After not doing it for nine years, we're suddenly going to fix the most revered public health care system. That's not what we're seized with on this side of the House.

Chair, as you well know, there are many more things I could go on about, but seeing the clock at 1:05, I suggest that we adjourn this meeting at this time and pick it up later.

I move to adjourn.

(Motion negatived)

The Chair: The meeting is not adjourned.

Dr. Powlowski is next on the list.

Mr. Marcus Powlowski: Let me start by asking what the order is after me.

The Chair: I have Mr. Doherty and then Mr. Thériault.

● (1305)

Mr. Marcus Powlowski: Clearly, the Conservatives are filibustering. They don't want to have a vote on this motion. They don't want to study the increasing privatization of health care. Why is that?

They know very well that the Canadian public does not agree with this. You see one survey after another asking Canadians what it is to be a Canadian. What's the most important thing that distinguishes us as Canadians? Invariably, it comes down to two things: hockey and our public health care system.

I think the vast majority of people don't believe in the privatization of health care. I think the Conservatives' filibustering clearly indicates the fact that they don't want to talk about this, because they don't want to publicly show their support for the privatization of health care since they know it is not a winning issue among the Canadian public. That's why they're filibustering.

With that said, I see there are a bunch of Conservative speakers afterwards.

I move to adjourn the meeting.

(Motion agreed to)

The Chair: The meeting is adjourned.