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Chair: Hedy Fry



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• (1100)

[*Translation*]

The Chair (Hon. Hedy Fry (Vancouver Centre, Lib.)): Good morning, everyone.

I call this meeting to order.

[*English*]

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

[*Translation*]

We recognize that we meet on the unceded territory of the Algonquin Anishinabe peoples.

[*English*]

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders.

I want to remind participants of the following points.

Please wait until I recognize you by name before speaking. I wanted to remind you that your comments should be addressed through the chair. I also wanted to remind you to be careful about your audio, because we don't want anybody to have feedback that harms their ears.

You have a little decal on your desk. Remember to put your phone there so that it doesn't interfere with the sound.

For members in the room, raise your hand when you wish to speak, and I will recognize you. Because this is a meeting where we all have the order of speaking, I just wanted to remind you that the first round is a six-minute round; the second round is five minutes, five minutes and 2.5 minutes for the Bloc; and then it's five minutes and five minutes. We're going to see how many rounds we can get in.

We have all of the participants in the room, so I'm going to suggest that we just go straight through the two hours and not break it into two one-hour segments.

We will begin.

Pursuant to the motion adopted on Tuesday, September 23, the committee will commence the briefing session with Health Canada officials—

[*Translation*]

Luc Thériault (Montcalm, BQ): Madam Chair, I have a point of order.

Right out the gate, you just decided that we were going to hold a single two-hour meeting rather than two one-hour meetings. I'd like to point out that when it comes to my right to speak, I'm entitled to six minutes of speaking time during the second hour when we hold two one-hour meetings.

Do you want to give me only two and a half minutes of speaking time in the whole second hour?

[*English*]

The Chair: Excuse me, Mr. Thériault. I can't hear you. I didn't have my earpiece in my ear. I'm getting old and deaf. I'm sorry. Please go ahead.

[*Translation*]

Luc Thériault: That's fine. No problem. I hope everyone puts their earpieces in, so I don't have to go through this again today.

I said that you had decided, from the outset, that we would hold a two-hour meeting rather than two one-hour meetings. However, I'd like to point out that when we hold two one-hour meetings, I'm entitled to six minutes of speaking time at the start of the second hour.

Does your decision mean that I'll get only two-and-a-half-minute turns in the second hour?

[*English*]

The Chair: I think the Bloc will have six minutes in the first round as per usual, but the agreement at this committee over the last while and now is that in the second round the Bloc will have two and a half minutes. The Liberals and Conservatives will have five minutes each.

[*Translation*]

Luc Thériault: That isn't my question, Madam Chair. I'll start again.

We have a two-hour meeting. We agree on that, right? That means I'd have six minutes of speaking time in the first round. In the second round, I'd have two and a half minutes of speaking time. I'm asking you whether I'll have two and a half minutes for the rest of the meeting, or whether I'll be able to get another six-minute turn, as is the case when we do two one-hour meetings.

[*English*]

The Chair: No, because we're not breaking it into two separate hours. We are doing one full meeting, so we will go through and the first round will be six minutes and then the second round as has been always done, unless you wish to suggest that your colleagues want to give you equal time. I would entertain that, if you wish to ask them.

Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Madam Chair, I would favour giving him a second six-minute round, and we can move on.

Are the Conservatives okay?

We'll give him two six-minute rounds.

The Chair: I'm sorry. The second round is not six minutes. It's five.

Marcus Powlowski: No. In the second or third round, maybe he could have six minutes. That's what he's suggesting.

The Chair: Is everyone in agreement that we give equal time to the Bloc?

Marcus Powlowski: Yes.

The Chair: Yes? Good. I see nobody dissenting. We will do that.

Thank you, Mr. Thériault.

I want to say that, pursuant to the motion adopted on Tuesday, September 23, the committee will begin the briefing session with Health Canada officials and the president of the Public Health Agency of Canada.

I want to welcome our witnesses. I'm going to give the Department of Health five minutes to speak, and then the Public Health Agency of Canada will have five minutes to speak. I will start with the Department of Health.

• (1105)

We have here today Greg Orencsak, deputy minister; Jocelyne Voisin, senior assistant deputy minister, health policy branch; Pamela Aung-Thin, assistant deputy minister, health products and food branch; Matt Jones, assistant deputy minister, healthy environments and consumer safety branch; Kendal Weber, assistant deputy minister, controlled substances and cannabis branch; and Dr. Supriya Sharma, chief medical adviser.

From the Public Health Agency, we have Nancy Hamzawi, president; Stephen Bent, vice-president, regulatory, operations and emergency management branch; and Michael Collins, vice-president, health promotion and chronic disease prevention branch.

The two principals have five minutes each. I will give you a two-minute sort of warning so that you can begin to wrap up, and a warning at 30 seconds at the very end.

If that's okay with everyone, we will commence, and we'll begin with Mr. Orencsak.

Please begin, sir.

Greg Orencsak (Deputy Minister, Department of Health): Thank you, Madam Chair and honourable members. Thank you for inviting us here before the committee today. We welcome this op-

portunity to discuss Health Canada's priorities and to describe how the work we do supports the Government of Canada's priorities.

[*Translation*]

Last spring, the Prime Minister sent ministers a shared mandate letter that announced seven key priorities. Today, I'm happy to share how Health Canada is helping to achieve those objectives.

[*English*]

I will begin with our work modernizing regulations.

The government launched a red tape review this past summer. For us, the goal is to eliminate outdated or overly complicated rules and reduce duplication and overlap that delay decision-making, while still prioritizing health and safety.

[*Translation*]

Health Canada's report lists 42 measures that the department and the Public Health Agency of Canada are taking to reduce the administrative burden, all while continuing to protect the health and safety of Canadians.

[*English*]

Key areas of focus include reducing trade barriers by aligning with international standards, improving client experience and service delivery, adopting risk-based approaches, streamlining regulations and simplifying rules, and enabling new products and technologies.

[*Translation*]

I'm going to move on to the distribution of toxic illegal drugs and the overdose crisis.

[*English*]

Through Canada's border plan, Health Canada works with partners across the government to disrupt illegal drug production and distribution. For example, we are providing additional domestic capacity to deliver quality drug-profiling information and services to Canada's law enforcement and public health agencies to more strategically target actions to address the synthetic drug threat.

Health Canada has also launched a new precursor chemical risk management unit to increase oversight and enhance monitoring and surveillance to enable timely law and border enforcement actions. Earlier this year, Canada put new controls in place for three fentanyl precursors, using an emergency scheduling pathway. We will continue pushing these efforts forward.

[Translation]

From a public safety perspective, the Canadian drugs and substances strategy informs our efforts to address the overdose crisis and the risks associated with substance use.

[English]

A strong health care system depends on having a well-supported and capable workforce. That's why we're taking concrete steps to help more internationally trained health professionals put their skills to work here in Canada. It's not just about bringing in top talent; it's about giving them the tools, resources and support they need to successfully join the workforce and start caring for patients without delay.

[Translation]

Technology also plays a key role in improving access. We're striving to ensure that everyone receives the care they need, and digital tools are helping us make that objective a reality. Access to personal health information is essential. That's why we're continuing to advance the health data program with the provinces and territories.

• (1110)

[English]

Mental health is another key priority for Health Canada. We're working with our partners in the provinces and territories to support the expansion of integrated youth services and community-based mental health initiatives through the youth mental health fund.

[Translation]

Health Canada is also continuing to administer programs that help make life more affordable for Canadians.

[English]

For example, the Canadian dental care plan continues to grow, with more than five million Canadians approved for coverage.

We remain focused on our core mandate, which is helping Canadians maintain and improve their health.

This is essential to Canada's success, because when Canadians are healthy, they can participate more fully in our country's civic and economic life.

I want to thank the committee for its work in helping us drive our priorities forward and ultimately improve health outcomes for all Canadians.

That concludes my opening remarks. Thank you for the opportunity.

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

Now, I'd like to go to Nancy Hamzawi, president of PHAC, please.

You have five minutes.

Nancy Hamzawi (President, Public Health Agency of Canada): Madam Chair and honourable members, thank you for inviting us before the committee today. It is an honour to be here to discuss the Public Health Agency of Canada's mandate and priorities.

A strong public health system contributes to ensuring Canada's economic and national security and is fundamental to supporting a healthy and productive workforce, social and economic prosperity, and the long-term well-being of our society.

[Translation]

Health Canada's mandate is to improve the health of every individual and community in Canada by responding to threats to public safety, preventing illnesses and injuries, and fostering good physical and mental health. The mandate includes mitigating the public health impacts of infectious disease outbreaks and health emergencies, such as pandemics and natural disasters.

[English]

Against the backdrop of increased geopolitical complexities, the agency is focused on building resilience and preparedness and contributing to Canada's defence posture.

While the agency's reach is broad, three public health concerns are top of mind for the agency this fall: highly pathogenic avian influenza, the ongoing measles outbreaks and the toxic drug crisis.

[Translation]

On avian influenza, PHAC, in partnership with health portfolio departments and agencies, as well as provincial and territorial partners, continues to enhance efforts in risk assessments, surveillance, response and coordination, and medical countermeasures to increase our readiness to protect the public.

[English]

While the current risk to the public remains low, avian influenza can cause serious illness in people. Canada is being proactive and has already obtained 870,000 doses of human vaccine against avian influenza to help provinces and territories protect Canadians against this emerging global threat.

I'll turn to measles. Over the past 30 years, Canada has been considered by the World Health Organization to have officially eliminated measles. Canada is now at risk of losing our measles elimination status as early as this month, given that transmission will have been sustained for over one year.

As of September 26, a total of 5,449 cases have been reported to the agency. The majority of these cases are linked to a multi-jurisdictional outbreak that started in October 2024 and is ongoing.

Overall, the risk remains highest amongst unvaccinated individuals—93% of cases were unimmunized or had unknown vaccination histories—and children, where we are seeing that 70% of cases were under 18 years of age.

[Translation]

The agency is actively monitoring recent increases in measles detected worldwide, as well as supporting provinces and territories as needed with new cases in Canada.

[English]

Canada is also working hard to combat the toxic drug crisis, which has had significant and tragic health, social and economic impacts on Canadian society.

Over 12 months, between April 2024 and March 2025—our most recent reporting period—there was a daily average of 18 opioid toxicity deaths, 15 opioid-related hospitalizations, 64 emergency room visits due to opioid-related poisonings and 95 responses by emergency medical services for suspected opioid-related overdoses. That's every day.

The agency is carefully monitoring this ever-changing situation and providing activities to advance the government's drug policies through surveillance and applied research, upstream prevention approaches and targeted public education.

Throughout all streams of work at the agency, scientific excellence is at the heart of what we do.

The agency now has an advisory committee on science, which is composed of external experts to provide impartial and timely scientific advice on the agency's science and research agenda.

[Translation]

This committee is mandated to provide critical assessments of our proposed scientific activities, including science planning, innovation in public health science and research and health equity promotion.

[English]

As you may have seen in the news, the agency is undergoing transformation as it continues to ramp down from our pandemic response toward a sustainable posture that concentrates on our health security mandate.

During this period of recalibration, we remain steadfast in our commitment to delivering for Canadians by advancing our mandate with a renewed focus on public health impact and alignment with the government's mandate and missions. It is the unwavering commitment to public health and public service of all PHAC employees

that drives our work forward for all Canadians. It's a commitment that is truly a privilege for me to observe and recognize every day.

It is a privilege for my colleagues and me to appear before this committee today to share with you all the work—

• (1115)

The Chair: Thank you very much.

Now we will begin the question and answer period. I would like to say that it's a six-minute round, and the six minutes include the questions and answers. Just be reminded of that, and I will give you a time call when I think you're getting near the end of that time period.

We will begin with a six-minute round, starting with Mr. Mazier for six minutes for the Conservatives.

Mr. Mazier.

Dan Mazier (Riding Mountain, CPC): Thank you, Chair.

Thank you to the officials for coming out this morning.

My questions will be for Health Canada.

Ms. Weber, Health Canada is the federal department that approves supervised consumption sites. Is this correct?

Kendal Weber (Assistant Deputy Minister, Controlled Substances and Cannabis Branch, Department of Health): Yes, when a request comes in to seek an exemption to put a supervised consumption site in place, Health Canada reviews the exemption request for public health and public safety.

Dan Mazier: According to Health Canada's website, a supervised consumption site is a place where “a person brings their drugs to a site to consume” and “depending on the site, drugs are injected, snorted, inhaled or consumed as pills”.

Is that description still accurate?

Kendal Weber: The supervised consumption sites provide a place for individuals to go to use illegal substances in a place where there is supervision, so that if there is an overdose, there is support for the individual.

• (1120)

Dan Mazier: It is a place where they consume, where drugs are injected, snorted and inhaled.

Kendal Weber: Yes.

Dan Mazier: That's what they do.

Is crack cocaine allowed to be used in some federally approved supervised consumption sites, yes or no?

Kendal Weber: The supervised consumption sites are approved taking into consideration public health and public safety concerns. They provide a place for individuals who use substances to go into a supervised place to use illegal drugs.

Dan Mazier: Crack cocaine could be allowed to be used in these federally supervised sites.

Kendal Weber: Illegal drugs are used in the supervised consumption sites, so that individuals—

Dan Mazier: Crack cocaine, as an example....

Kendal Weber: There's an assortment of illegal drugs.

Yes, illegal drugs are used in supervised consumption sites, so individuals have health practitioners who are nearby to oversee if there's an overdose and to prevent death.

Dan Mazier: Is meth allowed to be used in these sites?

Kendal Weber: Illegal substances are used in supervised consumption sites, so that health practitioners can be there to oversee if there is an overdose.

Dan Mazier: Meth is allowed to be used in these sites. It's an illegal substance.

Kendal Weber: Illegal substances are allowed to be used in the sites.

They seek an exemption from the Controlled Drugs and Substances Act, so that health practitioners can be there to oversee the use of the drugs in case there is an overdose.

Dan Mazier: What is the most common drug used at the supervised consumption sites that Health Canada approves?

Kendal Weber: I don't have the most common drug, but I suspect it's fentanyl, given that the largest volume of deaths we see right now is associated with the use of illegal fentanyl in and across Canada.

Dan Mazier: Yes, you're right. According to your website, it is fentanyl.

Forty-nine per cent of visits to the supervised consumption sites that your department approves include fentanyl use. Is that correct?

Kendal Weber: What's important is that the supervised consumption sites seek.... The organizations come in to seek an exemption from the Controlled Drugs and Substances Act so that individuals can go in and use illegal substances. A health practitioner oversees the use in case there's an overdose.

Dan Mazier: Yet, 49% of those visits are due to fentanyl, according to your website. That's all I'm confirming.

Is your website correct?

Kendal Weber: Yes. There are individuals across Canada who are using illegal fentanyl. The sites provide a place where they can go to use it, and there's a health practitioner to oversee and support in case of overdose, to prevent death.

Dan Mazier: Thank you, Chair.

Health Canada is considering an application for a supervised consumption site in Whitehorse, Yukon. The location is only 200 metres from École Whitehorse Elementary School, 300 metres

from Kidz Learnville Daycare, and 400 metres from Footprints Daycare.

Will you commit today to rejecting this application, given its proximity to children's schools and day cares?

Kendal Weber: If that request is in for review, we will assess it based on public health and public safety.

One of the key components involved in an exemption request from the community is consultation with the community. That will be a key component of the application coming in from the community: to look at community consultation, public health needs and public safety needs.

Dan Mazier: You're not willing, then, to commit today to rejecting this application, being that it's this close. You have illegal drugs 200 metres away from public schools and public day cares, and you're not willing to commit to that today. You can't give any indication to the public on how you're considering this and whether you will reject or seriously consider rejecting this proposal.

Kendal Weber: We review each exemption request on a case-by-case basis—

Dan Mazier: You can't give me a yes or no. Okay. That's good. I have another question for you.

Does Health Canada automatically reject applications for supervised consumption sites if they are next to schools or day cares, yes or no?

Kendal Weber: We do not have a prohibition in the legislation related to the distance from schools. Some provinces in Canada do have restrictions on the distances from schools. In particular—

Dan Mazier: Has Health Canada ever received reports of discarded drugs, used needles or crack pipes ending up in school playgrounds or day care yards next to the supervised consumption sites the department has approved?

• (1125)

Kendal Weber: I can't speak to the complaints. We are aware that there is public use of substances in communities.

Dan Mazier: You've never had reports come across your desk.

Thank you, Chair.

The Chair: Thank you.

I will now go to Mr. Eyolfson for the Liberals for six minutes, please.

Doug Eyolfson (Winnipeg West, Lib.): Thank you, Chair.

Thank you all for coming. It's a pleasure to see everyone here today.

I have follow-up questions for Ms. Weber, regarding supervised consumption sites.

To your knowledge, how many overdose deaths have taken place at supervised consumption sites in Canada?

Kendal Weber: There have been no deaths, but the sites have responded to over 65,000 overdoses, and they've been visited more than 5.3 million times.

Doug Eyolfson: Can it be a reasonable assumption that, had these people been consuming drugs in places other than a supervised consumption site, they would have had a significantly higher chance of dying?

Kendal Weber: If there were not the supports needed, such as naloxone, to save the individual, then that could be the case.

Doug Eyolfson: Thank you.

There have been reports of people saying that there are things like crack pipes or discarded needles found near these places.

At a safe consumption site, when someone is using a needle, do the people take these needles with them, or are they disposed of on site?

Kendal Weber: There is safe disposal on site.

Doug Eyolfson: Thank you.

Is there any estimate on disease prevention? We do know that reusing needles can increase the risk of transmission of diseases like HIV, hepatitis B or hepatitis C. Is there any data or evidence on what the supplying of clean needles to people using at these sites.... What is the burden of disease that would have been prevented at these sites?

Kendal Weber: Yes, definitely, the burden of disease is reduced. The actual origin of supervised consumption sites a few decades ago actually originated around the time of HIV and also infectious disease.

Doug Eyolfson: Thank you.

Ms. Hamzawi, regarding mitigation of outbreaks, there are various estimates in the medical literature on this. The public health actions taken during the pandemic were controversial and not accepted by a lot of people. Is there an estimate of the number of lives that were saved in Canada by these public health measures that were taken in Canada?

Nancy Hamzawi: I do not have the specific number handy with me now, but I can get back to you with the number of lives saved.

Doug Eyolfson: Am I correct in understanding that the relative mortality due to COVID in Canada during the pandemic was one-third that of the United States?

Nancy Hamzawi: It was significantly less. That was thanks to the largest vaccination campaign in the history of Canada; 152 million vaccines were distributed across Canada.

Doug Eyolfson: Thank you.

We were talking about the measles outbreak and how it's increasing. I'm seeing yet another headline from Manitoba yesterday of another large outbreak that's happening. That's my home province. Do we have any strategies on how we can better improve vaccine uptake in Canada?

Nancy Hamzawi: Just on the measles in particular, I'll note that this is an area of active collaboration with provinces and territories.

This is all hands on deck, and in fact the deputy and I were meeting with our deputy counterparts last week in Edmonton, where we did have a discussion around measles and how all governments are seized with this issue. We are working together to make sure that we're bringing the best available information to Canadians.

The vaccinations are being delivered particularly, for example, to populations that are particularly vulnerable, to make sure they have the information they need so that they can make proper decisions for themselves.

● (1130)

Doug Eyolfson: Thank you.

I've been hearing claims that some of the measles outbreaks and other newer infectious disease outbreaks are due to increased immigration in Canada. Is there any data to support that?

Nancy Hamzawi: I'm not aware of any data to support that.

As I noted earlier, 93% of cases are individuals who are unvaccinated.

Doug Eyolfson: Thank you.

How much time do I have, Madam Chair?

The Chair: You have 26 seconds.

Doug Eyolfson: I don't think I can ask a meaningful question in that time.

Thank you very much.

The Chair: We'll now go to the Bloc Québécois.

Monsieur Thériault, you have six minutes, please.

[*Translation*]

Luc Thériault: Thank you very much, Madam Chair.

Good morning, everyone.

Ms. Hamzawi, I'd like to start by congratulating you on your new position.

In early September, you indicated that you were going to cut 320 positions. You also said at the time that this would lead to you re-establishing priorities, streamlining certain programs and, in some cases, shutting down certain activities altogether. Are there priorities that you're going to abandon? If so, which ones? What activities are you going to shut down?

Nancy Hamzawi: Thank you very much for the question.

I want to emphasize that we were very serious about making decisions to adjust programs at the agency, which was created in the wake of a pandemic crisis. Our priority is health security.

Our cuts focus more on staff reductions, and we will maintain the agency's range of activities. For example, the health promotion and chronic disease prevention branch will continue its regulatory activities. Based on the lessons we've learned from the COVID-19 pandemic, we're going to build our capacity in a few areas, such as waste water surveillance and genomics. Those are capacities that we didn't have before the pandemic. There will be cuts in a number of areas, but as of now, the agency isn't going to shut down any specific activities.

Luc Thériault: You can't tell me today, then, which activities will cease or which priorities will be abandoned.

By the way, I appreciate your speaking in French, but if you're more comfortable in English, I can have access to the interpretation. I don't mind. That might speed up the pace of our conversation and give me more time to ask my questions.

Nancy Hamzawi: I'll try to speak faster in French.

The focus is on health security. We aren't going to abandon any priorities; we're going to adjust our staff across all our activities.

Luc Thériault: What I understood was that all the cuts applied to all the programs, and that this could also affect the activities of the national microbiology laboratory. As far as I know, the laboratory's work is quite essential in terms of research, diagnostic tests, surveillance and disease containment. It also plays a crucial role in national, and even international, biosecurity.

Why cut jobs there? How do you guarantee that we won't find ourselves in the same pre-pandemic movie where a government—not the last one, but the one before it—had cut programs and put us in a situation where the pandemic hit us hard? How can you assure us that Canadians won't be put at risk when an organization as essential as that one will be subject to cuts?

• (1135)

Nancy Hamzawi: The budget cuts aren't the same in each branch. For example, the national microbiology laboratory branch was the least affected one. It had a 4% reduction, which focused on areas where there were efficiencies or areas where university research was being done as opposed to applied research. It was the least affected branch within the agency.

The 320 positions represent 10% of our current workforce. For example, in branches like the group that supports me and Canada's chief public health officer, there's been a 50% reduction. We tried to make cuts on the oversight and administration side to avoid touching the programs that are crucial for Canadians' health.

Luc Thériault: You talked about measles and infectious diseases earlier. We know there's a vaccine issue, and we can come back to that, but can you assure us that you have everything you need to deal with this trend and the fact that serious diseases will resurface?

Nancy Hamzawi: Yes, I'm absolutely confident that we have the resources. We're ready.

[English]

The Chair: Thank you very much, Mr. Thériault. I'll now go to the second round.

I'd like to clarify. I understand that in the second round Mr. Thériault had six minutes, and after that he reverts to 2.5 minutes in subsequent rounds. That is my understanding.

That's okay?

He is nodding. Thanks.

I'll go to Ms. Konanz for five minutes, please, for the Conservatives.

Helena Konanz (Similkameen—South Okanagan—West Kootenay, CPC): Thank you so much, Chair.

Thank you to all the experts in the room. I'm excited to find out more about your priorities.

I think I will direct my first question to Ms. Weber.

In 2023, the B.C. government and the federal government created a pilot program that allowed any adult to possess illicit hard drugs in British Columbia. Since then, more than 6,000 people—husbands, wives, daughters, sons—have died in drug deaths. This has created havoc in our communities.

This decriminalization pilot program is expiring in January 2026. To date, have you received a request from the B.C. government for an extension on this deadly experiment?

Kendal Weber: No, we have not.

Helena Konanz: I think I'll ask a question of you again, Ms. Weber, if I may, through the Chair.

This was a federally approved pilot project. I'd like to know—and I'm sure the residents of B.C. would like to know—what the top three metrics are that you're using or you use to judge the success of this project.

Kendal Weber: The decrim—the goal of the exemption related to personal possession of certain drugs—was to reduce stigma and also reduce the fear of criminal prosecution that prevents people from seeking help. It's the first exemption of its kind, and I think what's important is that throughout the exemption and through the oversight of the pilot project, consultation continued with stakeholders. B.C. actually came in twice to seek a modification and amendment to the exemption.

As such, right now, the exemption is limited to personal possession in homes or in addiction clinics or also in overdose prevention sites. It's quite limited, and it's illegal in public places.

Helena Konanz: Excuse me, Ms. Weber. That's really good information, but what are the metrics you're using to judge the success of this project? We've seen thousands of people die on the streets of British Columbia. It has been recommended by many experts that this project not continue. You must have some metrics that you're using. Otherwise, it wouldn't have continued to this point.

• (1140)

Kendal Weber: We do require reporting from the Province of British Columbia on a quarterly basis. They put their reports on their website, and you'll see there that there are four dimensions to the reporting, the oversight and the metrics, the first being the utilization of health care services; then the well-being of the people who use drugs; law enforcement; and, of course, public awareness and understanding of decrim.

They report on different indicators under those four themes on a quarterly basis. That is actually published on their website for public review.

Helena Konanz: You believe this has been a success, or you wouldn't have continued it up to this point.

We have, unfortunately, drug-addicted people wandering the streets like zombies. They are high on drugs. Is that deemed to be an acceptable outcome as part of this pilot program?

Kendal Weber: We continue to monitor the exemption. It expires in January 2026. We have not received a request for a renewal of the exemption. It has been amended twice—

Helena Konanz: Excuse me.

If you do receive a request by the British Columbia government to extend it, will you extend the program?

Kendal Weber: We're not at the end of the pilot right now. When the request comes in, it will be under the Controlled Drugs and Substances Act, and we'll assess public health and public safety and look at the indicators.

Helena Konanz: Right now we have had requests from multiple communities to end this program. We've also had requests from the RCMP. We've had requests from the British Columbia Association of Chiefs of Police and the Canadian Association of Chiefs of Police, calling on the federal government to reverse its position.

Why hasn't your organization reversed this decision, when you have the opportunity to give that advice to the minister?

Kendal Weber: The Province of British Columbia did come in to seek amendments to the exemption. Twice we've made amendments. It's narrowed down now, as I mentioned earlier, to the four locations where individuals can't possess—

Helena Konanz: Excuse me.

Do you believe this program is a success?

Kendal Weber: The exemption is not complete. It's a three-year exemption until January 2026.

The Chair: Excuse me, time is up.

I now go to the second person from the Liberals.

Ms. Sidhu, you have five minutes.

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

Thank you to all of the officials for appearing at this committee today to share your important insights with Canadians.

I would like to direct my first questions, on artificial intelligence, to Health Canada.

Earlier this year, the federal government announced the guiding principles on pan-Canadian AI for health. Could you please share with this committee how these guiding principles can play a transformative role in modernizing Canada's health system?

Greg Orencsak: The principles were developed through collaboration with the provinces, territories and federal government. They are incurred in ensuring privacy, transparency and accountability. They are also aligned with some of the international best practices in this regard. They do provide certain rules for the road in respect to the safe and trustworthy adoption of AI in Canada's health system.

By virtue of having these principles, they are promoting public trust and the responsible use of AI in health. They are also helping to ensure alignment across the country, given the broad participation by provinces and territories.

Sonia Sidhu: Can you share with the committee the role AI can play in the future of health systems?

Does AI adoption in the health system help increase diagnostic efficiency within primary care and emergency care, do you think?

Greg Orencsak: In terms of adoption, I think there are many promising ways in which AI can help transform health care in a number of different ways, from detection to better diagnostics, while maintaining high standards and an appropriate use of resources.

We're seeing a fair bit of adoption and success in terms of adoption in doctors' offices as it relates to AI scribes, for example. It's helping to relieve some of the administrative burden that practitioners are facing.

It's being used in hospitals to predict certain events. It's also being used to predict wait times.

It's also helping to support research and innovation, predicated on having good, high-quality standardized data to enable the use of these kinds of technologies in the health care space.

• (1145)

Sonia Sidhu: Thank you.

We heard about the longer wait times. Do you think it can reduce wait times and optimize the allocation of medical resources? Do you believe in that?

Greg Orencsak: There have been examples of that kind of deployment in large and complex settings like hospitals, for example, so it's been deployed in that way, yes.

Sonia Sidhu: My next question is for Health Canada and PHAC, so anybody can answer it.

With the present process of clinical trials in Canada, given that some Canadians are getting alternative treatment in the U.S. or other countries for a faster process, could you please share with this committee what Health Canada is doing to streamline the process while safeguarding our health standards?

Greg Orencsak: Clinical trials obviously play a really important role in advancing health research and the effectiveness of medical treatments, and it's a very active ecosystem.

What we're doing at Health Canada is introducing new regulations to streamline processes in a deficiency of establishing clinical trials, so that we can have more clinical trials take place in Canada to support innovation and access to drugs for Canadian patients.

Sonia Sidhu: I'll pass, then.

The Chair: Thank you.

Mr. Thériault of the Bloc Québécois, go ahead for six minutes, please.

[*Translation*]

Luc Thériault: Thank you, Madam Chair.

Ms. Weber, I want to talk about recommendations 48 and 42 in the final report of the expert panel that conducted the legislative review of the Cannabis Act.

You're no doubt aware that a number of problems have been created since the act came into effect. For example, the fact that four people can grow cannabis at the same address has led to abuses and excessive produced quantities. The Health Canada website still says that this is possible under the rules.

At what point are you going to implement the expert panel's recommendation to make it so that only one person can grow cannabis per location?

[*English*]

Kendal Weber: I do not have the numbers of the recommendations. Are you talking about personal production of cannabis and the number of licences we have in authorizations per home? Is that the question?

[*Translation*]

Luc Thériault: It's for production for medical purposes.

[*English*]

Kendal Weber: The question is about medical use. Okay.

[*Translation*]

Luc Thériault: Four people were allowed to produce cannabis in the same place. That has led to excesses. The expert panel said that the limit should be reduced to one person per site. When are

you going to implement that recommendation? A number of people are waiting for that.

Kendal Weber: Thank you.

[*English*]

We do allow up to four individuals to have authorizations in their homes for medical cannabis. What we have done is taken significant measures to revoke or refuse those authorizations if we see that individuals are growing more than the amounts authorized by their physicians. They see their physician; the physician makes the recommendation—

• (1150)

[*Translation*]

Luc Thériault: There's a problem: You don't intend to implement the expert panel's recommendation, but even police authorities can't intervene given that the act is set up that way. When police officers have to intervene, they have to intervene because someone's gone beyond what the act allowed.

That said, I'd also like to talk to you about the expert panel's 42nd recommendation, which states that pharmacists should be allowed to distribute cannabis products to individuals who hold a medical authorization. The Association québécoise des pharmaciens propriétaires tells us that pharmacists are in the best position to provide therapeutic monitoring of cannabis for medical purposes. Patients could then benefit from their professional advice, particularly when it comes to interactions. People who take cannabis for medical purposes often take other medications as well.

Do you intend to implement this recommendation by allowing pharmacist-owners to distribute cannabis for medical purposes? That is done in Australia, France, Germany, Israel, Italy and the United Kingdom.

Kendal Weber: Thank you for the question.

[*English*]

For distribution in retail outlets, the oversight is with provincial governments. If there is a desire for distribution in pharmacies, that is something that can be considered at the provincial level. The medical access is done through federal licence-holders, and it is something we continue to oversee. If there is an interest in retail outlets and pharmacies, that's something for provinces to also look at.

[*Translation*]

Luc Thériault: However, there's a provision in the act that means that distribution isn't necessarily done by pharmacists. Yes, provincial governments can legislate in this area. However, will your department be proactive about this recommendation and argue that it is indeed a safer solution for patients?

[*English*]

Kendal Weber: It really does involve a collaborative approach with the provinces, given the jurisdiction in the space for retail and, also, oversight of pharmacies.

[*Translation*]

Luc Thériault: Does that mean we have to wait and see?

A committee of experts is telling you that this is an important solution for patient safety. Are you going to promote that, or are you going to wait and see until, all of a sudden, the provinces decide to do it? Do you or do you not have a plan for that, or are you telling me that the expert panel overstepped its mandate?

[English]

Kendal Weber: No. The review committee did an excellent job, provided a number of recommendations and did extensive consultations. A number of them were directed specifically at the federal government, and a number of recommendations involved federal, provincial and territorial jurisdictions working together. In this space, it's important that we work with the provinces and territories that have an interest in exploring this.

The Chair: Thank you very much, Monsieur Thériault.

We go to the Conservatives for five minutes. Mr. Bailey, go ahead for five minutes, please.

Burton Bailey (Red Deer, CPC): Thank you, Madam Chair.

I direct my question to Health Canada. The tobacco strategy has set a target of less than 5% tobacco use by 2035, countrywide. What is the current estimate of the number of Canadians who smoke cigarettes—just a percentage?

Greg Orenszak: According to 2024 data, approximately 11% of the Canadian population over the age of 18 smoked cigarettes during the last 30 days.

Burton Bailey: Does Health Canada have any updated data, which has been collected since 2022, to prove that the tobacco strategy is working?

Greg Orenszak: We continue to receive survey data of the rates of smoking and vaping by Canadians, so we continue to monitor that.

Burton Bailey: One of the four main themes of the strategy is to help Canadians quit tobacco by “giving information on and access to less harmful sources of nicotine”. In your evaluation, would a less harmful source of nicotine include nicotine replacement therapy pouches?

• (1155)

Greg Orenszak: As you know, cigarette smoking is one of the leading causes of preventable disease and premature death. We are committed to continuing to help people quit smoking, to keeping vaping products out of the hands of children, and to looking at ways in which we can help smokers quit.

Burton Bailey: Data from 2022-25 would suggest that the use of nicotine pouches as an alternative to smoking cigarettes led to a marked decrease in cigarette sales, from the point of Health Canada regulation, of about 4%. Why was the sale of pouches approved by Health Canada in the first place?

Greg Orenszak: Nicotine pouches were approved as one of the products that exist in terms of other ways in which people can consume nicotine and that are less harmful than cigarettes.

Burton Bailey: Madam Chair, I'm having trouble hearing. Can we turn up Greg's mic or...? I can't hear him.

The Chair: We'll suspend your time for a second while we find out what's wrong.

Burton Bailey: Thank you.

The Chair: Is your volume up?

Burton Bailey: Okay, I'll try again.

Why did the former minister of health, Mark Holland, unilaterally restrict nicotine replacement pouch sales to behind the counter in pharmacies, making it significantly more difficult for those who wish to find alternatives to cigarettes?

Greg Orenszak: In August 2024, Health Canada did publish a ministerial order that introduced new measures around nicotine replacement therapies. That was done, in large measure, as a result of concerns that had been expressed by health care professionals about youth using nicotine replacement therapies like pouches recreationally.

Burton Bailey: In order to help Canadians quit smoking and achieve Health Canada's target of 5% or less tobacco use by 2035, would it not make sense to give Canadians access to nicotine pouches?

Greg Orenszak: Nicotine pouches continue to be accessible to Canadians. They're available in pharmacies behind the pharmacy counters. Canadians who choose to use that kind of nicotine replacement therapy continue to be able to access it.

The measures that were taken by the former minister were, in large measure, to protect youth from the harms of the recreational use of these pouches.

Burton Bailey: Will Health Canada give Canadians the freedom to choose to stop smoking by reversing the former Liberal health minister's order and regulating the sales of nicotine pouches in the same way that cigarettes are sold, which is with valid, government-issued ID to legal adults only, to protect against youth access while supporting Canadians who wish to stop smoking?

Greg Orenszak: We will continue to review and consider many sources of evidence to inform these new rules, including data on the flavour appeal to youth, for example, as well as any feedback that we get through consultations. We'll continue to consider the risk factors going forward in terms of measures that may be appropriate to mitigate harms, especially as they relate to youth, while continuing to strike the right balance to maintain access to smoking cessation tools for those who need them.

The Chair: Thank you. The time is up, Mr. Bailey.

I now go to Mr. Powlowski for five minutes, please.

Marcus Powlowski: A number of us here were on the committee at the outbreak of COVID-19, including Monsieur Thériault and Sonia. I see Todd Doherty sitting over there; I think he was on the health committee at the time.

In the weeks leading up to COVID-19, we had Dr. Tam here, and Dr. Njoo, I think. We asked about the assessment of the risk. We were repeatedly told in the weeks preceding the actual shutdown of our society that the risk was low. This was despite the fact that I think you could have gone into any locker room or hockey arena in Thunder Bay and asked a beer hockey team what they thought the risk was, and the majority of people would have said, “Yeah, it’s coming.”

I think the Public Health Agency of Canada and Health Canada underestimated the risk. I think our response to the initial outbreak was suboptimal. I think there have been a number of inquiries looking at why that was.

The Globe and Mail had an article in which it investigated and talked to a lot of people about what the problem was with PHAC. I know the Auditor General also came out with a report. I certainly know that one of the things The Globe and Mail criticized was the fact that, in their assessment, the Public Health Agency of Canada and Health Canada had become heavily dominated by bureaucrats rather than medical people. That is something that has taken place over a number of years. That made it feel as though this was one of the factors that contributed to our suboptimal response.

I would note that Madam Hamzawi, the new leader of the Public Health Agency of Canada, is not a doctor. Dr. Tam, who was a doctor, was previously there.

I do not think that you need to be a doctor to be the head of the Public Health Agency of Canada, but what can you do to reassure people like me and the Canadian public that our government has addressed the concern about the lack of medical people?

I’m glad Dr. Sharma showed up here, because she is a medical person.

How can you assure us that in fact you are getting the medical input and the best medical evidence in making your decisions?

• (1200)

Nancy Hamzawi: First off, I should clarify that the Public Health Agency of Canada Act is very clear. There is a president of the agency, and that is me. Essentially, I act as the chief executive officer of the organization. There is also a chief public health officer, who also is part of the leadership of the agency. Those are two distinct positions. In fact, in the act, there are four more provisions associated with the chief public health officer than there are with the president, in recognition of the very important role of the chief public health officer.

Currently, the interim chief public health officer is Dr. Howard Njoo. There is a competitive appointment process that is under way, and we look forward to the conclusion of that process soon.

What I can assure you is that the agency continues to have science and medical advice at the core of its work, and we’re continuing to ensure that we bolster that to the fullest extent possible. As I noted earlier in terms of the reductions, we have been very careful to minimize the reductions in those areas. For example, the lab is the least impacted by the changes.

Perhaps I might note—and this goes back to an earlier question, Madam Chair—that, in terms of the COVID-19 pandemic, without

public health measures or vaccines, there would have been up to 800,000 deaths. The observed number of deaths, as of April 24, 2022, was 38,783. Without public health measures or vaccines during the pandemic, up to two million hospitalizations were expected, and there were 150,602. Without public health measures or vaccines, there would have been up to 34 million cases, but there were 3.3 million reported cases. Those are the facts in terms of what happened during the pandemic and what the modelling shows.

The Chair: Thank you, Dr. Powlowski.

I will now go to the third round. I’ll begin with the Conservatives.

Mr. Strauss.

Matt Strauss (Kitchener South—Hespeler, CPC): Thank you, Chair.

Thank you to all the officials who have come. I used to be a public health official, and I had to present myself to the board of health. It is always stressful, so I appreciate what you’re doing, being here today.

My questions are for Ms. Hamzawi.

I want to say before I start that I noted when you were appointed that there was a lot of unfair and, frankly, ugly and inappropriate criticism of your appointment. I thought you handled that with a lot of grace and composure, so thank you for your service.

I reviewed this document, the Public Health Agency of Canada science strategy. I know it was prepared before your tenure. I don’t know if you’ve had time to review it, but there are parts of it that I found very interesting, and I want to ask you some questions about it.

With respect to this document, several references are made to decolonization and science. In your view, is the Public Health Agency of Canada science strategy currently colonized?

• (1205)

Nancy Hamzawi: That essentially reflects the importance of health equity in the work that we do. I would interpret that as making sure that we reflect the importance of reaching all Canadians and having an anti-racist lens to the work that we do.

Matt Strauss: I take that as a yes then, that the science currently being pursued is colonized.

Do you have an example of colonization in the science that the agency is currently doing?

Nancy Hamzawi: I would say that a key priority for the agency is health equity, ensuring that we reach all populations. There are some populations that are more impacted than others. There are our indigenous populations. We have specific programs for Black Canadians. There are a number of populations that need additional supports to ensure that they receive supports for access to health care.

Matt Strauss: Health equity is very important, and “health equity” is in the document many times. It seems like you have a preference for the term “health equity” over the term “decolonization”. I wonder if you would commit to, if that’s what the term means, using the term “health equity” more often in these documents when they are prepared.

Nancy Hamzawi: Thank you for that. I’ll take a look at that.

Matt Strauss: Thank you.

Similarly, the report says that the Public Health Agency of Canada “recognizes that taking meaningful action against racism in science...is crucial for achieving science excellence.”

Is science, in fact, currently racist, and what racist science will you be taking action against?

Nancy Hamzawi: That statement essentially reinforces that we take an anti-racist lens to our work. An example I can think of is from when I was at Health Canada, and it was around the issue of sunscreen in terms of the requirements. An assumption of a lighter tone of skin rather than a darker tone of skin has an impact in terms of the kind of advice that comes forward. That’s an indicative example of what we’re looking at trying to avoid in the advice, the best possible scientific advice, that we can give to you.

Matt Strauss: I will say that it’s a terrific example. I remember it from when I was in medical school in 2004, and I was thinking exactly that.

The report says that PHAC wants to diversify its science workforce. Does this mean that PHAC will strive to have scientists from diverse academic disciplines working on diverse problems with diverse methods, or does it mean something rather cruder about racial quotas in hiring scientists?

Nancy Hamzawi: We have employment equity obligations enshrined in law, so I would say that it’s both ensuring that we meet our obligations for employment equity but also ensuring that we have multidisciplinary streams of thoughts that support our work. We’re looking at multidisciplinary and interdisciplinary aspects as well as meeting our obligations for employment equity.

Matt Strauss: Are these employment equity outcomes quotas?

Nancy Hamzawi: They are not quotas. They ensure that we engage at a rate similar to workforce availability in each of these areas.

Matt Strauss: I think you called them a mandate. Where does the mandate come from to pursue these parameters?

Nancy Hamzawi: We have employment equity obligations under statute.

Matt Strauss: It’s under statute. Okay. If you could table those statutes later, I would be interested to review them.

Is there a way to know if what you called the racial equity parameters are being met, and are they being met right now?

Nancy Hamzawi: I’m sorry, can you ask the question again?

Matt Strauss: With respect to the parameters that you have to follow under statute, are they being met right now? Are the necessary requirements being met at this moment?

Nancy Hamzawi: I last looked at our employment equity gaps last week. This is particularly important for us as we recalibrate as part of the reductions that I was speaking to earlier. We are not meeting our targets in terms of persons with disabilities nor with indigenous populations. Those are two areas that we are continuing to work on in terms of making sure that we close those gaps.

The Chair: Thank you very much.

We now move on to the Liberals.

Ms. Chi, you have five minutes.

• (1210)

Maggie Chi (Don Valley North, Lib.): Thank you to all the officials for attending the meeting today. Thank you for letting us pick your brains on various topics.

As we know, Canadians understand that mental health is health and that supporting mental wellness is just as critical as treating physical illnesses.

From an economic perspective, poor mental health can drive absenteeism, lower productivity and lead to premature workforce exits. Conversely, when people have access to mental health supports and resources, whether through their family doctor, community groups or organizations right in the workplace, they are more resilient and more engaged in the labour force. It’s especially important as Canada faces demographic and workforce pressures in the years ahead.

Could you outline how Health Canada’s broader mental health initiatives are helping Canadians stay engaged in the workforce and support economic participation? How do you work with the provinces, territories and partners to ensure that Canadians can access the supports they need in a timely way?

Greg Orensak: You’re right that mental health issues are highly prevalent. I think that the statistic showed that about one in three Canadians will experience mental illness in their lifetime.

The work that we’re doing through Health Canada is one of a collaborative nature with provinces, territories and stakeholders to support a multidisciplinary system that helps integrate mental health as part of the patient-centred approach to health care, so it’s supported and integrated as part of the continuum of care. That includes going from promotion to prevention and supports to services for treatment.

One of the areas of priority through the working together agreements to improve health care for Canadians was on mental health, including the \$25 billion that was set aside for shared priorities with provinces and territories. There are bilateral agreements with each province and territory that include that mental health pillar. It’s one of those priorities.

Maggie Chi: Thank you.

What are the most common barriers that Canadians face when trying to access mental health care and support? How are you and Health Canada working with partners to reduce those barriers?

Greg Orencsak: One of the barriers is stigma. Obviously that's a significant concern. It comes to promotion and prevention. That's an important part of the work we do.

We also look closely at mental health challenges faced by young people that might prevent them from participating fully in society or in educational pursuits that are critical in helping youth to thrive.

In 2024, we launched the new youth mental health fund. That is an investment that's helping to improve access to care that's close to youth, directly in communities, to help youth thrive and help enable the wraparound services that are important from a continuum of care approach.

Maggie Chi: Thank you.

In terms of technology, my colleague Ms. Sidhu mentioned the adoption of AI, which can help streamline services.

Have you seen virtual care or digital platforms being used to expand access? In remote and rural communities, how are those supporting or expanding services that are tough for them to access?

Greg Orencsak: That is part of the tool kit. We've seen that used in a number of different ways in the context of supporting mental health, and youth mental health in particular. There are organizations like Kids Help Phone that are looking to make inroads with that, consistent with the more technologically savvy nature of younger people these days.

We've also seen the adoption of digital tools in post-secondary institutions in relation to mental health and wellness. These help to provide resources 24-7 and also help in remote and rural communities.

• (1215)

Maggie Chi: Thank you.

The Chair: Thank you.

I will now go to Mr. Thériault for two and a half minutes.

[*Translation*]

Luc Thériault: My question is actually more of a request to you, Mr. Orencsak.

On December 12, 2024, I asked Health Canada to table the Sun Life contract before the committee. Health Canada agreed to do so. There was obviously the prorogation and so on. However, I'd like to know when you're going to table that contract.

Greg Orencsak: Thank you for your question.

[*English*]

We would be happy to make available any details that are pertinent with respect to the contract. We'd be working with our colleagues at Public Services and Procurement Canada to do so if the committee continues to want us to proceed.

[*Translation*]

Luc Thériault: What we want is the contract. You had agreed to share it with us, so we're waiting for the contract.

You chose Sun Life to manage the program. However, according to the president of the Canadian Dental Association, care providers have to be patient when dealing with this insurer. In some cases, he and his colleagues can wait weeks, sometimes months, for a pre-authorization response only to find out that the insurer needs additional documentation.

That doesn't fly. The same dentists pre-authorize in the private sector with the same insurer and it goes quickly. It's as if there's a double standard, two measures. Are you going to follow up on that?

[*English*]

Greg Orencsak: We are aware of the concerns that existed with pre-authorization when it was introduced at the end of last year.

You're right that there was a backlog associated with those approvals. The backlog has now been cleared, and pre-authorization requests are being processed within service levels, well within a week's time, so those have now been resolved.

The Canadian dental care plan is somewhat different from private sector plans in terms of how pre-authorization is used, because what it looks for is whether services are medically necessary. It requires a slightly different approach from what exists for private sector plans.

The Chair: Thank you very much.

I now go to Mr. Doherty of the Conservatives for five minutes, please.

Todd Doherty (Cariboo—Prince George, CPC): Thank you to our guests for being here.

Mrs. Hamzawi, you rattled off some pretty incredible numbers regarding our COVID response. Can you state those again for us?

Nancy Hamzawi: Sure, not a problem.

This is actually from a publication called "Counterfactuals of effects of vaccination and public health measures on COVID-19 cases in Canada: What could have happened?" We are happy to provide that publication to you.

In terms of the numbers in table 1 of this publication, without public health measures or vaccines, there would have been up to 800,000 deaths, but what was observed as of April 24, 2022, with public health measures and vaccines, was 38,783. Without public health measures and vaccines, there would have been up to two million hospitalizations, but what was observed was 150,602. Without public health measures, there would have been up to 34 million cases, and with public health measures, there were actually 3.3 million cases.

Todd Doherty: Is this your modelling? Is this Public Health's...?

Nancy Hamzawi: This is modelling, yes.

Todd Doherty: Can you table that with the...?

Nancy Hamzawi: Yes, we're happy to table this publication. That's no problem. It's in the public domain.

Todd Doherty: How many Canadians died from opioid overdoses last year, and how does that number compare to 10 years ago?

Nancy Hamzawi: The total number of deaths in the period from April 2024 to March 2025.... I'm sorry, I just....

Todd Doherty: That's okay.

Nancy Hamzawi: I have the total number of deaths. From January 2016 to March 2025, it was 53,821. I have the number of opioid-related deaths at 6,601, which was a reduction of 21% relative to the year before.

• (1220)

Todd Doherty: Would you say the government has been successful in bending the curve on this in the last 10 years?

Nancy Hamzawi: We have seen a decrease quarter after quarter for the last four quarters, so we're now ready to say there is a decrease, but that is experienced at the national level. It is very different across the country, and there are different populations, such as indigenous—

Todd Doherty: Right. Take, for instance, my province, British Columbia, which has the highest rate.

Nancy Hamzawi: That's right. Absolutely.

Todd Doherty: What performance metrics, if any, does your department use to measure success in reducing opioid deaths?

Nancy Hamzawi: Our focus from a surveillance perspective is on—

Todd Doherty: Do you have performance metrics? Do you have a national target that you want to hit?

Nancy Hamzawi: We are driving to zero. The intent is to get out of this crisis, but what we're monitoring to be able to see progress is the number of deaths, the number of hospitalizations, the number of visits to the ER and the number of emergency—

Todd Doherty: Okay. Are those going down?

Nancy Hamzawi: Right now, last year, there was a 21% decrease in deaths, a 17% decrease in hospitalizations, a 19% decrease in ER visits and a 19% decrease in emergency service response.

Todd Doherty: Okay.

Nancy Hamzawi: However, again, I want to say this is a national, high-level number. It is highly variable across the country, and at a [*Inaudible—Editor*].

Todd Doherty: Thank you for that.

Ms. Weber, you stated that there were 5.3 million visits to supervised consumption sites. Was that per year? Was that last year?

Kendal Weber: No. I believe that's since 2017.

Todd Doherty: Is that number going up, or is it going down?

Kendal Weber: It continues with people visiting on a daily basis, so the number will increase.

Todd Doherty: Okay.

Do we have a target for reducing opioid deaths? I guess zero is the target.

Nancy Hamzawi: That's the target.

Todd Doherty: Okay. I'll skip to the next one.

SUAP funding is set to expire this year. Is there a replacement program coming, or is that going to be extended?

Nancy Hamzawi: Did you say SUAP?

Todd Doherty: Yes.

Kendal Weber: The SUAP funding is not expiring this year. We do have funding until 2028, and we do have A-base funding for the substance use and addictions program.

There have been top-ups in previous budgets, and some of that is coming up to sunset, but we do have ongoing funding, and then we also have some that will expire at the end of our Canadian drugs and substances strategy, in March 2028.

Todd Doherty: Thank you for that.

Has the department ever provided the minister with a warning that current policies were failing to stop overdose deaths, to your knowledge?

Greg Orensak: The department has briefed ministers in respect to the opioid crisis—

Todd Doherty: Did they follow the information and the guidance that you provided?

Greg Orensak: They have taken advice in terms of the Canadian drugs and substances strategy.

Todd Doherty: Thank you.

Ms. Hamzawi, is PHAC racist? Was that your testimony earlier?

Nancy Hamzawi: No.

No, PHAC is not racist. We are committed—

Todd Doherty: I believe that's kind of what you were—

Nancy Hamzawi: That was not what I was saying.

Todd Doherty: Okay.

The Chair: Thank you.

I think we can do one more round.

We will start with Mr. Mazier for the Conservatives.

You have five minutes, please.

Oh, I'm sorry. I missed Mr. Eyolfson.

I'm sorry, Doug.

Doug Eyolfson: No problem. Thank you, Madam Chair.

Thank you, everyone.

I have some questions for a few of the witnesses here.

Mr. Orencsak, we were talking about the tobacco pouches. Now, I was not in government at the time, but when former minister Holland made changes to the regulations on nicotine pouches, was there not a concern that under the regulations at the time, these were being sold with flavours that were considered more preferred by younger people, and the perception was that this might be increasingly used by young people?

Greg Orencsak: Yes. That was one of the concerns the former minister had. These pouches were attractive to young people by virtue of some of the flavours that they came in, as well as how they were being promoted, advertised and packaged.

• (1225)

Doug Eyolfson: All right. Thank you.

A number of different smoking cessation therapies are available. I know about addiction to tobacco in my own experience. I'm an emergency physician, and I know how addictive this substance is.

To your knowledge, is there any evidence you're aware of that nicotine pouches as a smoking cessation tool are superior to the more conventional approaches, like nicotine patches and nicotine gum?

Greg Orencsak: I don't have that available with me. I can take that back.

I think nicotine pouches have been a fairly recent product that's been introduced on the market. The department continues to look at all kinds of evidence in respect to a variety of smoking cessation tools.

Doug Eyolfson: Thank you.

There's also been a lot of industry-sponsored promotion of the use of vaping as a smoking cessation technique. Do you have any data available that this is an effective smoking cessation technique compared to the more traditional approaches?

Greg Orencsak: I'm going to ask Ms. Weber to jump in on that one.

Kendal Weber: Smoking cessation products that are approved by Health Canada meet safety, quality and efficacy and are approved as a therapeutic product or natural health product. We have not approved any vaping products to date for smoking cessation for safety, quality and efficacy.

We know that individuals use a variety of tools for smoking cessation. Cold turkey is probably the number one and the most effective that people have used. We have seen people use nicotine replacement therapies, as we just discussed, and some people have indicated to us that they have stopped smoking using a vaping product.

Doug Eyolfson: All right. Thank you.

Is there any evidence that if someone starts vaping and has not been exposed to tobacco at all, the likelihood is that they will go on to smoking cigarettes, versus those who don't try vaping at all?

Kendal Weber: On vaping as a gateway for smoking, it's still early days. We don't have evidence at this point that vaping is a gateway to smoking. We monitor it closely, but the Tobacco and Vaping Products Act was just passed in 2018. It's been legal in Canada for just a few years. We continue to monitor it closely.

Doug Eyolfson: Okay. Thank you.

Ms. Weber, I'm going back to supervised consumption sites. Is there any evidence that these sites promote or increase the likelihood that people will take illegal drugs?

Kendal Weber: They actually are a safe place for people to go into to use the drugs that they're currently using.

Doug Eyolfson: In regard to the selection of sites, there are people who will object to them being in certain places. I remember Manitoba was setting one up. Are they not set up where people are actually already using drugs?

Kendal Weber: The communities come in, and they come in with an application, with a site that they have picked. It's based on the public health needs in that community, in that area of the community, and the public safety needs of that community. Then, they also do community engagement. The community comes forward with the location. They provide that evidence and the information to the department, and then the department assesses the public health and public safety balance of that request.

Doug Eyolfson: Thank you. How much time do I have?

The Chair: That's it.

We'll go to one more round. I think we can fit that in.

I have Mr. Mazier for five minutes.

Dan Mazier: Thank you, Chair. I have a follow-up on Mr. Eyolfson's line of questioning.

Ms. Weber, does Health Canada have any concerns with approving supervised consumption sites next to a school, yes or no?

Kendal Weber: It's important that we look at the application—

• (1230)

Dan Mazier: It's just a yes or no. Do you have any concerns with that?

Kendal Weber: It is part of the consideration when an application comes in. The community that is coming forward needs to consult with the community, including nearby schools.

Dan Mazier: You have concerns. What are those concerns?

Kendal Weber: A consideration is the engagement with the community as to their concerns or their support for the supervised consumption sites.

Dan Mazier: Health Canada has no concerns, then?

Kendal Weber: The location of the site and the engagement with the community are important when they come in. That's part of the application, and we review that when we assess whether there's an approval or rejection of the application.

Dan Mazier: Will safe supply continue to be funded by this government?

Kendal Weber: Health Canada funded 31 projects and is no longer funding safer supply projects. They were funded under our SUAP program, which is the substance use and addictions program, and that program is to test innovative solutions to respond to the overdose crisis. In this case, we did fund the sites, and then it is up to the provinces and territories whether they want to scale up or continue with those safer supply or prescribed alternative sites.

Dan Mazier: Thank you.

Is any funding provided by Health Canada or the Public Health Agency of Canada being used to purchase crack pipes?

Kendal Weber: No.

Dan Mazier: According to The Globe and Mail, a foreign drug maker named Grifols is using Canadian-donated blood plasma for products sold offshore. This is despite a promise from Canadian Blood Services that all products used from Canadian blood donations would stay in Canada.

Is Health Canada investigating this, yes or no?

Greg Orencsak: The contract with Grifols is with the Canadian Blood Services, so they would be able to answer questions associated with that. We are not investigating this at the moment.

Dan Mazier: Yet Health Canada is responsible for the regulatory oversight. You're not investigating it, correct?

Greg Orencsak: We're not part of that contract.

Dan Mazier: Okay, thank you. I'll cede my time to Ms. Konanz.

Helena Konanz: Thank you. Through the chair, I'm going to ask a question of Ms. Weber again about the 2023 agreement with the B.C. government and the federal government for the decriminalization of drugs, only in B.C. at this point.

Have other provinces asked to join this decriminalization program?

Kendal Weber: We do not have any other exemption requests in front of us for review. There were others that had considered it in the past, but we do not have any other provinces that have approached us currently.

Helena Konanz: Ms. Weber, why do you think there have been no other requests from any other provinces to join this program?

Kendal Weber: It's not a program; it's an exemption request that comes in from a jurisdiction—

Helena Konanz: It's a pilot project. Is that correct?

Kendal Weber: It's an exemption from the Controlled Drugs and Substances Act, and the Province of B.C. came in as part of their comprehensive approach to respond to the overdose crisis.

In each jurisdiction, it is up to those provinces, should they choose to—

Helena Konanz: Thank you, Ms. Weber, for answering that question.

I have a question about the possible suspension of the program if it's deemed that it's not safe. There have been multiple communities in British Columbia—as well as RCMP and first responders—that are crying out for this program to end.

This exemption, from what I understand, may be suspended without prior notice if the minister determines that such a suspension is necessary to protect public health or public safety.

Under what circumstances will you advise this? Under what circumstances would you say that you would suspend this program, this pilot project?

Kendal Weber: As noted earlier, we monitor it closely, and the Province of B.C. monitors it closely, and they engage with stakeholders. We have amended it twice over the past years at the request of British Columbia, given concerns from law enforcement, and it is now currently administered—

Helena Konanz: Do you believe this is a successful program?

Kendal Weber: As noted earlier, the exemption expires in January 2026.

Helena Konanz: Is it successful?

The Chair: Thank you.

I now move to Monsieur Powlowski from the Liberals.

You have five minutes, please, Mr. Powlowski.

● (1235)

Marcus Powlowski: I have to say that I'm a little confused here on this line of questioning from the Conservatives. Yes, B.C. decriminalized the use of drugs, but I thought they asked specifically to reverse that, and I thought we had done so.

What is the status of that currently in B.C.?

Kendal Weber: They have requested two amendments to the exemption. The most recent amendment was previously approved by the minister. Now it is limited to personal possession in private homes, shelters and addiction clinics, so public use is not permitted outside of those locations I just listed.

Marcus Powlowski: On a second point of clarification, it seemed to me that you said—but I just want to confirm that this is true—that, on the issue of safe supply, there is no longer any safe supply being funded by the federal government through the SUAP program

Kendal Weber: That is correct. It ended in March of this year.

Marcus Powlowski: My next question is for Mr. Orencsak.

I think you said that our government was taking concrete steps to facilitate foreign nationals in the health care field being credentialed in Canada.

I know that health care is an area of shared jurisdiction, but certainly licensing is under the provinces. What specifically is our government doing in order to try to facilitate the licensing of foreign nationals?

Greg Orencsak: There are almost 200,000 internationally educated health professionals who are employed in Canada. They form an important part of the health system and help to address some of the workforce shortages with the skills they bring to the Canadian health care system.

As much as credential recognition is within the domain of the provinces and territories, we are working with our health system partners in a number of areas to help streamline immigration and foreign credential recognition processes, and to support recruitment integration and the retention of internationally educated health professionals to support health systems.

Marcus Powlowski: Can you point to any successes in this?

I know, as a physician having spoken to the Ontario College of Physicians and Surgeons, that we have implemented the program that allows evaluation of foreign credentials. Maybe you could fill me in on the name I'm forgetting, but it seems that the program has not really resulted in a lot of people being credentialed.

Greg Orencsak: Yes, I think you might be referencing the licensing of physicians. There has been an Atlantic registry that's been on the leading edge of that. You're right that we are supporting processes by which we can help streamline licensing and information sharing among regulators in particular, so they don't have to duplicate work and have the ability to go into one system to be able to check for the most up-to-date information on the licensing—

Marcus Powlowski: There's certainly been a call for national licensure. I think Australia has converted from state-based licensure to national licensure. There's been a lot of talk in Canada about national licensure.

What, if anything, has been the progress toward that?

I'll give you a great example of how that's a problem.

Dr. Eyolfson here is an emergency room doctor in Winnipeg. A Kenora emergency room had not enough physicians and was looking at closing. Someone from Winnipeg, even though it's a two-hour drive from Kenora, couldn't go there without first getting licensed in Ontario. This made little sense when I, as a Thunder Bay emergency room.... Are we any different? No, I don't think so, and it's a six-hour drive from Thunder Bay.

Has there been any progress on this?

Greg Orencsak: Yes, there has been progress and momentum. We're working with FMRAC, in particular, and engaging provinces and territories to support more of a national licensure model for physicians.

We're optimistic that there are a number of provinces that are keen to help address these challenges. I've spoken with Atlantic Canada, in particular. They've been at the forefront of this, but other provinces are also participating.

• (1240)

The Chair: Thank you, Mr. Orencsak.

I now go to Monsieur Thériault.

You have two and a half minutes, please.

[*Translation*]

Luc Thériault: Thank you, Madam Chair.

Mr. Orencsak, it's well known that Health Canada has undue delays in licensing drugs. I've been on this committee for six years, and I've been raising this issue for six years. A drug authorized in the United States since 2023, by the European Commission since 2025, in the United Kingdom since 2024, in Japan since 2023 and in China since 2024 is still being assessed in Canada.

Are you understaffed?

[*English*]

Greg Orencsak: Our approval timelines and standards, when you look at the overall statistics, compare quite favourably with those in other G7 countries. Last year, the department completed 97% of new drug reviews and 84% of generic drug reviews within established timelines.

[*Translation*]

Luc Thériault: There have been issues with licensing for six years. I could give you a list of drugs.

I'm asking you if you're understaffed, but you're not answering the question. Is your department too understaffed to compete with foreign regulators, such as the U.S. Food and Drug Administration, yes or no? When that body authorizes a drug, why don't you conduct an ongoing study, rather than waiting until the end of the process to begin the assessment?

There are plenty of solutions. I've been proposing them to you for six years, but nothing is changing. Are you doing anything more at Health Canada that other countries aren't doing and that they should be doing? What do you do?

[*English*]

Greg Orencsak: There are two things.

We are deploying staff and resources to support drug approvals. We're confident that we have adequate capacity to support drug approvals, but we're always looking to increase that, if possible.

We're working with other trusted partners to support mutual reliance, so that if one regulator approves a product, we might be able to rely on their approvals, which would help in terms of accelerating drug approvals.

I would also say that getting products to patients is not only up to Health Canada. We work with the provinces and territories in terms of their listing processes, which is often what takes more time.

The Chair: Thank you very much.

I now go to Mr. Bailey, for the Conservatives, for five minutes, please.

Burton Bailey: Thank you, Madam Chair.

I'm going to start by asking this: Why is it easier to buy cigarettes when we want people to stop smoking? Why aren't we allowing these nicotine replacement pouches to be bought in convenience stores, as cigarettes are?

Greg Orencsak: The ministerial order in respect of nicotine replacement therapies was put in place as a way to protect youth from the harms of nicotine replacement pouches. That was the reason behind the ministerial order.

Burton Bailey: Cigarettes are still available with proper ID, though. Why can we not have the same for replacement therapy with the nicotine pouches?

• (1245)

Greg Orencsak: The ministerial order was put in place, again, as a way to protect against access by youth.

Burton Bailey: Okay.

There are 6.5 million Canadians without doctors, and not once did I hear that we're going to do something in Canada to increase seats or help the provinces to get more seats in the universities. Are we not looking at this, Health Canada? Are we not looking at other ways, other than looking at immigration for future doctors?

Greg Orencsak: We are looking at other ways as well to support the health workforce. We are working with provinces and territories, including through programs to help increase the number of residency and training positions at universities to help train more doctors and other health professionals.

Burton Bailey: With the lack of specialists, we are only going to see increased waiting times, and we're only going to see more situations of the kind that went on in Thunder Bay. We need specialists. Without increasing the spots here in Canada, we're constantly running out of anaesthetists.

Is Health Canada going to take a serious look at helping the provinces with these specialists?

Greg Orencsak: We are working with provinces and territories. The delivery of health care is, as you know, within their jurisdiction. Some of the priorities under the working together agreements speak very directly to helping to increase access to care for Canadian patients, and those investments are intended to support a variety of initiatives that are being advanced by the provinces.

Burton Bailey: Okay. Thank you for that. I have one last question, and I will be sharing my time with my colleague, Dr. Strauss.

How many recovery spaces does Health Canada believe are necessary across Canada to address the opioid crisis?

Kendal Weber: The treatment beds and the recovery spaces are in the jurisdiction of the provinces and territories. We have transferred money through health transfers to support them in funding those. It depends—

Burton Bailey: Okay. I was just looking for a number. Thank you.

Kendal Weber: The rates do differ by province.

The Chair: Thank you.

You have one minute and 24 seconds, Mr. Strauss.

Matt Strauss: Ms. Hamzawi, we had a few more questions about the science strategy report. I think I had asked if the phrase “diversify the scientific workforce” means racial quotas, and you said no, that it means employment equity targets or goals. Do I have your phraseology correct?

Nancy Hamzawi: Our obligation is towards the Employment Equity Act. We have obligations to meet in terms of that.

Matt Strauss: How, in your view, are those obligations different from quotas?

Nancy Hamzawi: Essentially, they're relative to workforce availability.

If there's a certain proportion available within the workforce, then we should be representative of the country.

Matt Strauss: Okay. I mean, that sounds rather like a quota to me.

Do these targets or these obligations include religious minorities? I ask partly because my family fled a Communist country as a religious minority.

Nancy Hamzawi: Religious minorities are not specifically named in the Employment Equity Act.

Matt Strauss: That's interesting.

On a bit of a change of topic, the report mentions the Healthy Canadians podcast. I note that the last episode was put up on YouTube eight months ago, and it got four likes.

Has it been discontinued?

Nancy Hamzawi: Not to my knowledge. I'm not aware of that podcast being discontinued.

Matt Strauss: That's interesting. Thank you.

Nancy Hamzawi: Just to be clear on the Employment Equity Act, it includes women, indigenous people, persons with disabilities and members of visible minorities.

The Chair: I will go to Ms. Sidhu for the Liberals for five minutes.

I really need to do some homework with us. When we finish with Ms. Sidhu, I'm going to ask our guests to leave, and we can quickly do some homework.

It's not going to take us long—maybe three to five minutes—but I'd like everybody to be very precise, because I'm going to stick to the time.

Sonia Sidhu: Thank you, Madam Chair. My question is for Health Canada.

Chronic diseases like diabetes, cancer and cardiovascular diseases are the leading causes of death and disability in Canada. We know that many of them are preventable. Can you explain how our federal investments and programs, like the healthy Canadians and communities fund, are helping Canadians to adopt healthier lifestyles and preventing those diseases?

Greg Orencsak: I'm going to ask my colleague from the Public Health Agency to answer that, given the programs you're asking about.

Sonia Sidhu: Yes, they can answer.

Nancy Hamzawi: Thank you very much.

Indeed, more than two out of every five adults over the age of 18 living in Canada have at least one chronic disease, such as diabetes, cancer or heart disease. The proportion is even greater among populations that experience conditions of social and economic disadvantage. Yes, the prevalence is increasing.

The agency is working with our partners, such as provinces, territories and community organizations. We're working in three buckets of work. The first is with respect to surveillance and research, and you can find that online on the health infobase. The most notable is the Canadian chronic disease surveillance system, which is a collaborative network of provincial and territorial surveillance systems that is supported by the agency. It includes things like cardiovascular and musculoskeletal diseases and a number of others. The work we do in terms of analyzing national data to monitor trends, for example, includes the cancer in young people in Canada program.

We also lead the pan-Canadian health inequalities reporting initiative to strengthen the measurement, monitoring and reporting of health inequities. We have indicators of individual behaviours we're tracking, like physical activity, sedentary behaviour and sleep indicators.

A second key bucket is the work we do in guidance, such as, for example, the work of the Canadian task force on preventative health care. That particular body is being modernized at this point in time, and we look forward to that organization relaunching in a modernized form. There are other guidelines, as I noted, like the 24-hour movement guidelines.

In terms of funding programs, we have the healthy Canadians and communities fund, which supports healthy living among those who have faced inequalities and are at the greatest risk of developing major chronic diseases, such as diabetes, cardiovascular disease and cancer. The fund provides approximately \$20 million annually, leverages additional funding from other partners and supports projects that focus on addressing behavioural risk factors for chronic disease.

We also have an intersectoral action fund, which supports community capacity for upstream collaborative action that addresses things like poverty and food insecurity and supports preventative health measures by reducing risk factors that lead to and/or worsen chronic diseases. There's also the work being done on diabetes, including the government's investment of \$35 million over five years for diabetes research, surveillance and prevention, and the work we're doing under the framework for diabetes in Canada.

We also have an important partnership with Participaction. Other programs we have are the community action program for children and the Canada prenatal nutrition program. There is almost \$80 million in that area too.

• (1250)

Sonia Sidhu: I also want to mention celiac disease. Are there any current guidelines for the food establishment and food operators for serving gluten-free food? The quality of life is impacted when someone consumes gluten. I just want to know that.

Nancy Hamzawi: I don't believe the agency has specific guidelines in that area, but I'm certain there are others who are very active in this space. We'll watch that closely.

Thank you for noting that for us.

Sonia Sidhu: Thank you.

Women's health has historically been under-researched and underfunded, which has resulted in gaps in care and outcomes. In recent years, we have seen a stronger federal focus on addressing these gaps.

How can you address those gaps?

Greg Orencsak: We're working with a number of partners, including the Canadian Institutes of Health Research, for example, in terms of evidence as it relates to some of the gaps you've observed. It's also an area where we are able to work closely with provinces and territories as it relates to the health programs they offer.

The Chair: Thank you very much.

I would now like to thank the witnesses for coming and having to answer a barrage of questions. Well done.

I am going to ask if you would please leave, so that we can move in camera to discuss some business. Quickly please; we have five minutes.

Thank you.

Do we have to move in camera?

A voice: No, we don't.

The Chair: We won't meet in camera, guys. It will take too long.

Let's do this quickly.

We are resuming the business part of the meeting. Please, can you take your seats, so we can get this done? We have five minutes to get it done. Thank you.

Now, we have three budget studies. You have been sent the calendar, etc., with the three budget studies. I need your consent to adopt the budgets. One is for the study on women's health, the other is for our upcoming meeting with the Minister of Health. The third is for our meeting with Health Canada today.

I have signed those. Are you okay with them?

Some hon. members: Agreed.

The Chair: You have a draft calendar in front of you, based on the motions adopted during the last meeting, with studies the committee will undertake and the priority for those studies. That's been circulated.

We're requesting you to meet the deadline for witness lists for the upcoming study that Mr. Mazier put forward. I want to remind you that the deadline to submit lists for the study on the impact of immigration policy on health care and barriers to integrating internationally trained professionals is Friday, October 10, at 5 p.m. Everyone, please submit them at that time so we can move on with the studies.

I suggest that briefs submitted should not exceed 2,000 words.

Are there any objections or comments?

No. Is everything cool?

Our next meeting will be on October 7 at 11 a.m. on the study—

• (1255)

Dan Mazier: Chair.

The Chair: Yes, Mr. Mazier.

Dan Mazier: This is just to confirm that the minister is coming on the 9th for two hours.

The Chair: Yes, it's in your calendar.

Dan Mazier: She'll be here for the full two hours.

The Chair: Yes.

Dan Mazier: Okay. Thank you.

The Chair: Thanks very much. I'll adjourn the meeting.

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