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• (1110)

[*Translation*]

The Chair (The Honourable Hedy Fry (Vancouver Centre, Lib.)): Hello, everyone.

I call this meeting to order.

[*English*]

Welcome to meeting number 16 of the House of Commons Standing Committee on Health.

[*Translation*]

We acknowledge that we are meeting on the unceded territory of the Algonquin Anishinabe people.

[*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.

For those of you who are appearing virtually, please remember to turn off your mics when you are not speaking, and speak only when I call you by name. Everything goes through the chair, so if you have an issue or a problem, address it to the chair.

If you look on your computers, you will see a little globe icon. That's where you get your interpretation. You can pick whichever you want—English, French or floor—and move from one language to another.

For the people in the room, remember to put your earpiece on the decal so it doesn't bother the hearing of the people who are interpreting.

Madame Larouche, go ahead.

[*Translation*]

Andréanne Larouche (Shefford, BQ): Madam Chair, I just want to confirm that this meeting will work the same way as the last one.

[*English*]

The Chair: Sorry, I am going deaf. I can't hear people without my earpiece.

[*Translation*]

Andréanne Larouche: I just want to confirm that this meeting will work the same way as the last one and that I will have a second six-minute speaking turn during the second hour of this meeting.

[*English*]

The Chair: Absolutely.

I want to inform everyone that there is one witness, Dr. Karl Weiss, who is not going to be able to be on because he didn't have—

Maggie Chi (Don Valley North, Lib.): I have a point of order.

I absolutely agree with Madame Larouche getting the six minutes. For the future two hours, can we keep doing that for the Bloc so that she gets the six minutes as well?

The Chair: She asked, and the chair has said yes.

Maggie Chi: Not just for this meeting but going forward, can we make sure that Madame Larouche has the six minutes?

The Chair: That's going to be the usual practice for her when we do the two-hour meetings.

We're going to do two one-hour meetings next time, because officials are coming and they cannot be on a panel with anybody else.

Dan Mazier (Riding Mountain, CPC): Are the officials coming on Tuesday?

The Chair: Yes.

Dr. Weiss is not able to be on because for some reason his headset's not working. He's going to come back another time when we can get him ready to speak.

Today, pursuant to the motion adopted on Tuesday, September 23, 2025, the committee shall commence the study of antimicrobial resistance.

I want to welcome our witnesses.

[*Translation*]

Andréanne Larouche: Madam Chair, just—

[*English*]

The Chair: We have Dr. Judith Fafard, medical doctor.

From Fedora Pharmaceuticals Inc., we have Sameeh Salama.

[*Translation*]

Andréanne Larouche: Before we begin the testimonies, I would like to take a moment to ask one last question.

I would like to verify why Mr. Weiss did not have the correct equipment.

Did the clerk or another member of the team provide information about what happened?

[English]

The Chair: I'm not hearing the member in English or in French.

I'm going to suspend to get this fixed before we start the meeting.

• (1110) _____ (Pause) _____

• (1110)

• (1115)

The Chair: I was in the process of reading the names of the witnesses.

We have Dr. Judith Fafard, who is a medical doctor.

From Fedora Pharmaceuticals Inc., we have Sameeh Salama.

Finally, we have Jennifer Buckley, senior director, Innovative Medicines Canada.

To the witnesses, you have five minutes each for opening remarks. I will give you a one-minute shout and a 30-second shout so you can wrap up. If you don't get to finish what you have to say, you will obviously get an opportunity during the question-and-answer period to elaborate on whatever you want to say.

I'll begin with Dr. Fafard for five minutes please.

[Translation]

Judith Fafard (Medical Doctor, As an Individual): Hello.

Thank you for inviting me to testify before the Standing Committee on Health.

My name is Judith Fafard. I am a microbiologist and infectious disease specialist. I have been working at the public health laboratory of the Institut national de santé publique du Québec, or INSPQ, for six years. I initially worked as a medical consultant and have been the medical director since 2021. My comments reflect my personal views and are based on my experience at the INSPQ, but do not represent the official position of the INSPQ.

The INSPQ supports provincial and regional public health authorities in their decision-making. It also informs the public about major public health issues, such as antimicrobial resistance. It manages several monitoring programs in health care settings that track infections caused by multidrug-resistant strains, such as vancomycin-resistant enterococci, methicillin-resistant *Staphylococcus aureus* and carbapenemase-producing Gram-negative bacteria.

The Laboratoire de santé publique du Québec, LSPQ, produces monitoring reports on several resistant microorganisms, including *Mycobacterium tuberculosis*, the causative agent of tuberculosis, and those responsible for sexually transmitted or blood-borne infections, such as *Neisseria gonorrhoeae*. The LSPQ works with hospital laboratories to align practices and tests used to identify resistant microorganisms. It also works with other provincial laboratories and the National Microbiology Laboratory, or NML, to collect clinical and laboratory data on antimicrobial resistance through the Canadian Public Health Laboratory Network.

Antimicrobial resistance complicates and prolongs medical care, overloads health infrastructure and increases the risk of complications and death, particularly in vulnerable individuals.

Monitoring antimicrobial resistance enables us to adjust our interventions designed to address it. The *Neisseria gonorrhoeae* bacterium is a good example. While this bacterium had an azithromycin resistance rate of 1.7% in Quebec in 2013, this resistance rapidly increased, reaching a peak of 44.3% in 2022. Treatment guidelines for sexually transmitted and blood-borne infections, STBBIs, have been adjusted in Quebec, and azithromycin is no longer listed as the treatment of choice for chlamydia or gonorrhoea. Resistance levels subsequently declined to 16.3% in 2024, representing a 63% reduction in two and a half years.

Therefore, it is beneficial to pool data from such surveillance programs to observe trends in neighbouring provinces and territories and predict those in our own provinces and territories. As a result, we are able to implement measures where they will be most effective. The Public Health Agency of Canada recently updated the list of priority pathogens for antimicrobial resistance control, taking into account the disproportionate impact of antimicrobial resistance on certain populations. Most of these pathogens are already being monitored, but the picture of antimicrobial resistance remains fragmented across provinces and Canada.

Some pathogens are monitored through a number of different programs, each of which covers a certain segment of the population, while other pathogens, such as the bacterium *Mycoplasma genitalium*, are not currently monitored at all. It would be beneficial to continue to encourage alignment and sharing of surveillance protocols and data on antimicrobial resistance in humans.

One goal to pursue would be to target more representative coverage and encourage alignment and sharing of surveillance protocols and data on antimicrobial resistance in humans.

One of the interventions I would like to suggest is exploring the barriers that hinder better coverage of existing surveillance programs. Since most surveillance programs rely on voluntary enrolment by institutions or provinces and territories, we could raise awareness among decision-makers and the general public about the public health implications of the first two priority pathogen groups.

We could encourage research on the economic and health impacts of these resistant pathogens in Canada and improve the dissemination of data obtained through existing programs.

We could also encourage research on methods of monitoring resistance that are independent of human behaviour or access to health care, such as research on waste water metagenomics or the integration of animal and environmental monitoring systems to reach more vulnerable populations.

Thank you.

• (1120)

[English]

The Chair: Thank you very much, Dr. Fafard.

I will now go to Fedora Pharmaceuticals and Sameeh Salama for five minutes, please.

Dr. Sameeh Salama (Chair, Canadian Antimicrobial Innovation Coalition, Chief Scientific Officer, Fedora Pharmaceuticals Inc.): Thank you, Madam Chair and members of the Standing Committee on Health.

My name is Dr. Sameeh Salama and I serve as the chief scientific officer at Fedora Pharmaceuticals, an Edmonton-based antibiotic drug discovery company.

I'm also the chairman of the board of directors of the Canadian Antimicrobial Innovation Coalition, CAIC, a national coalition of life sciences organizations working to address antimicrobial resistance, AMR.

Our company's scientific legacy includes the discovery of tazobactam, or Zosyn, a drug now used globally to treat serious infections, which saves millions of lives every year.

Our second flagship product, nacubactam, is currently in phase three clinical trials. This experience gives us direct insight into the scientific, regulatory and market barriers that must be addressed if Canada is to sustain antimicrobial innovation.

AMR is already having a profound effect on Canadian health systems. According to the Canadian Council of Academies, 26% of the infections in 2018 were resistant to first-line antibiotics, a number projected to rise to 40% by 2050. If nothing changes, AMR will result in nearly 400,000 Canadian deaths and hundreds of billions of dollars in health system and economic losses. More importantly, it threatens the foundation of modern medicine, cancer care, organ transplantation, neonatal care and even common surgeries.

Canada has taken an important step by releasing the "Pan-Canadian Action Plan on Antimicrobial Resistance". I was part of the drafting of both the framework and the action plan. However, the plan has not yet been implemented or funded and therefore cannot drive change across jurisdictions or across health systems.

As we look ahead, it will be essential to develop action plan 2.0 and to build it on one central insight. Innovation is not one pillar of the AMR strategy; it is the backbone that enables all others. For example, surveillance depends on new diagnostics and data tools. Stewardship requires access to novel antimicrobials to prevent reliance on failing drugs. Infection prevention and control is strengthened by new vaccines, therapeutics and technologies. R and D depends on the stable ecosystem that supports development, manufacturing and commercialization.

For action plan 2.0 to succeed, innovation must be embedded across all pillars, not siloed. This cannot be done without structured ongoing consultation with industry. Companies, both large and small, understand financial, regulatory and operational barriers that prevent new antibiotics and diagnostics from reaching the Canadian market. Without this engagement, Canada risks designing policies that look good on paper but cannot be implemented.

Canada's scientific strengths are real. We have companies in traditional antibiotics, antifungal vaccines, phage therapy, diagnostics and information technologies, yet these trends are undermined by structural weaknesses that make it difficult to translate research into products that reach patients.

Most notably, Canada has no domestic manufacturing of antibiotics and active pharmaceutical ingredients, making AMR a national security issue as well as a public health issue.

To support innovation, Canada needs both push and pull incentives. On the push incentives, Canada should expand early R and D funding, including through IRAP and the health emergency readiness Canada program and other federal programs. Many international funding streams require companies to contribute cost-share funds. A domestic mechanism to help Canadian companies meet those obligations would increase our effectiveness and keep innovation here at home.

On the pull incentives, international experience is now very instructive. The United Kingdom subscription model, for example, provides predictable—

• (1125)

The Chair: One minute.

Dr. Sameeh Salama: —de-linked pay system companies.

Sweden has a system that guarantees payment and the European Union is pushing towards transferable exclusivity.

In closing, Canada is well positioned to lead by leadership and action by implementing the current action plan, building strength to fully fund the action plan 2.0, and working in real partnership with industry to remove the barriers that stand between discovery and success. By doing so, Canada can protect the health system, support global competitive life sciences and be a major player in the international field.

Thank you very much, Madam Chair.

The Chair: Thank you.

We'll go to the final witness, Jennifer Buckley, who is senior director of the regulatory affairs and clinical research transformation.

Go ahead please, Ms. Buckley.

Jennifer Buckley (Senior Director, Regulatory Affairs and Clinical Research Transformation, Innovative Medicines Canada): Thank you, Madam Chair.

Good morning, committee members.

My name is Jenny Buckley, and I'm the senior director of regulatory affairs and clinical research transformation at Innovative Medicines Canada, IMC. Thank you for the opportunity to speak with you today.

While I represent Canada's innovative pharmaceutical industry—the companies that are discovering, developing and delivering life-changing medicines, diagnostics and vaccines—I want to begin with a story from the hospital floor. It's a story we shared with the science and research committee, and I'd like to share it with you too.

A Canadian hospital pharmacist was called to consult on a patient with a severe infection caused by multidrug-resistant bacteria. None of the usual antibiotics worked. A newer medicine that might have helped was not on the hospital formulary. The care team scrambled as the infection spread. Every hour mattered. That pharmacist said something that stays with me: "This isn't rare anymore. This is becoming routine."

Antimicrobial resistance is not a future threat. It's a present crisis. Globally, drug-resistant infections claim more than a million lives annually. By 2050, that number could reach 10 million, with global economic losses measured in the trillions.

AMR is a crisis of innovation and access. We are running out of effective antibiotics faster than we can replace them. Development is complex, economically challenging and, in Canada, often slowed by regulatory and reimbursement processes that delay timely access. Between 2010 and 2021, Canada secured access to only three of the 18 new antibiotics that were launched globally. This puts patients and providers at a serious disadvantage. Solving this requires urgency and action.

Canada has long supported global push mechanisms such as CARB-X to stimulate early-stage development, but push alone is not enough. We need a reliable pull system to bring innovative antibiotics to Canada and to the patients who need them.

IMC welcomes the federal pull incentive pilot that's currently under development. We urge the adoption of the refinements put forward by the Canadian Antimicrobial Innovation Coalition to build a learning, evidence-driven policy environment that strengthens access.

Other countries are already moving. The U.K. has a subscription-style pull incentive, and Italy launched one during its G7 presidency. France has made AMR a priority for its presidency next year. Canada's G7 presidency is ending, but we can still be a leader in preparedness and global health security.

However, incentives alone are not enough. Regulatory and reimbursement systems remain duplicative and slow. Health Canada's effort to allow reliance on trusted international reviews is an important step forward towards faster approvals, without compromising

safety, efficacy or quality. Still, Canadians wait far too long. On average, it takes two and a half years from a Health Canada approval to public formulary listing. For antibiotics targeting multidrug-resistant infections, every day matters.

AMR is not just a health issue; it's an economic security and geopolitical issue. With the U.S. increasingly focused inward, Canada cannot assume external support in a future crisis. We must strengthen innovation at home, secure our antibiotic supply chain and partner with countries committed to science and global health security. If we act decisively, we won't just contain AMR; we will build a stronger, more resilient Canada.

Thank you, Madam Chair. I look forward to your questions.

• (1130)

The Chair: Thank you very much. That was a very crisp presentation. You went one and a half minutes under time. That's great.

Now, we go to the question-and-answer segment. The first one is a six-minute segment. The six minutes include questions and answers, so if we could all be as crisp and focused as Ms. Buckley was, we will be able to get a lot of questions in.

I begin with the Conservatives.

Ms. Konanz, you have the floor for six minutes, please.

Helena Konanz (Similkameen—South Okanagan—West Kootenay, CPC): Dr. Salama, thank you so much.

In Canada, what kind of demographic or regional differences are we seeing in antimicrobial resistance? Are you seeing it worst among young versus old or rural versus urban?

Dr. Sameeh Salama: I'm not an epidemiologist, so maybe this question should be directed to an epidemiologist as you conduct your studies. I can't really answer that question with accuracy.

Helena Konanz: Is there another person on our panel who would have some insight into that question?

I can repeat it: In Canada, what kind of demographic or regional differences are we seeing in antimicrobial resistance—for example, differences between young versus old or rural versus urban?

The Chair: I don't think we have anyone who is prepared to answer that.

Helena Konanz: That's okay. Thank you.

Dr. Fafard, a pharmacist I spoke with noted to me that many newcomers to Canada are surprised at the lack of over-the-counter access to the antibiotic or antiviral drugs that we consider to be prescription medications here. In their countries, they're able to just walk in and get these drugs. Are you seeing a higher rate of antimicrobial resistance among newcomers to Canada?

The Chair: Dr. Fafard, are you going to answer that?

[*Translation*]

Judith Fafard: Yes, I can answer that question.

In fact, we are seeing resistant microbes being imported by people who travel, not necessarily migrants. We are seeing these microbes moving between populations through tourism, whether medical tourism or leisure tourism. Sometimes there are unexpected hospitalizations during a trip.

We are seeing patients returning to our country with resistant microorganisms. *Candida auris*, a fungus that is resistant to almost all first-line antifungals, is a very good example. South of the border, in the United States, this fungus colonizes hospital intensive care units. We are seeing more and more diagnoses related to this fungus in people who have travelled. The proportion remains very low for now, but we expect an increase in the future. Most of the time, it is associated with travel.

[*English*]

Helena Konanz: Thank you for that answer: You're not seeing that among newcomers.

Have you heard that they are having trouble finding antibiotic or antiviral drugs and that they're concerned that they can get them at home but not here?

• (1135)

[*Translation*]

Judith Fafard: In Canada, you normally need a prescription from a doctor, pharmacist or front line professional to access antibiotics.

In some countries, regulations surrounding access to antibiotics are much less stringent. Individuals can access antibiotics in their country without a prescription and without consulting a health professional. This is not an advantage for people outside Canada. In fact, it is a disadvantage, because easy access to antimicrobials abroad will promote increased antimicrobial resistance.

[*English*]

Helena Konanz: Thank you.

Dr. Fafard, in Canada, is there an over-prescription of any antibiotic, antifungal or antiviral drug for infections that you can name in particular?

[*Translation*]

Judith Fafard: There is currently little research on prescribing patterns for antimicrobials. However, several countries are making efforts to publish guidelines for clinicians to reduce the number of

unnecessary prescriptions for antimicrobials. More guidelines should be developed. They should be produced for other common infections and shared with clinicians. However, we do not really have any statistics on prescribing patterns.

[*English*]

Helena Konanz: Dr. Fafard, can you name a condition or ailment for which the treatment is most publicly over-prescribed at this time? What are the front-runners?

[*Translation*]

Judith Fafard: As I explained, we do not have statistics on prescriptions. However, the optimal-use guidelines produced in my field cover certain common infections, such as community-acquired pneumonia, which can sometimes be confused with viral respiratory infections, for which antibiotics are not necessary. The same applies to ear infections in children; the recommendation is to wait before prescribing antibiotics.

These are the types of infections targeted by optimal-use guidelines to improve prescribing practices.

[*English*]

The Chair: Thank you, Dr. Fafard.

I now go to Mr. Eyolfson, the next questioner for the Liberals.

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

Thank you, all witnesses, for coming.

I should just clarify. I think we all knew this, but in colloquial French, "fungus" translates to exactly the same word as "mushroom" in French. For the English speakers, when she was talking about the "infectious mushroom", it was an infectious fungus. It's the classic case of being lost in translation.

Dr. Fafard, thank you so much for coming.

I was quite shocked to hear of the increased resistance to azithromycin for chlamydia. I know that for years, when someone came in with an STI, the standard treatment was to automatically give one gram of azithromycin and 400 milligrams of cefixime, and then we would wait for serology on syphilis.

Are resistance patterns emerging for cefixime or to the first-line drugs as treatment for gonorrhoea, or to ceftriaxone, or are there any resistance patterns for syphilis?

[Translation]

Judith Fafard: For syphilis, there is none. In fact, when azithromycin was still recommended as first-line treatment, there were cases of failure and resistance in the United States. Currently, good old penicillin is recommended as treatment for syphilis. There is no resistance.

However, we have identified strains of the *Neisseria gonorrhoeae* bacterium in Canada that are resistant to ceftriaxone. This antibiotic is administered by intramuscular injection, which means that patients with resistant infections must receive intravenous antibiotics to treat their infection. These cases are still rare, but we are seeing more and more of them.

[English]

Doug Eyolfson: All right. Thank you.

As you know, physicians use different resources to keep up with what is latest. A lot of physicians subscribe to a peer-reviewed service called UpToDate, where you can find out in real time the latest scientific consensus on a disorder that you haven't seen in a while. One of the things that has been a frustration for a lot of physicians, particularly in emergency and other primary care settings, is getting the latest evidence-based recommendations for a given infection, particularly when you have to treat empirically and you don't have time to wait for cultures.

UpToDate will give recommendations, but it will then say to be aware of local resistance patterns. That's not always easy to keep up with. In an emergency department, it's hard enough, but at least we're always regularly seeing our specialists in internal medicine and infectious diseases. It's even harder in a family doctor's office.

What would be the solution for disseminating, in real time, the latest local antibiotic resistance patterns to physicians so that they can make better prescribing choices for infections?

• (1140)

[Translation]

Judith Fafard: I'm sorry, I think the interpreter may have missed some parts of your question, but from what I understand, you were talking about local resistance.

You are right when you say that we have guidelines for clinicians, but the ideal situation would be to have a picture of local resistance in one's own environment, hospital or community. This is because resistance profiles can vary greatly between a community hospital and a university hospital.

In an ideal world, we would need to be able to extract data from each hospital, based on the pathogens found and the antibiotics for which these pathogens have been analyzed, in order to create a database.

National data on antimicrobial resistance would also need to be provided. However, we would also need to be able to refine the picture of resistance locally in a given setting, to enable the use of the antibiotic with the narrowest possible spectrum to curb the emergence of resistance.

[English]

Doug Eyolfson: Okay. Thank you.

Is there a method in Quebec of getting this latest local information out to primary care providers in offices? In hospitals—

The Chair: You have one minute.

Doug Eyolfson: Thank you.

Again, my practice has been almost exclusively hospital-based, in an emergency department. We get the interdepartmental memos that there's now resistance to whatever and, therefore, we need to switch to another antibiotic.

Is there a means in Quebec for keeping rapid dissemination of this information on the local resistance patterns to primary care providers who are not in a hospital setting?

[Translation]

Judith Fafard: In Quebec, at this time, this type of system does not exist at the provincial level. These are local initiatives. Each hospital has its own antibiotic stewardship committee, which is responsible for compiling a local picture of resistance and sharing this picture within their hospital. I work for a provincial organization, and from a central perspective, we do not have access to this local data at this time.

[English]

The Chair: Thank you. The time is up.

I now go to the Bloc Québécois.

Madame Larouche, you have six minutes, please.

[Translation]

Andréanne Larouche: Thank you very much, Madam Chair.

I would like to thank the witnesses for being here with us today for this important study.

Personally, what strikes me is how we are realizing that antimicrobial resistance knows no borders. That is something we must keep in mind.

Ms. Fafard, at the very end of your presentation, you spoke about the importance of metagenomic research on waste water.

Could you tell us a little more about the importance of this type of research?

Can you tell us what we can learn from waste water?

Judith Fafard: This is research and development. It's a work in progress. What you have to understand is that the data we're currently receiving comes from hospital systems or culture prescriptions by clinicians. This requires the patient to come in for an emergency room visit, be admitted to hospital, or see their doctor.

Obtaining a picture of resistance using genomic methods in an environmental sample, such as waste water, bypasses patient behaviour. It therefore makes it possible to identify patterns of resistance that could be found in people who do not consult the health system for all sorts of reasons.

• (1145)

Andréanne Larouche: Thank you very much.

Clearly, waste water can reveal more than we think.

Mr. Salama, in your opening remarks, you mentioned the European Union. You spoke about it briefly, but what useful experience could we draw on for this study and here in our country?

[English]

Dr. Sameeh Salama: What I was saying is that the United Kingdom has introduced and actually legislated a new law that came into place that would basically reimburse or pay drug developers. It's a subscription model whereby a developer that introduces a new antibiotic into the United Kingdom would be able to receive up to 10 million pounds per product per year.

The issue that we see with antibiotic resistance is that different countries see different antibiotics being introduced to that market. Due to the reduced number of antibiotics being introduced by the pharmaceutical industry, and that's really driven by the broken market within the antibiotic space, we see a serious lack of new antibiotics being introduced. To incentivize companies to get back into the space, different countries have introduced different legislation.

As mentioned, in the U.K., there's the new rule that came into place to introduce a subscription model. Sweden has piloted a guaranteed payment model, as I mentioned earlier on, and the European Union now is discussing a transferable exclusivity voucher. This would allow different companies that are introducing antibiotics into the markets to have an extension of their exclusivity beyond the patent of their antibiotics in that particular market or they can use that exclusivity voucher for other products that they introduce.

I think we can learn a lot from the European experiences. In particular, Canada has actually been working toward initiating a pilot in the antibiotic space to introduce new antibiotics. Canada lags behind the rest of the G7 and the G20 in terms of introducing antibiotics into the market. We have only three antibiotics out of 18 that are approved in the United States. We can learn from those experiences.

The one model that I think would be very helpful to follow is The Lancet's eClinicalMedicine's recommendation for a fair share of guaranteed revenue for antibiotics produced in Canada in the range of \$11 million to \$21 million per year.

The Chair: Thank you.

You have 35 seconds.

[Translation]

Andréanne Larouche: I want to turn to Ms. Jennifer Buckley to complete the response on international models.

Mr. Salama mentioned pilot projects in the United Kingdom, Italy and France.

Could you give us your comments on this in 30 seconds?

• (1150)

[English]

Jennifer Buckley: Just to follow up on what Dr. Salama said, the idea is to create an incentive where there isn't an incentive. The problem with the current approach, of course, is that we want there to be appropriate stewardship of these new medications. You want the medications to be available in Canada, but you want them to be available only when they're needed as opposed to free access. As a result, there will be less utilization and therefore there's less of market, which requires the pull incentives to be able to compensate for that.

As Dr. Salama said, the U.K. has a subscription model that provides that. The European Union is looking at something and France is talking about things for next year as well. Basically, the idea is to correct some of the market failures that currently exist, but also make sure that we protect and ensure that the antibiotics that do come in are available and don't themselves become resistant to treatment.

The Chair: Thank you, Ms. Buckley. We've gone a bit over time on that.

I now want to go to the second round, which is a five-minute round. I will begin with the Conservatives.

Mr. Bailey, go ahead.

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

Dr. Salama, Canada relies on foreign manufacturing for 90% of its antibiotics. I think you said three of 18—my information was two of 13—last-resort drugs are available versus the U.S. where all 13 are available or, with your numbers, that would be 18.

Is this vulnerability, as was exposed in the 2020 PPE shortage, why Canadians face 20% higher AMR risks?

Most importantly to me, what is the timeline for domestic production?

Dr. Sameeh Salama: There are different parts of your question. I'll try to address them.

In the numbers that I have—and I do have a list here—of the three out of 18 in Canada, one was approved just recently.

The issue that we have in Canada is that there are no incentives for companies to bring their products into Canada. In the models that are being entertained by other nations, we've seen legislation in the U.K., as I mentioned, as well as in Italy and in Sweden, but we don't have those.

With reliance mostly on existing drugs, we face a major problem, because any physician who wants to prescribe an antibiotic to a patient will have to go through the formulary. If the bug is resistant to the antibiotic that's on the formulary, they have to go through the special access program. That creates a logistical problem, because it's not easy to go through that process. It's time-consuming and it really puts pressure on the hospital budget, because the cost for the antibiotic has to come from the hospital budget.

Going back to your question in regard to manufacturing capacity, you're 100% correct: Over 90% of the antibiotics are manufactured in China. If you look at any issues arising between the two nations where.... We've seen with COVID that when companies become self-centred in terms of the need to satisfy the local markets, Canada will be in a very difficult situation. When we are relying on other nations to provide to us, that presents not only a health care crisis but also a national security crisis.

As my colleagues mentioned, antibiotics are at the core. They are the backbone of modern medicine. That really is something that needs to be addressed. Our manufacturing capacity is nowhere near where it needs to be. Obviously, we need to address that.

The majority of antibiotics that are being prescribed belong to a class called beta-lactams. These beta-lactam antibiotics, such as penicillin, need a specialized manufacturing facility. You cannot use the same facility to manufacture anti-cancer drugs or other drugs, because some people have sensitivities to penicillin, for example, so these drugs have to have a dedicated manufacturing facility.

We do need to address the manufacturing capacity. We need to address the R and D capacity in Canada. I mentioned incentives in my opening statement, so I'll stop here and see if there are any follow-up questions.

• (1155)

Burton Bailey: Thank you.

I'd like you to explain Health Canada's approval process for new medicines and give any recommendations on how this process could be improved.

Dr. Sameeh Salama: Perhaps Ms. Buckley would like to answer that.

Jennifer Buckley: Currently, the Health Canada approval process is actually not the major problem with the regulatory and reimbursement process. There are current challenges in terms of backlog, but for the most part, the way that Health Canada approves drugs is consistent with international approaches. They're considered a world-class regulator and they do a fairly good job of doing that. The challenges come after Health Canada approval.

It takes two and a half years after that approval for drugs to be listed on the public formulary. There are quite a few steps in the process that happen after that approval, and they are the reasons that we see challenges for Canadians in getting access to antibiotics, as well as to a host of other drugs.

Health Canada can always get better, and we all can get better, but I would say that it's actually post Health Canada approval that the real challenges are faced in terms of access to medications in this country.

The Chair: Thank you.

I now go to Ms. Sidhu for the Liberals.

You have five minutes, please.

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

Thank you to all the witnesses.

Dr. Fafard, we know that the AMR strategy places strong emphasis on early detection and rapid diagnosis. How can we expand laboratory capacity to help identify emerging resistant infections more quickly, with actionable results?

[*Translation*]

Judith Fafard: Thank you for your question.

Many resistance tests rely on culturing the microorganism and growing it in a medium that contains the antibiotic. This is known as phenotypic resistance. Genotypic detection needs to be improved through polymerase chain reaction, or PCR, tests to detect resistance quickly. This could improve how quickly scientists are able to detect resistance.

We also have problems related to last-line beta-lactams, which Mr. Salama mentioned. These antibiotics are available through Health Canada's special access program. Some are approved by Health Canada.

We do not yet have commercial tests approved by Health Canada to verify resistance to most of these antibiotics. We have to rely on reference laboratories, such as the National Microbiology Laboratory or provincial public health laboratories, to perform the tests, which increases the time it takes to obtain this information.

[*English*]

Sonia Sidhu: To follow up, regarding collaboration across jurisdictions and sharing data between laboratories, from your perspective, what improvement would help strengthen coordination between provincial labs and federal surveillance programs?

[*Translation*]

Judith Fafard: Advocating for the harmonization of diagnostic methods and protocols could help facilitate the flow of information. Agreements must also be reached between different levels of government if we want to see genuine data sharing.

[*English*]

Sonia Sidhu: Thank you.

Dr. Salama, you talked about the Italy model and the Sweden model, but, in Canada, how can industry, government and academic researchers work more closely to address AMR collectively?

Dr. Sameeh Salama: I mentioned earlier the pan-Canadian action plan that was launched in 2023, which addressed the four pillars. The four pillars that are outlined in the action plan are surveillance, stewardship, prevention control, and research and development, but the plan also included leadership. That plan was really supposed to be a funded plan that would drive that kind of partnership between the various levels of government and also between academia and industry. It has now been two years since the launch of the plan, and we are still really not seeing a great deal of push, just because that plan has not really been well funded. That's why I'm proposing that we take a look at the pan-Canadian plan 2.0.

The idea here really is to try to stretch that research and innovation across all four pillars. That would allow for more interaction. I would like to emphasize that there needs to be a strong partnership with industry in terms of how these plans are put together so that they are really implementable. We do see great work, great research, happening in Canada here at the academic level, for example, but we don't really see a translation of that into products and services. That's because a lot of the research that happens at the university level is not able to make it. That's why we're calling for push incentives to stimulate the translation of those innovations from the academic level into actual products and services, and similarly for pull incentives.

• (1200)

Sonia Sidhu: To follow up quickly, if you can, explain what role surveillance plays in the national and global responses to AMR.

Dr. Sameeh Salama: I'm not involved in surveillance, so I will not be able to answer that.

The Chair: Is there anyone who wishes to answer that?

Sonia Sidhu: Ms. Buckley.

Jennifer Buckley: I also wouldn't be able to answer a question on surveillance. I apologize.

The Chair: We're going over time now, Dr. Sidhu. Maybe we can explore that with Dr. Fafard or with somebody else later.

Thank you.

Now we'll go to Madame Larouche for six minutes, please.

[*Translation*]

Andréanne Larouche: Thank you very much, Madam Chair.

For this second round of questions, I will first address you, Ms. Fafard.

In your presentation, you spoke about the need to encourage research and surveillance programs, as well as the economic impact of antimicrobial resistance.

At our last meeting, I did not have enough time for the witness to elaborate. At the end of the meeting, the witness mentioned a lack of means and resources, implying that investments in the health care system were crucial and could have an impact.

Research is also a part of all this, but do you agree that increasing transfers to the provinces for health care and investing directly in the health care system are two important aspects?

How would providing more financial resources to the health care system in Quebec and other provinces help the situation?

Judith Fafard: I imagine there are similar problems in other Canadian provinces and territories, but Quebec's health care system is currently under financial pressure. Resources are therefore being allocated to address immediate problems and emergencies.

Although antimicrobial resistance is becoming an increasingly important issue, it may still seem to decision-makers that it is a distant priority in the grand scheme of priorities and emergencies. Allocating resources to research on antimicrobial resistance, monitoring programs, detection tests and the acquisition of new drugs or formulations in pharmacies may be postponed in order to devote scarce resources to more pressing curative problems.

Andréanne Larouche: It would be important to increase health transfers to Quebec and the other provinces in order to provide them with more financial resources.

Would you agree?

Judith Fafard: I cannot comment on the origin of the resources, but having more resources in health systems would be beneficial.

Andréanne Larouche: In addition to health care transfers, the federal government is responsible for supplying personal protective equipment, or PPE, funding research and procuring vaccines.

What would be one priority to keep in mind?

Judith Fafard: As I mentioned in my presentation, I believe that improving our monitoring systems in order to better target interventions would be important.

• (1205)

Andréanne Larouche: Mr. Salama, in your presentation, you also mentioned the importance of protecting the health care system.

In addition to the answers to the questions I just asked Ms. Fafard regarding the resource and financial needs of the health care system, how could increased federal government transfers and investments in the health care system be useful in the fight against antimicrobial resistance?

[*English*]

Dr. Sameeh Salama: As I mentioned before, the one thing being faced by hospital budgets is the fact that whenever we need to prescribe an antibiotic that is not on the formulary, the hospital has to make a decision to order that antibiotic. If a hospital administrator is faced with a decision to either order an MRI or put money toward antibiotics on a special access program, guess what will go through?

If we are not able to fix the system at the root of the problem and address it by providing incentives to bring more antibiotics in the country to make sure they are on the formulary, this pressure will continue on the hospital budget. I see that from a local issue at the hospital level, but you can multiply that across hospitals right across the country.

[Translation]

Andréanne Larouche: Thank you.

Ms. Buckley, you began your opening remarks by talking about the story of a patient with a serious illness. I would like to give you the opportunity to take more time to explain how this case illustrates the issue of antimicrobial resistance. The ideal medicine for him was not available.

Did I understand that correctly?

Please explain this patient's situation to us in detail.

[English]

Jennifer Buckley: The challenge, currently, is that there will be patients who will have a resistant infection. Physicians who are treating the patient will try what they have available on the formulary, so that's first-line or second-line antibiotics. When they get to a point that those that are currently available are not working, they have to try third-line and sometimes fourth-line antibiotics.

Generally speaking, we don't have access to those in Canada, so those medications must be sourced through a special access program where they're imported from another country where they are available. With some of these infections, that delay in treatment can actually be fatal or it can cause much more serious consequences for the patients because of that delay.

The Chair: Thank you. The time is up.

I go to Mr. Strauss for the Conservatives.

Matt Strauss (Kitchener South—Hespeler, CPC): Ms. Buckley, multiple witnesses today, and actually in a meeting earlier, mentioned this issue that only three out of 18 new antibiotics over the last 10 years have made their way to Canada. In another answer, you were describing that, by your lights, the problem isn't Health Canada and the regulatory process necessarily, but post Health Canada.

To zero in on these 15 missing antibiotics, are they post Health Canada or are they pre-Health Canada? Why specifically did they not make it here?

Jennifer Buckley: I don't know that I can speak in specific detail about those antibiotics, but I can tell you that generally what happens is companies will decide not to even attempt to get a regulatory approval in Canada, given the challenges post approval. Because it takes up to two years for those things to be listed, they may not even try to get a regulatory approval at all. That's what causes the challenge with access. They're not even launched here. We don't try to approve them here.

Matt Strauss: Can you educate me on what this post-approval process is? Is it under the federal government's auspices or not, if it's post Health Canada?

Jennifer Buckley: It's a combination of federal and provincial responsibilities. Generally, what happens is that there is a Health Canada approval, which looks at the quality, safety and efficacy of a treatment to make sure it's safe for patients and it's effective.

Then it will go through a health technology assessment done by the Canadian drug agency, which is a federal agency but not part of the government. It's a stand-alone agency. They will look at the treatment to determine whether or not it's cost-effective for the health system. Is the cost congruent with investments based on whether it's going to have a big enough impact on patient care?

Then it moves to the provincial level. The CDA will determine whether or not it's cost-effective and then it goes to the provinces through something that's called the pan-Canadian Pharmaceutical Alliance. In that step, there will be a negotiation between the provinces and the companies to determine what the price may be and whether it will get listed. Once that's decided, it will be listed on the provincial formularies.

That can take two and a half years. If you look at the list time to market for, say, a private sector...or something listed on a private plan, it takes much less time. The challenge with the process is, of course, that there are multiple steps, as I've just explained by going through them, but there can also be delays even between when those steps happen. Something may be completed and it may take up to six months for the next step to even pick up the file and work on that.

All those steps and all that process means it takes a really long time for the drugs to get to Canadians.

• (1210)

Matt Strauss: It seems to me that Health Canada decides if this is safe and effective, based on your answer. Then the CDA decides if it's cost-effective and then provincial governments, with some interface with hospitals, decide whether they're actually going to pay for it.

It seems like those second and third steps—is it cost-effective and should we pay for it—are the same step. It almost seems to me like that second step with CDA could be removed or abolished. What would you think of that?

Jennifer Buckley: I'm not sure I can answer that question, but I certainly can follow up with some additional information on that once I speak with some of my colleagues, if that would be appropriate.

Matt Strauss: Yes, it would be interesting.

How does it manage to take two and a half years to do this, post Health Canada? If I think of how I would analyze whether a drug is cost-effective, I don't see how I spend two and a half years doing that. Do you have any info on that?

Jennifer Buckley: As I said, the steps themselves take some time. There's obviously some work that needs to be done, but one of the challenges is that there are delays in when things are picked up.

For Health Canada and CDA, the gap between those two steps in the process seems to be getting shorter, which is great, but what will often happen is that the CDA will make a decision about whether something is cost-effective and then it may take up to six months for the PCPA to be able to pick that file up.

Matt Strauss: If I'm a drug company and I'm like, "Oh man, this is going to take years. I don't even know if the CDA's going to pick up the file", why don't I say, "I'll still put the application in to Health Canada. I might as well just get the ball rolling."

Is there a financial cost? What is the cost of just getting the ball rolling and putting in the application in the first place?

Jennifer Buckley: There is a fairly significant cost to starting the process. There are fees related to applying for Health Canada approval. There's staff time and there are investments that go into that. I think that's part of the challenge.

I think a lot of companies do try to launch medications even though they know that the process is going to take a lot of time. In the antibiotics space, what complicates it further is there's that complication related to the process, but then there's also the market issue itself.

A standard medication or treatment would get launched and then a lot of patients would use it. That's the typical model. In the antibiotics space, as I said earlier, we don't want people to use these unless they absolutely have to, so it's harder from a market perspective, which is why the pull incentives are so important. They make sure that we can protect and have appropriate stewardship of those medications, so that they are available when they're needed and then they don't themselves become resistant, which is what's happened with a number of the antibiotics that have been developed in the past. They've been—

The Chair: Thank you, Ms. Buckley.

We've just gone one minute and 15 seconds over time here. Because we only have three witnesses and we have time, I am letting a lot of this go over time, but can I ask committee members to be careful? If I give you a 14-second warning, you only have 14 seconds and not an extra one minute and 14 seconds.

I will allow this because we only have three witnesses. When we have a full slate of witnesses, it may not be possible.

We'll go to Ms. Jaczek for five minutes, but we'll go over if you wish.

• (1215)

Hon. Helena Jaczek (Markham—Stouffville, Lib.): Thank you to our witnesses. I've had the pleasure of having conversations with Dr. Salama and Ms. Buckley previously at the science and research committee on this very topic.

I really do appreciate the previous colleagues' questions because this is exactly what I would like to ask Dr. Salama. We've heard from Ms. Buckley in terms of the process with Health Canada and then Canada's Drug Agency and so on.

Would you recommend, or is part of the pan-Canadian action plan to push the federal government to look very seriously at this process with a view to, in some way, speeding it up?

Dr. Sameeh Salama: [*Technical difficulty—Editor*]

The Chair: Let me suspend.

• (1210)

(Pause)

• (1215)

• (1220)

Hon. Helena Jaczek: Dr. Salama, did you hear my question? It related specifically to the line of questioning that Dr. Strauss had in relation to the lengthy process of Health Canada and then Canada's Drug Agency, etc.

Is this part of the pan-Canadian action plan? Is this a gap that you would like to make a recommendation related to?

Dr. Sameeh Salama: I'm having some audio problems [*Technical difficulty—Editor*].

I'm sorry. Would you mind repeating the question?

Hon. Helena Jaczek: Dr. Salama, we've heard that the process for—

[*Translation*]

Andréanne Larouche: There is no interpretation. We cannot hear what Mr. Salama is saying.

[*English*]

The Chair: Apparently, the interpreters will no longer interpret Dr. Salama, because of the issues with the sound, so we have a problem here.

Hon. Helena Jaczek: Perhaps I should pose my question to Ms. Buckley, if Dr. Salama can no longer be considered a witness. Is that correct?

The Chair: He is not going to be interpreted. Madame Larouche isn't going to get interpretation.

What do you think about that, Madame Larouche? Are you prepared to do without interpretation? That's asking a lot, but are you prepared?

[*Translation*]

Andréanne Larouche: Madam Chair, of course not. We are entitled to interpretation in both languages. It is my right as a member of Parliament to understand Mr. Salama's answers. It is important.

Normally, when a witness can no longer be interpreted, we can no longer ask them questions.

[*English*]

The Chair: Thank you.

Dr. Salama, we can no longer use you as a witness for this meeting because of the sound and the impact on the interpreters; it causes problems with their hearing. Because you cannot be interpreted and because we have a right to have testimony in both languages, we will ask you to no longer be a witness. You can leave if you wish. I am so sorry for all of this.

It's very difficult sometimes to get people virtually to get the right headsets, the right equipment. This is a problem sometimes, and I really apologize for all of this. Thank you, Dr. Salama.

Hon. Helena Jaczek: Thank you, Madam Chair.

If Dr. Salama heard the question, perhaps he could submit a response in writing to the committee.

The Chair: Thank you. He seems to have left, but the clerk will ask him to submit a response to the committee in writing.

Hon. Helena Jaczek: Thank you. To this point, he's certainly been a very valuable witness.

Now, I will just return to Ms. Buckley.

You were telling us about the whole process in terms of approval of new drugs into Canada's marketplace. Just to finish that conversation, would you make a recommendation that the pan-Canadian action plan on AMR include a need to look very closely at this process, with an eye to expediting it? Would you be in favour of that as a recommendation?

Jennifer Buckley: Yes, I think I would. I would also say, though, that another thing that should be included in the AMR action plan is that full incentive, because it's sort of two separate problems. I do think there would be real value in having a look at the drug approval and reimbursement process with an eye to making it more effective so that Canadians have better access to innovative treatments.

• (1225)

Hon. Helena Jaczek: I certainly concur. There are two different issues.

What the terms "push incentive" and "pull incentive" actually mean is money for research and for commercialization, presumably from the federal government, do they not? That's what is involved in a pull incentive or a push incentive.

Jennifer Buckley: Yes, the push incentives sort of operate at the global level. There are a number of international organizations the Government of Canada supports, CARB-X being one of them, that pool money across the world to try to bring researchers together to develop new antibiotics. It could happen at the academic level. It could happen at the company level, but the idea is to drive that initial innovation.

On the pull side, as I mentioned earlier, it's essentially to correct that market failure, that failure that sort of exists with the model of something like a novel antibiotic. That's because there's that stewardship piece built into it and because you're sort of asking to have access to a treatment that you don't really want to use that often, as opposed to a normal medication where it would get approved and be accessible and anybody who needed it would have access to it. In the antibiotic space, it's different because we would want those treatments to be very limited to hospital pharmacists, to the experts, the infectious disease doctors, those who would know when it was appropriate to bring out those treatments to really deal with the cases where traditional antibiotics wouldn't be available.

Hon. Helena Jaczek: Yes, your point about stewardship is very well taken. The market would be small. We would want it to be small.

In terms of those pull incentives, though, Dr. Salama referenced the U.K. Have they been used anywhere in the form of a loan in some way to the pharmaceutical companies? After all, pharmaceutical companies do make a great deal of money on other medications. In developing a new antimicrobial drug, they're obviously going to face, as we've said, a very small market, but in the grand scheme of things, they are very profitable companies, so would it not be reasonable, as is done in federal economic development grants, to do it in the form of a loan?

Jennifer Buckley: I can only speak to the U.K. model. As Dr. Salama said, it is a subscription model. It's essentially a process to guarantee a price based on access.

The EU one is slightly different. Again, that hasn't been adopted yet. They're exploring it, and that's sort of a transfer of exclusivity. It's not necessarily a direct financial contribution, but a recognition of the ability to have longer market access for another treatment in exchange for that.

I'm certainly happy to follow up with more details on that and to do some exploration about whether or not there would be some value in that. At this point, what the global pull incentive process would look like hasn't been discussed. There has been quite a bit of research done on what it would need to look like at the global level to really drive innovation in this space. They've strongly suggested the pull incentive and have identified what the fair share would be by country, based on population size and so on, but I can certainly follow up with more information for you after the meeting.

Hon. Helena Jaczek: Thank you.

The Chair: Thank you. If you have it in writing, you could send it to the clerk so that it can be distributed to the committee.

If I may be so bold, because I've been here for so long, there used to be something called Technology Partnerships Canada in the 1990s and the early 2000s. It was run by the federal government. It was cancelled by a new administration in 2006 and it has never been brought back, but I do know that the person who was the deputy minister at the time who ran it at Industry Canada is now a senator, Senator Peter Harder. I don't know if the committee would like to hear from him, but he might be able to tell us how it worked and whether there is a made-in-Canada model we can go back to or whether we can just look at other models and find another one.

I now go to another round.

Mr. Mazier, for the Conservatives, you have five minutes, please.

• (1230)

Dan Mazier: Can we go two and a half minutes, Madam Chair?

The Chair: No, we're going to go to her after you. We have time. It's only 12:20, Mr. Mazier.

Dan Mazier: Okay, thank you.

Thank you, Chair, and thank you to the witnesses.

In a 2023 report on antimicrobial resistance, the Auditor General found concerns in Health Canada's oversight of drug regulation, including delays, poor tracking systems and a lack of performance measurement.

Ms. Buckley, according to the Auditor General, the government had not implemented key recommendations from previous audits. What are the risks when continued problems go unaddressed by this government?

Jennifer Buckley: I haven't seen the report, so I can't speak in great detail to it.

I do know, as I work fairly closely with Health Canada, that there have been efforts made recently to address some of the challenges that have arisen with concerns regarding backlogs, etc., and to look at regulatory modernization to build on lessons learned over the last number of years, but without seeing the report itself, I can't speak to it.

Dan Mazier: What are the risks? If items are not addressed, which they haven't been, what is at risk here?

Jennifer Buckley: Again, it's hard to speak without knowing exactly what the risks are, but there's always a risk when challenges that have been identified are not addressed.

However, as I said earlier, I think I probably would need to see the report itself to really be able to answer a question about the specific risks related to those issues.

Dan Mazier: Ms. Buckley, in budget 2024, the government granted the Minister of Health the authority to “rely on information or decisions of select foreign regulatory authorities in specific instances to satisfy requirements in the Food and Drugs Act and/or its regulations.”

This was supposed to reduce regulatory duplication by recognizing the work of foreign regulatory authorities. According to the government, they have not exercised this new authority.

Can you comment on this and explain what it means?

Jennifer Buckley: I can, actually.

The reliance order would allow Health Canada to work with trusted foreign regulators, such as the European Medicines Agency, the Medications and Health Products Regulatory Agency in the U.K. and the FDA in the U.S., for example, to essentially rely on their decisions related to treatment, based on their assessment. That is in the works.

From what we've been told, regulations will be put into the Canada Gazette later this month to actually put in place the ability to do that. The expectation is that this will be done and that it will be available to Health Canada by, I believe, the summer of 2026, so to your point that they have not yet implemented it, they are taking steps to have it available, which is a great development.

Dan Mazier: Ms. Buckley, can you explain Health Canada's special access program and the impact it has on obtaining pharmaceuticals?

Jennifer Buckley: I can't speak to it in granular detail, having never used it, but I can give you a general overview.

Essentially, what it means is that a treating physician has to go through Health Canada to be able to access a medication that's been approved in another country but isn't available here.

Oftentimes it happens that we'd be accessing medications from the U.S., so a physician or a pharmacist or whoever the health care provider is would fill out the form. They would essentially have to fill out paperwork to say that they needed access for patient X for these conditions. Then somebody at Health Canada would approve that request, and then they would have the ability to import it. That's the high-level overview of what an SAP looks like.

Dan Mazier: Would you know of any issues with the special access program?

Jennifer Buckley: Again, having never used it myself, I can't speak in great detail to it, but we can follow up with more information.

• (1235)

Dan Mazier: I just have one quick question here.

The Auditor General's report states that “the Public Health Agency of Canada, in collaboration with Health Canada, had not finalized an approach to coordinate federal, provincial, and territorial activities to preserve the effectiveness of antimicrobials.”

Has this coordination been finalized, to your knowledge?

Jennifer Buckley: My understanding is that there is a pull incentive in development. It has not yet been finalized. As Dr. Salama mentioned earlier, there is an AMR action plan, and I think there will be an update on that shortly as well.

The Chair: Thank you very much.

We'll now go to the Liberals and Ms. Chi for five minutes, please.

Maggie Chi: Thank you, Madam Chair.

My first question is for Dr. Fafard.

In your testimony, you spoke a lot about surveillance in Quebec. I want to get a sense from you of which resistant organisms or strains are rising the fastest in Quebec right now, and whether you are aware of trends in other provinces. Do you even have data on that?

[Translation]

Judith Fafard: Carbapenemase-producing Enterobacteriaceae are among the most concerning bacteria on the rise in Quebec and elsewhere in Canada. These bacteria are resistant to last-line beta-lactams. They often acquire other genes that confer resistance to other antibiotics. The number of these bacteria is increasing in Quebec and elsewhere.

However, as I explained, detection protocols are not necessarily standardized from one location to another. Comparisons therefore remain difficult, but these are the most worrisome and resistant bacteria at this time. They represent a therapeutic dead end.

[*English*]

Maggie Chi: Thank you for that.

You mentioned that it's not harmonized. Have you been seeing advances in genomic sequencing or any other approaches to allow us to detect them earlier by maybe having a more harmonized approach?

[*Translation*]

Judith Fafard: Networks of researchers are conducting research and development to detect and predict antimicrobial resistance. In addition, the National Microbiology Laboratory, in collaboration with the provinces, is conducting work to predict antimicrobial resistance. Progress is being made.

[*English*]

Maggie Chi: That's fantastic. I'm looking forward to seeing more of that collaborative work across the country. Thank you, Dr. Fafard.

Ms. Buckley, you talked a lot about the regulatory process. I want to pick your brain on current antibiotics development. Why is it so different from the generic traditional drug market, and what do you see as the current challenges to support AMR innovations globally, not just in Canada?

Jennifer Buckley: I think there are a couple of things.

It's different from the traditional market just because of the market size. It would be similar if you looked at a rare disease medication, for example, for a small population size. In this case, it's by design from the stewardship perspective for rare diseases, because there's a small population.

I think there is a lot of great work going on internationally. Global programs that have been around for a number of years have supported that development and innovation.

Canada has some of the best scientists in the world who look at some of these things. The challenge is really from the access perspective in the Canadian context, as I said earlier. From both the market question and from the numerous steps in the approval process in this country, there's a real disincentive to do that. I'll leave it at that.

Maggie Chi: No, I appreciate it.

Can you also help us understand the APIs from a global supply chain perspective?

• (1240)

Jennifer Buckley: That would probably be a question I would need to follow up on. I can speak generically to APIs, but I think it would probably be better for us to have an answer from one of our member companies that would deal more directly with the supply chain question.

Maggie Chi: If you can send us a little more information on that to include in the study, it would be much appreciated.

I think that ends my round. Thank you so much.

The Chair: Yes, your time is up, Ms. Chi.

I now go to Madame Larouche.

[*Translation*]

Ms. Larouche, you have the floor for two minutes and 30 seconds.

Andréanne Larouche: Thank you very much, Madam Chair.

It is unfortunate that we have one less witness because he did not receive the equipment on time. We lost another one due to connection issues. I would like to thank the two witnesses who are still with us to conclude today's meeting.

I had a question for Mr. Salama, but perhaps you can answer it one after the other, Ms. Buckley and Ms. Fafard.

In one of his answers, Mr. Salama mentioned our dependence on China for certain medications that are manufactured there. We ask a lot of questions about how we should be less dependent on other countries. At the last meeting, when China was discussed, the discussion focused mainly on PPE, and I will come back to that.

I would like to address the issue of vaccines manufactured in China. At the last meeting, witnesses spoke about the importance of not purchasing products that may have been manufactured using modern slavery. One of them mentioned China and the Uyghurs.

How do you view this supply of vaccines from China?

How important is it to ensure that we are less dependent on countries that practise modern slavery and that we are able to purchase quality products?

[*English*]

The Chair: Who would like to take that?

[*Translation*]

Judith Fafard: Thank you for that question.

Unfortunately, I cannot answer that question as I do not have any information about vaccine manufacturing methods abroad.

Andréanne Larouche: Ms. Buckley, can you answer that?

[*English*]

Jennifer Buckley: I think also it would be something that I would need to follow up with in terms of an answer. Given that I'm not a supply chain expert, it would probably be best for us to follow up with an answer once we've spoken to the supply chain folks in our membership, if that's okay.

The Chair: Thank you.

[*Translation*]

There is 10 seconds left.

Andréanne Larouche: I will conclude by saying that my question mainly concerned the doubts that might exist about the quality of these vaccines, but I may have the opportunity to return to this subject during a future round of questions when discussing personal protective equipment.

[*English*]

The Chair: I now go to Ms. Konanz from the Conservatives for five minutes.

Helena Konanz: Thank you, Chair.

I have a question for both witnesses, if you could answer quickly.

I asked a question at the beginning about the regional differences in antimicrobial resistance. It would be really important to know what part of the country needs to be focused on. I also asked whether it is young or old, rural or urban, that we need to focus on most with this very serious.... I got an answer that there is no data on this at all. That concerns me a lot, but maybe I misunderstood.

Do either of you have an answer? If you don't know the answer to this demographic or regional difference, where would someone get this, or is this data absolutely not available?

[*Translation*]

Judith Fafard: Thank you for your question.

There are several monitoring systems, but there are gaps. The best monitoring systems are those that focus on resistant bacteria in hospitals. They do not necessarily cover rural communities, healthy people and young people. That does not mean that it does not exist, but there are certainly improvements to be made to monitoring systems to get a better picture of what is happening in communities.

• (1245)

[*English*]

Helena Konanz: Ms. Buckley.

Jennifer Buckley: I wouldn't be able to answer that. I would defer to my epidemiological colleagues.

The Chair: I think we may need to get an epidemiologist to answer those questions, Ms. Konanz.

Helena Konanz: Yes, but I think my main question was whether this data is even available. I had heard, probably mistakenly, that this data is not available. I'm hoping that it is.

I have a follow-up question.

I live in a more rural community, and we've been talking a lot about the lack of medical workers, doctors and nurses. We have hospital closures. We have backups in waiting rooms. I know there are backups in rural waiting rooms throughout the country, but with the hospital closures in rural communities, is that going to cause even more heightened problems with antimicrobial resistance?

Ms. Buckley.

Jennifer Buckley: I'm not sure that I could answer that because I'm not a practising clinician. That might be something that Dr. Fafard would be able to address.

Helena Konanz: Thank you.

Dr. Fafard.

[*Translation*]

Judith Fafard: It is difficult to answer that question. Certainly, when people have less access to care and they have an infection, it may become more complicated before they have the opportunity to see a doctor. However, I do not have any data on that.

If I may return to your question about rural areas, I invite you to consult the FoodNet Canada program, which studies pathogens present in agricultural environments and their link to human infections.

[*English*]

Helena Konanz: Oh, that's great. Thank you.

Dr. Fafard, my daughter went to the hospital last year. She knew she had strep throat; she's had it a lot. Everyone in our family has had it many times, so we know what the symptoms are. Last Christmas, she went to the hospital. She was in a lot of pain, and she doesn't have a doctor. There's no walk-in clinic, so she had to go to the hospital. She waited between four and five hours to see the doctor, even though she knew it was strep throat. He took a swab. He said that he knew it was strep throat but that the results weren't going to come, so he was going to give her some antibiotics.

Is that something that you're worried about—that antibiotics are being given because the hospitals are over...and we have somebody sick who has been sitting in the waiting room for a long time? Is that one of the issues that you're concerned about?

[*Translation*]

Judith Fafard: You're right. It is worrying, given that the symptoms you describe could also be caused by viral infections. There are rapid tests specifically for streptococcal infections. It's a shame that rapid tests for this type of infection are not more widely available in the community.

[*English*]

Helena Konanz: Yes. There were no rapid tests available. The results were not going to come for a couple of days, but he gave her the prescription for antibiotics anyway, knowing that this was strep throat.

Those are some of the issues we need to solve—backups in the hospitals and the lack of medical professionals.

The Chair: Thank you.

I'll now go to Mr. Eyolfson for five minutes, please.

Doug Eyolfson: Thank you, Chair.

I'd like to say that I do appreciate Ms. Konanz's intervention on that. As someone who works in emergency, we have that problem all the time. Different departments have very different accessibility to these rapid tests. Yes, mononucleosis can look a lot like strep throat. At the same time, for the person with a high fever, toxic..., you're not going to wait 48 hours for that swab. It is a problem. We're looking forward to more widespread introduction of these rapid tests.

Dr. Fafard, I have a question regarding some vaccines that have been developed over the last few years. We know that most vaccines are against viruses, but many of them are against bacteria. I'm thinking particularly of the *Haemophilus influenzae* vaccine, or what they call "Hib", and the pneumococcal vaccine. Have either of those made a dent in antibiotic resistance patterns of those organisms?

• (1250)

[Translation]

Judith Fafard: Thank you for your question.

I will need to check our monitoring reports. I can send them to you after the meeting. In Quebec, descriptions of serogroups have been established over the years, as well as antimicrobial resistance profiles.

[English]

Doug Eyolfson: All right. Thank you.

Dr. Fafard, we talked about how there is surveillance in the hospitals. It's very hard to get surveillance in the communities, because not every primary care office, of course, will be doing cultures in a doctor's office. One problem we found—this came from a number of witnesses—was that there was no reporting in a number of jurisdictions from personal care homes. We have a lot of people coming into hospital from personal care homes with infections, but we don't have mandatory surveillance of these facilities.

Is there such a system in Quebec in terms of mandatory surveillance of personal care homes? Are you aware of any in Canada?

[Translation]

Judith Fafard: Outbreaks are reported in some private facilities, but infections, strictly speaking, are not. Studies on infections and treatments are being conducted based on doctors' billing data, but for now, these are pilot projects, research projects. There is no established system.

[English]

Doug Eyolfson: Thank you. I think that's something we need to be pushing forward on. Again, the hospital that I see gets a lot of elderly patients, many of them from personal care homes. I think that's an environment where we can make a big difference in this issue in the community.

How much time do I have left, Chair?

The Chair: You have one minute and 18 seconds.

Doug Eyolfson: Thank you, Chair.

Ms. Buckley, we've talked about domestic production or the lack thereof. We used to have antibiotic and vaccine production in

Canada. There was a federally owned lab, Connaught Labs. It's a bit of history lesson there, because it goes back quite a ways. This was a government laboratory. It was sold to a private interest that had subsidiaries in the States. It was closed, of course, to consolidate production in the United States.

Do you know what would be needed from provincial and federal governments and how we could re-establish that kind of manufacturing base in Canada?

Jennifer Buckley: I actually can't answer that with any authority, but I can certainly circle back and provide some information around that.

Doug Eyolfson: Thank you very much.

I believe that's my time.

The Chair: Thank you very much.

With it being 10 minutes before one, we could go for one truncated, shortened round.

However, I think we have some problems that I would like the clerk to discuss with regard to getting witnesses, getting witnesses the right equipment and what witnesses are going to be here next Tuesday. Some of that information might be helpful. I hope you think it might be.

Go ahead, Clerk, and tell us your problems.

The Clerk of the Committee (Catherine Ngando Edimo): On the next meeting, we have confirmation for the first hour for this study. It's going to be PHAC, CIHR and possibly NML for the first hour. This is for the study we have now. We have no confirmation from the minister for the supplementary estimates (B).

On the second hour, I invited some witnesses, but I'm still waiting for confirmation. Sometimes we don't receive the answer on time because of the short notice. Sometimes the contact information we have is not good, so we have to search for the contact.

When we invite witnesses 48 hours before, we cannot send the right headset. We have to ask them to purchase one. Sometimes they don't purchase the right equipment.

We are just trying to get as many witnesses as we can.

Thank you.

• (1255)

Dan Mazier: I imagine committee members will have lots of questions for the minister.

This is about supplementary estimates and about spending taxpayers' dollars. We have \$800 million spent on the interim federal health program. We have a licensing announcement that has no outcomes. We can't get any answers on how many doctors are going to be licensed in Canada. We have an update. We haven't heard anything about the vaccine injury support program, with \$54 million gone to a consulting firm and 1,700 people still waiting for some kind of compensation from the program.

We have lots of questions for the minister. I would encourage her to please come to that meeting on Tuesday, because Canadians deserve to know the answers to these questions.

The Chair: As you well know, Mr. Mazier, sometimes ministers have other things they're doing and cannot come. I think the minister is aware. I know she's going to try very hard to make an appearance.

Don't forget that we do have time after the Christmas break for her to appear then, if she wishes. There's enough time left on estimates for her to do it then.

With that being said, I want to thank the witnesses. I'm sorry that the two of you were left holding the bag, but you did a very good job.

I know some questions really should have been asked of an epidemiologist, and I don't know if we should go back and look at our witnesses to see if we have any epidemiologists who could come and talk about rural data, etc., which Ms. Konanz was asking about. We could look at some of those things.

We know that we have a problem with trying to get people headsets on short notice. Christmas is coming, and a lot of people are busy travelling and are not able to come.

Madame Larouche.

[*Translation*]

Andréanne Larouche: Today, we were supposed to welcome Dr. Karl Weiss, chief of the microbiology and infectious diseases department at the Jewish General Hospital. I hope he will be invited again.

The Clerk: Yes, he has already been invited to attend an upcoming meeting.

[*English*]

The Chair: Yes, I think he couldn't get the proper headset on time. As I said at the beginning of the meeting, he will be reinvited, and he intends to come. That would be very good.

The Clerk: He confirmed that he will be here online on December 11.

The Chair: Mr. Mazier.

Dan Mazier: Clerk, did you say that PHAC is not coming to talk about supplementary estimates, or are they coming to talk about...? You mentioned antimicrobial....

The Chair: PHAC's coming to talk about this issue, I think.

The Clerk: PHAC was already invited on the work plan for the study of the antimicrobials. That was the invitation they received

before, and I sent the invitation for the supplementary (B)s after, but I did not get any answer yet.

Dan Mazier: Is there nothing at Tuesday's meeting about the supplementary (B)s?

The Clerk: It's about the antimicrobials.

The Chair: Because PHAC is responsible for surveillance, etc., and getting some of the information that Ms. Konanz is seeking, they're a necessary witness.

The motion went to the minister and the department. As I said, the minister says she cannot make it on Tuesday, and we're hoping that she might be able to do so sooner rather than later.

Dan Mazier: Those from the department who are coming on Tuesday are not coming to talk about the supplementary (B)s. We're continuing with the study.

The Chair: They're coming to talk about the study that's under way right now.

Dan Mazier: This motion is not going to happen by the date we requested.

• (1300)

The Chair: Well, the motion was accepted, but we have to wait on the minister. This is always a problem when you ask ministers to come. They have things arranged weeks in advance and may or may not be able to make the time that was specifically asked for. I'm afraid that is a problem...not a "problem", but a fact we have to deal with.

Is there anybody with any further questions of the clerk? We have her on the hot seat here, so let's get her to answer questions.

Ms. Chi, you had your hand up.

Maggie Chi: I move to adjourn the meeting.

The Chair: I'm sorry. I have Mr. Bailey.

Burton Bailey: Thank you, Madam Chair.

I was being patient—

The Chair: You were being patient. I did not see your hand, nor did the clerk. You need to raise your hand further.

We also, at the moment—I will be precise—do have a motion to adjourn.

A voice: He had his hand up.

Burton Bailey: I had my hand up before we were speaking with the Bloc. I was being polite. I thought the clerk had seen my hand up, and then Mr. Mazier went.

Now, at this point, I would like to address the motion I made. I'm sorry. I'm not understanding. When I made a motion that was approved—

The Chair: Mr. Bailey, I'm sorry—

Burton Bailey: I know everybody wants to go—

The Chair: We have a motion on the floor to adjourn. It is not debatable, so I'm going to have to ask people to tell me whether they would like to adjourn, it being five minutes to...

I know that you had your hand up. I'm really sorry, Mr. Bailey, because I didn't see your hand, and the clerk didn't see it. We tend to try to keep track of people whose hands...you have to put your hand up so we can see it. If you do it nicely and genteelly, we may not see it; I did not see your hand.

Burton Bailey: Madam Chair, I'm trying to be polite because there's been some real friction. I'm really trying to be polite, not rude. I'm trying to be a gentleman, if that strikes any chords with you.

When I put my hand up, I was polite and allowed the Bloc.... Because this is their study, I felt it was very important that she had an opportunity to discuss what she needed to. Then, of course, you recognized Mr. Mazier, who is the vice-chair, and I thought the clerk had acknowledged my hand up and patiently waited.

Again, I don't want to come across as pushy, but I would like to discuss the motion I made and why it is not happening on Tuesday like we agreed on.

The Chair: I don't understand your question.

Burton Bailey: I am asking about the motion that I passed that we were going to have the minister here on December 4 or December 9. To say that it's going to happen after Christmas I feel is not acceptable. I think Canadians want answers. Dan listed the questions we have. These things need to be addressed now, not in the new year.

The Chair: I think we were discussing that. Mr. Mazier spoke to it. A couple of people spoke to it. The minister has been informed and the minister cannot make the date you gave her, because ministers have a lot of other duties. There's nothing we can do about it. I know you may not like it, but the bottom line is that the minister is not able to make that date.

Burton Bailey: Not by Zoom? Not by having any of the department come to answer some of these questions, to start the process? We're just going to let it go into the new year?

The Chair: I did not say it would go into.... I do not have the answer on the minister's schedule. The minister was duly sent the letter that we send when these motions pass. She was asked to come on that date. We heard from her that she's unable to make that date. Given that the House may rise on the...well, I don't know—

Maggie Chi: On a point of order, Madam Chair, I don't know that the clerk has heard back. I think that's a misconception. I don't think you've heard back from the minister. I think they are trying to work really hard to get the minister to come on short notice.

Have you heard back? I don't believe so.

The Chair: Put it this way: I don't know that we've heard back for that date particularly. It's always up to the minister to respond and let the clerk know. She may yet be able to come on Tuesday. I have no idea.

Ms. Sidhu.

Sonia Sidhu: Madam Chair, I want clarification on one thing. Is there committee business we are discussing today? Is there any schedule? We just listened to testimony.

The Chair: No, it's not committee business. We had a problem today whereby we were left with only two witnesses. I think the

clerk wanted to explain why we're not getting witnesses and why we have problems with interpretation, because she has a bit of a problem getting the equipment to people on time. Dr. Weiss couldn't get equipment on time. He would have liked to come. I wanted the clerk to explain some of the challenges she has in getting us a full slate of witnesses and getting witnesses to be effective virtually.

Also, Mr. Mazier asked a question about when PHAC officials are coming on Tuesday and what they are coming on; I think that was answered.

That's all that went on. It was not a business meeting at all; it was the clerk giving information, and she was asked a couple of questions.

Ms. Chi.

• (1305)

Maggie Chi: Thank you, Madam Chair.

I believe we were considering my motion. I don't know how we got derailed.

The Chair: We are going to because it's now one o'clock.

Because Ms. Chi moved a motion, we are going to have to vote on that. There is no debate.

Burton Bailey: I thought I had the floor. I didn't even finish my statement to you about how on the 10th, all of these budgets.... With this study that we've done, if we don't get to see the minister before the 10th, it will go to the House and we're going to miss out on that whole portion of this study.

I misunderstood you, Chair, and I apologize. I thought you indicated to this committee that we would see her in the new year. Maybe you were speaking to something else.

If you tell me there is still hope that the minister will appear here before December 10, which would be on the 4th or the 9th, prior to this going to the House, I will thank you and cease to speak any more, but I am not going to give up the floor until everyone realizes why I'm pushing for this motion. I moved the motion because we want to take this study to the House, and we cannot do it without speaking to the minister about these monies that we have questions about.

The Chair: Mr. Bailey, you were very clear about your intent. We understood it. Nobody is debating with you. This motion was passed unanimously by the committee, so no one is trying to block it. It is a matter of the minister not knowing....

The parliamentary secretary to the minister said the minister is working hard to try to make it. That's all we can go on. I have no further information for you, nor does the clerk or anybody here. The parliamentary secretary said the minister is aware and is working hard to try to make it before we rise.

Burton Bailey: Can I ask one last thing? Can the clerk make it known that we...?

I should put together some wording for the clerk to give to the minister, because I feel that if this doesn't happen before December 10, this study will have to be restarted.

The Chair: Do you mean this particular study?

Burton Bailey: If we cannot discuss all of the spending prior to the 10th, then....

The Chair: I'm sorry. I am not able to do anything about this or speak to it. When a minister is called on the estimates—this is very traditional—they are well aware and they try very hard to come. That's all I can tell you, I'm afraid.

Ms. Chi.

Maggie Chi: Mr. Bailey, I would suggest that the clerk reach out again. Would it be okay that we, as a committee, send the message again?

I know the minister is trying really hard to work out a schedule, and we haven't heard a yes or a no yet. If we can reach out again to say we're inviting her, would that be acceptable, Mr. Bailey?

The Chair: Absolutely. The clerk is always waiting for answers from people. She continues to ask some of the questions for answers about timing and when they can come. It's a given that the clerk is always doing that. We're waiting to hear from the minister's office. That's the only thing I can say. There is nothing else I can do.

Mr. Mazier.

Dan Mazier: Thank you, Chair.

The point is that Tuesday is the deadline. It's the last time we're meeting before the supplementaries get cut off. We need to talk about spending. I think everyone is in agreement on that.

Tuesday's meeting will be about spending. That's what we're requesting, as per the motion. If the minister makes it, that's a bonus, but the department should be here, full-court press at least, to discuss spending, as per the motion request.

Whether the minister makes it or not is totally up to her. She'll have to account for that, but we need the department, at least, and we need to talk about spending on health care in Canada.

The Chair: Okay. So we will have—

Dan Mazier: It's because of the supplementary estimates deadline. That's why the deadline was there.

The Chair: Ms. Sidhu.

Sonia Sidhu: Madam Chair, CIHR and PHAC are coming related to this study. They are coming on Tuesday. We still have Thursday. We have said that the minister is working hard on that.

We sent this invitation to PHAC, and on Tuesday the officials are coming related to this study. We can always discuss Tuesday when the minister is coming. Maybe the minister will give us the date. We sent the invitation and she didn't say no. She's working on her schedule.

• (1310)

The Chair: The minister did not say no. I spoke to the minister yesterday. She did know about this. She's working hard to try to get here on the date asked of her.

I cannot do anything further than that. We're belabouring a point that I don't have the answer to. We're going to hear from the minister. I can assure you that she's working hard to try to make the deadline.

Dan Mazier: Do I have the floor, Chair?

The Chair: Yes.

Dan Mazier: Tuesday's meeting needs to be about spending, even if it's just with the departments, as per the motion. We had asked the minister and departments to attend either today, December 4, or December 9, because those were the two dates we had before supplementary estimates were cut off.

That's the deadline, MP Sidhu. That's why it has to be December 9. It's cut off on December 10 and then it goes to the House. It's done. That's why there's a deadline and urgency to get it done by Tuesday.

The Chair: I will instruct the clerk to again send a letter to the minister and the department and suggest that the department could come on estimates if the minister cannot make it.

Usually, when you ask for estimates, the minister comes and brings the department. The minister is the person coming, with the department to back her up. But if you think you would like to do it without the minister and with only the department, the clerk can send that message off, as you're suggesting.

Mr. Strauss.

Matt Strauss: This is the parliamentary Standing Committee on Health. The health minister is spending billions and billions of dollars. We've already identified in previous parliaments that a lot of money has gone to places it shouldn't have gone, such as the VISIP consultants.

I'm wondering if we could ask the minister to please explain what the conflict is and who she's meeting with that is so important that she can't explain what she's spending all of Parliament's money to the parliamentary committee on health.

I would further note that her staff are right here, so I don't understand why we haven't heard back. The staff's right here. They could tell us what she is doing on Tuesday and why she won't come and defend her spending.

The Chair: Mr. Strauss, I think we're going to re-ask the minister and explain it to her and find out why the minister can't come. I think we're belabouring something that none of us have an answer for. We have to hear back from the minister.

The staffer is not allowed to speak at this meeting. You can go and ask them afterwards, if you like, but staffers don't speak at parliamentary committees.

The minister's parliamentary secretary responded and said that the minister is working very hard on trying to get here. I'm also being told that if the minister cannot come, we could get the officials.

That's what we're trying to work on, Mr. Strauss.

We're belabouring a point that none of us have control over. We're just repeating the whole thing over and over again.

I would like to adjourn this meeting.

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