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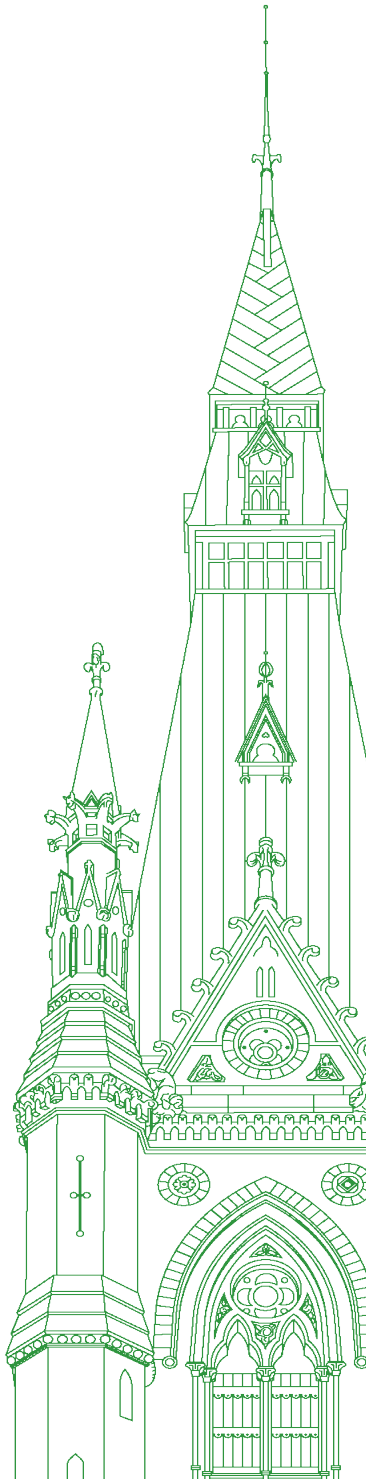

Chair: Hedy Fry

Standing Committee on Health

Tuesday, March 10, 2026

● (1535)

[*English*]

The Vice-Chair (Dan Mazier (Riding Mountain, CPC)): I call this meeting to order.

Welcome, everyone, to meeting 24 of the House of Commons Standing Committee on Health. Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders.

I would like to remind participants of the following points. For those participating by video conference, click on the microphone icon to activate your mic, and please mute yourself when you are not speaking. I remind you that all comments should be made through the chair.

Pursuant to Standing Order 108(2) and the motion adopted by the committee on Tuesday, September 23, 2025, the committee shall commence its study on Canada's pharmaceutical sovereignty.

I would like to welcome our witnesses today. We have, from Apotex, Jeff Watson, president and chief executive officer; as an individual, Michel Bouvier, professor; Julian M. Somers, full professor, by video conference; from the Canadian Generic Pharmaceutical Association, Jim Keon, president, and Jody Cox, vice-president; from the Canadian Pharmaceutical Manufacturers and Exporters Alliance, Terry Creighton, president; and from Innovative Medicines Canada, Bettina Hamelin, president and CEO, and Michael Dietrich, vice-president, market access and policy, by video conference.

Welcome, everyone. We have quite a list lined up for this afternoon.

Yes, sir, go ahead.

[*Translation*]

Maxime Blanchette-Joncas (Rimouski—La Matapédia, BQ): Thank you, Mr. Chair.

First of all, I want to congratulate you. You're doing a very good job as vice-chair filling in as chair.

Let me ask my colleagues for unanimous consent. It's just a technicality, but it's important for us to make sure that the committee works as well as possible.

I would like to submit a request to the committee that the committee meetings be divided into two one-hour blocks and that a maximum of three witnesses per hour be allowed to testify at subsequent meetings.

[*English*]

The Vice-Chair (Dan Mazier): I believe that was the agreement we made. Is the committee in agreement with that?

Some hon. members: Agreed.

The Vice-Chair (Dan Mazier): It was by unanimous consent, so we will adjust accordingly, Clerk.

Go ahead, Mr. Strauss.

Matt Strauss (Kitchener South—Hespeler, CPC): Chair, we had Grifols, the pharmaceutical company, on our work list to appear today. I'm wondering whether you or the clerk could advise us as to why they aren't here today.

The Vice-Chair (Dan Mazier): They have declined.

Matt Strauss: Chair, that was my suspicion, so, given that, I have a motion to summon the president or some other representative of Grifols to our committee to testify.

The Vice-Chair (Dan Mazier): Can you send that around?

Matt Strauss: It has been sent around.

The Vice-Chair (Dan Mazier): Go ahead, please.

Matt Strauss: The motion is:

> Given that Grifols and Grifols Canada has declined the committee's invitation to appear at its study on Canada's Pharmaceutical Sovereignty, the committee summon Mary Hughes, Vice President of Commercial Operations for Grifols Canada, to appear no later than March 27, 2026.

The Vice-Chair (Dan Mazier): Go ahead, Ms. Chi.

Maggie Chi (Don Valley North, Lib.): We haven't received it by email yet. Can you send it around?

Can we pause, Chair?

The Vice-Chair (Dan Mazier): We shall pause.

● (1539)

(Pause)

● (1540)

The Vice-Chair (Dan Mazier): We're back.

Go ahead, Ms. Chi.

Maggie Chi: Could I make a wording suggestion for the motion to clarify that this will be part a panel of witnesses?

Clerk, would you be able to make that revision? On top of summoning Grifols and Grifols Canada, clarify that they will be summoned, but they will be part of a panel of witnesses, as part of the pharmaceutical sovereignty study.

Matt Strauss: I think she would have unanimous consent to make that revision.

The Vice-Chair (Dan Mazier): Go ahead, Ms. Jaczek.

Hon. Helena Jaczek (Markham—Stouffville, Lib.): Thank you, Chair.

Could I ask the member opposite why this rather extreme measure is seen to be necessary, from his point of view? I'm relatively new to this committee, so maybe I missed something.

Matt Strauss: Welcome to the committee.

I think the reason they declined the invitation to come is that they were in the news quite a bit with regard to selling blood product that was donated to Canadian Blood Services abroad for profit. That is contrary to both the policy of Canadian Blood Services and the promise that Canadian Blood Services made to the donors. I think it speaks directly to Canadian pharmaceutical sovereignty if Canadians' blood is literally being drained and sold abroad for profit.

I am not surprised that they declined their invitation to discuss that with us. I think what they're doing is relatively extreme. I don't think the invitation or the summons is extreme.

● (1545)

Maggie Chi: Thank you, Chair. By the way, you're doing an excellent job. It's good to see you. I meant to say that at the beginning.

I'm just wondering if we can invite them. I remember that last time we did invite. Summoning is quite an extreme measure. I'm happy to revisit summoning. I'm just wondering if Matt is open to re-inviting.

Matt Strauss: No, thank you. I don't think other invitations are any more likely to be accepted than the one already sent out.

The Vice-Chair (Dan Mazier): Just to recap, when we invited the University of Toronto, they at least tried to reach out. They said there was some kind of miscommunication. Ultimately, we had to summon them anyway.

This will at least get their attention. They will get to a higher degree of whoever is going to end up getting summoned to the committee.

Maggie Chi: Okay. Thank you.

The Vice-Chair (Dan Mazier): Can you just send ...?

Maggie Chi: If we could take a quick, five-minute pause, we can do that.

The Vice-Chair (Dan Mazier): No, we have witnesses here.

Maggie Chi: Do you want to deal with it after the witnesses?

The Vice-Chair (Dan Mazier): The committee agrees on the intent that they won't be separated out or anything. They're part of another panel. This is on the public record. We all know the intent.

Yes, sir.

Burton Bailey (Red Deer, CPC): Can we have something typed up immediately and distributed?

The Vice-Chair (Dan Mazier): In the interest of time, if we have good faith here, I think we can make it work back in the clerk's office once we get it typed up.

Maggie Chi: Administratively, is the clerk okay with that?

The Vice-Chair (Dan Mazier): It's whatever the committee decides. We can instruct the clerk on whatever we want to do.

Maggie Chi: We could type it up really quickly right now. I can do it really quickly.

The Vice-Chair (Dan Mazier): We have 30 minutes of testimony to carry on with today and a bunch of witnesses online, so I would highly discourage that, but it's up to the committee.

Matt Strauss: Chair, can I seek unanimous consent to add, at the end of this motion, after “as part of a panel of witnesses”, the words “for one hour”?

The Vice-Chair (Dan Mazier): Are all agreed?

(Subamendment agreed to)

The Vice-Chair (Dan Mazier): There you go.

Just so we're clear, by unanimous consent, we're okay with the amendment that Grifols will be part of a panel.

(Amendment as amended agreed to [*See Minutes of Proceedings*])

(Motion as amended agreed to [*See Minutes of Proceedings*])

The Vice-Chair (Dan Mazier): We'll get it clarified with the clerk, as far as the wording is concerned, after the meeting.

Thank you so much, committee.

With that, we shall start into testimony from our witnesses.

Mr. Watson, you have five minutes.

Jeff Watson (President and Chief Executive Officer, Apotex Inc.): Thank you, Vice-Chair and members of the committee.

My name is Jeff Watson, president and CEO of Apotex Canada. Apotex greatly appreciates this important and timely opportunity to contribute to the Standing Committee on Health's study of pharmaceutical sovereignty for Canada.

There's no question that the pandemic experience, coupled with recent shifts in the international political and economic environment, heightened the urgency of having a public policy response to ensure that Canadian patients, and the health care system more broadly, continue to have access to critical generic medicines that domestic producers like Apotex manufacture.

As a Canadian company founded over 50 years ago in Toronto, Apotex is, today, a unique Canadian pharmaceutical manufacturing asset, with five FDA- and Health Canada-approved manufacturing sites employing over 6,000 employees worldwide and 4,000 here in Canada. To remain state of the art, Apotex annually spends over $500 million in Canada on its operations, and plans to invest $900 million in R and D and capital expenditures over the next five years. Importantly, while based in Ontario, Apotex is a global company providing drugs and therapeutics for millions of patients in over 70 countries. Apotex is also Canada's largest exporter of generic drugs and therapeutics to the U.S. market.

Its manufacturing facilities together with its global head office in Toronto make Apotex Canada's largest pharmaceutical company, pharmaceutical manufacturer and pharmaceutical employer. It's from this vantage point I offer perspectives in the context of the committee's study.

While likely shaped by current events, which I will address later in my remarks, the committee's study reflects a common concern among many governments, which, following the COVID-19 experience, recognized the risks of not developing pharmaceutical sovereignty. As a result of the pandemic, many countries developed and implemented strategic plans to prepare for the next pandemic-like event. Canada prudently sought to address gaps in its life sciences ecosystem through the biomanufacturing and life sciences strategy and its corresponding investments.

The Apotex pandemic experience provides valuable lessons on the importance of having a strong domestic generic pharmaceutical manufacturing sector, with companies like Apotex at its core. From the outset of the pandemic, Apotex was called upon by governments and acted unilaterally to address evolving pandemic-related health care challenges, which the company was uniquely positioned to do. Apotex quickly identified ways it could shift its manufacturing platform and supply chain to meet emerging and urgent health care needs.

For example, early in the pandemic, when sanitizer was in short supply, Apotex was able to retrofit its Brantford facility, normally a dedicated active pharmaceutical ingredient site, to manufacture hand sanitizer, which we donated to health care organizations in Canada. As a manufacturer of hydroxychloroquine, we donated two million doses of the product for clinical trials to evaluate the effectiveness of hydroxychloroquine in treating COVID-19. Most importantly, when other countries came to us, we prioritized Canadian patients to ensure that we had enough product to cover those who needed the drug for other indications, such as rheumatoid arthritis and lupus.

The effective Apotex-government relationship that emerged during the pandemic ensured that Canadian patients had access to vital generic drugs and served to underscore the importance of having direct access to domestic generic manufacturing capacity during a health crisis.

We are currently experiencing a global shift. A new global pharmaceutical manufacturing landscape is emerging in jurisdictions such as the U.S. In the past six months alone, the U.S. has implemented over 10 specific measures aimed at supporting existing manufacturers and attracting companies and manufacturers from other jurisdictions.

Make Canadian pharmaceutical manufacturing a policy priority. This is why I'm happy to attend today with all of you. Given those policy incentives being adopted in the U.S. and Europe, and our overreliance on generic pharmaceuticals produced outside North America, Canada's pharmaceutical manufacturing sovereignty is at risk. Accordingly, we strongly urge the committee to recommend that the government add generic pharmaceutical manufacturing as a priority sector within the buy Canadian policy.

● (1550)

Apotex strongly endorses the recommendations made by the CPMEA, a colleague joining us here today, and would emphasize the need for the buy Canadian policy initiative to provide Canadian generic pharmaceutical manufacturers with a dedicated regulatory approval process and establish a preference for Canadian-manufactured generic products—

The Vice-Chair (Dan Mazier): That's time.

Jeff Watson: —in the context of federal procurement.

Vice-Chair, that concludes my remarks.

Again, on behalf of Apotex, I'd like to thank you for the opportunity to contribute to the committee's important study. I look forward to questions that some of the committee members may have.

The Vice-Chair (Dan Mazier): Thank you, Mr. Watson.

Go ahead, Mr. Bouvier, for five minutes.

[*Translation*]

Michel Bouvier (Professor, As an Individual): Mr. Chair, members of the committee, thank you for the opportunity to contribute to your consideration of Canada's pharmaceutical sovereignty.

My name is Michel Bouvier. I'm a professor of biochemistry and molecular medicine at the Université de Montréal and principal investigator at the Institute for Research on Immunology and Cancer, or IRIC. I led this state-of-the-art institute with more than 400 scientists for 10 years until June 2024.

I also cofounded IRICoR, which is an organization specializing in intellectual property protection and research valorization and commercialization. Its mission is to transform scientific discoveries from university labs into concrete therapeutic applications, including through partnerships with the biopharmaceutical industry and the creation of spinoff companies here in Canada.

Today I want to talk to you about the IRIC-IRICoR model, which illustrates how innovation infrastructure can directly contribute to Canada's pharmaceutical sovereignty.

Pharmaceutical sovereignty does not depend solely on the ability to manufacture drugs. It starts well upstream with the ability to innovate locally, develop tools, discover new therapies and bring them to clinical development.

It is precisely with this in mind that the federal government created the centres of excellence for commercialization and research program, or CECR, in 2007. Through the program, IRIC was able to develop, alongside our basic research activities, a major university-based drug discovery unit. This infrastructure is now one of the largest of its kind in the world, consisting of more than 60 chemists and biologists specializing in drug discovery in a university setting.

The strength of the model relies on the synergy of three complementary components: a high-level university research institute, an integrated drug discovery platform and a structure specializing in the valorization and commercialization of innovations. This combination creates a true therapeutic innovation ecosystem.

In concrete terms, the model has already produced tangible results. It has created five spinoff companies that operate in Canada as well as numerous partnerships with the broader international pharmaceutical industry. Several ecosystem projects have progressed towards clinical development and have generated millions of dollars in revenue. The revenue can then be partially reinvested in the research and development of new therapeutic solutions.

The infrastructures also have another strategic value. Beyond innovation, they represent a domestic capacity that can be mobilized in times of crisis. Drug discovery and development platforms can be quickly repurposed to support the production of therapeutics, whether generics or other essential products, in the event of supply chain disruptions or geopolitical tensions, as we are currently experiencing.

Unfortunately, the federal CECR program was discontinued in 2018. IRIC, its drug discovery unit and IRICoR have been able to continue their operations through own-source revenue and various partnerships. However, the lack of structural support such as that provided by the CECR program now limits their ability to grow and expand.

I think it's important to recognize that therapeutic innovation and pharmaceutical production capacity are national security issues. In the current geopolitical context, and given the significant changes happening with our neighbours to the south, it is becoming essential for Canada to protect and strengthen its domestic capacity to discover, develop and produce the drugs needed to treat Canadians.

Integrated models, such as the one developed at IRIC, show that Canada already has the scientific expertise and infrastructure needed to play an important role in this area. With appropriate policy support, these platforms could contribute even more significantly to our country's pharmaceutical sovereignty.

What is needed now is a strategic commitment to support and develop these domestic capabilities in the short, medium and long term.

Thank you for your attention. I will be happy to answer your questions.

● (1555)

[*English*]

The Vice-Chair (Dan Mazier): Thank you very much.

Please go ahead, Mr. Somers, for five minutes.

Julian M. Somers (Full Professor, As an Individual): Greetings from snowy North Vancouver today.

I'm Dr. Julian Somers, and I work as a clinical psychologist and full professor. My primary area of expertise is addiction practices and policies, and for 40 years, I have designed and implemented innovations in harm reduction and recovery-oriented services and policies. My body of work includes large-scale reforms to public services in Canada's provinces and territories, and randomized controlled trials demonstrating how to effectively reduce crime and medical emergencies and promote social reintegration among people who experience addictions and homelessness. I've also led multiple studies on pharmaceuticals, addressing addiction and other forms of mental illness.

I'm grateful for the opportunity to bring several points to the attention of this committee. In the past decade, Canada, including my home province of B.C., has introduced addiction policies that were ill-advised, misrepresented and intentionally unevaluated and that caused immense harm to citizens and communities. Canada was the only place in the world that prioritized dispensing an array of pharmaceuticals to people living in poverty with profound addictions as effective forms of intervention were marginalized and even maligned, and it is of vital public importance to understand why.

First, Canada differs from comparator nations, including the United States, by failing to require pharmaceutical companies to disclose the amounts they provide to clinicians, hospitals, activist groups and universities, and how those funds are used. Canadian academic organizations that previously focused on things such as infectious diseases shifted their focus to addiction, backed by pharmaceutical partners.

Second, senior public health and clinical leaders lobbied for the expanded use of pharmaceuticals while forming related companies that promoted “safe supply”. These apparent conflicts of interest involved people who held roles such as provincial health officer, deputy provincial health officer, senior researcher and director of health research funding. In addition, venture capitalists, such as the Safe Supply Streaming company, issued calls for early investors, claiming that Canada was on the leading edge, creating a roughly $360-billion expected market in pharmaceuticals for addiction.

There is no way to explain Canada's pharma-first addictions strategy without considering the role of money. The influence of private capital is evident in the emergence of conflicts of interest and in the uses of tax dollars to fund industry-friendly research and direct spending on pharmaceuticals with no hope of reasonably reducing mass addiction casualties. There was and remains no evidence indicating that pharmaceuticals were either safe or effective in promoting recovery from severe addiction.

For several years, the harms of Canada's pharma-first addiction policies were denied by governments and those with vested interests, but over time, it became impossible to deny what was increasingly evident to more and more citizens, first responders, business owners, parents and families. A large body of addiction science and practice was effectively displaced, with links extending back to the era of deinstitutionalization. I remember it well from my early days in the 1980s, working at B.C.'s Riverview Hospital. Canadians were promised a shift to community-based, recovery-oriented systems of care for people experiencing addictions and other mental illnesses. In 2006, a Canadian Senate committee led by Michael Kirby completed an exhaustive analysis that reinstated the urgent need to redouble our efforts toward that goal.

The overwhelming majority of Canadians who have died in the past decade from drug poisoning were unemployed. In B.C., where drugs have become the leading cause of death among youth, about three-quarters of those youth received services from our Ministry of Children and Family Development, which administers foster care.

When physicians, lawyers, airline pilots and public servants develop addictions, they are supported within intensive psychosocial interventions and are required to abstain from substance use, including pharmaceutical forms of addictive drugs. However, in recent years, if an average Canadian citizen develops an addiction, they receive no intensive psychosocial resources, regardless of whether they are unemployed or inadequately housed, and they are given the one thing that the previously mentioned groups are denied: drugs. It has been widely demonstrated that the same approach to addiction that works for physicians and others can be applied to assist people regardless of their circumstances.

An important step toward that single standard of care in Canada would be to require that pharmaceutical companies disclose funds provided to researchers, clinicians and other groups, and to ensure that public funds are applied to research and services that prioritize the goal of addiction prevention, social reintegration and recovery.

● (1600)

Those things are achievable, and I heartily encourage you to consider supporting that kind of course correction through the important work of your committee.

Thank you.

The Vice-Chair (Dan Mazier): Now we'll go to Mr. Keon.

I believe you're speaking on behalf of your group. You have five minutes.

[*Translation*]

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

Good afternoon, everyone.

Thank you for the opportunity to share the perspectives of the Canadian generic and biosimilar pharmaceutical industries on Canada's pharmaceutical sovereignty.

Generic and biosimilar medicines fill approximately 80% of all prescriptions for Canadian patients. These cost-effective products support the viability of pharmaceutical budgets and create the financial leeway needed for drug plans to cover new and innovative therapies.

Our member companies operate the vast majority of Canada's pharmaceutical manufacturing capacity, with extensive facilities and a highly skilled workforce.

Over the past two decades, price pressures and procurement policies that favour the lowest cost have progressively reduced domestic production incentives.

● (1605)

[*English*]

In terms of our perspective on pharmaceutical sovereignty, as a starting point, pharmaceutical sovereignty will require decision-makers to recognize that cost-saving generic and biosimilar medicines are not just budget line items; they are strategic assets that must be treated as health, economic and national security priorities.

Pharmaceutical sovereignty is about protecting the health of Canadians through a reliable, secure and sustainable domestic supply of medicines. It means ensuring that Canada has the domestic capacity and policy frameworks in place to reliably supply and produce essential medicines to meet the needs of Canadians.

There are thousands of prescription medications sold in Canada today. While it would be impossible to make all these medicines here, there are important opportunities to strengthen both Canada's domestic generic pharmaceutical manufacturing capacity and its strategic international pharmaceutical supply chains. However, there are market barriers.

Pharmaceutical sovereignty will require decision-makers to take action to address the significant existing barriers to market entry for generic and biosimilar medicines. This is needed to both ensure a robust pipeline of new generic and biosimilar medicines for Canadians and support domestic generic drug manufacturers that want to grow their manufacturing and R and D capacity here in Canada.

The lack of predictability and the significant risk that companies are facing in Canada today is unprecedented. It is extremely difficult for our member companies to plan and build a business case to make the investments needed to bring new, cost-saving medicines to the Canadian market. For example, there are exceptionally long delays in Health Canada drug submission reviews. There are over 100 generic drug submissions in the backlog. Some targets have been missed by years.

There is also very low uptake of more complex generic products in Canada because drug plans have not put the right policy levers in place to support their widespread use. This urgently needs to be addressed, as it represents most of the current product pipelines for generic drug manufacturers.

Patents for new uses of older brand-name drugs are now unfairly blocking generic and biosimilar market entry. That was not how Parliament had intended the intellectual property and regulatory system to work. Patent evergreening, product hopping and other life-cycle management strategies of originator companies are delaying and frustrating market entry. Any move to increase market exclusivity periods for originator drugs would harm Canada's pharmaceutical sovereignty.

On domestic investment, in addition to addressing these existing barriers, Canada must create competitive conditions for companies to invest in manufacturing upgrades and expand capacity. This includes tax incentives, grants, loans and modernized regulatory pathways with clear guidance. When governments send predictable, long-term market signals, companies invest. Without those signals, capital flows elsewhere.

Pharmaceutical sovereignty does not mean isolation. Canada will always be part of global supply chains. Sovereignty does mean having sufficient domestic capacity and trusted partners, so Canadians are not at the back of the line when risks of supply chain shocks occur. Canada should secure supply chain security agreements with key trading partners, building on the lessons learned through the pandemic.

In conclusion, Canada's pharmaceutical sovereignty must begin with generics and biosimilars—the products that meet most of Canadians' prescription drug needs. We have a strong foundation, but it cannot be taken for granted. By addressing current barriers, Canada can expand generic pharmaceutical manufacturing, strengthen supply chains and ensure that Canadians have timely access to cost-saving generic and biosimilar medicines.

[*Translation*]

Thank you.

● (1610)

[*English*]

The Vice-Chair (Dan Mazier): Thank you, Mr. Keon.

Now, from the Canadian Pharmaceutical Manufacturers and Exporters Alliance, we have Ms. Creighton.

Terry Creighton (President, Canadian Pharmaceutical Manufacturers and Exporters Alliance): Mr. Vice-Chair and members of the standing committee, I want to thank the committee for investigating Canadian pharmaceutical sovereignty. This is a topic that is near and dear to our organization. Strong domestic drug manufacturing is necessary for Canada to secure its own pharmaceutical sovereignty.

The Canadian Pharmaceutical Manufacturers and Exporters Alliance is a coalition of generic and contract manufacturing pharmaceutical companies with manufacturing facilities based here in Canada. Our members are the largest producers of medicines in Canada and collectively represent more than 30% of all prescriptions dispensed in Canada, making essential prescription medicines used by patients and in hospitals every day right across the country.

In the past, Canada had a significant number of companies producing medicines for Canadians and for export. Sadly, domestic production has declined over the last two decades, and we have become overly dependent on imported medicines, mostly from India and China. The loss of local drug manufacturing is a cause for concern, especially during this time of increasing geopolitical tensions. If Canadians cannot depend on domestic drug production to meet our needs, we are facing a looming national security and public health crisis.

Most of the pharmaceutical production that still takes place in Canada is generics and contract manufacturing, without which we would be even more vulnerable. Other countries, most notably the U.S. and the European Union, are taking aggressive steps to reshore production, offering attractive regulatory and industrial policies aimed at supporting their domestic producers and luring others to relocate.

We are still waiting for the results of the U.S. section 232 investigation into trade in pharmaceuticals, which is imminent, which is expected to include tariffs or other measures to further encourage reshoring of medicine production in the U.S. Canada has the same opportunity to secure its pharmaceutical sovereignty, and that's why we're here today. We have some specific solutions that we would like to share.

First of all, we're very encouraged that this government has recognized that biomanufacturing is a strategic sector. The buy Canadian policy has committed to direct federal purchases to Canadian suppliers. Why not medicines, too?

The recent national defence industrial strategy promises investment in medical countermeasures and stockpiling; however, this recognition must translate to concrete policies that strengthen domestic pharmaceutical manufacturing.

The CPMEA has developed a five-point action plan for Canadian domestic pharmaceutical production that I encourage you to review in your deliberations. The first action is to prioritize the regulatory review of submissions from Canadian producers by Health Canada. We recommend a priority pathway for new generic drug applications submitted by Canadian manufacturers. As it stands now, there is no distinction between applications submitted by Canadian producers and those submitted by importers, even though domestic producers invest significantly in Canadian clinical development, workforces and production facilities.

Health Canada is currently consulting on the reliance program, which is intended to speed up approvals by relying on authorizations from foreign regulatory agencies. We are concerned that this process will inadvertently harm domestic producers by giving priority to importers' submissions and push submissions from Canadian producers to the back of the line. Those unintended consequences would seriously undermine Canada's goal of greater pharmaceutical sovereignty.

Our next recommendation recognizes that drug production is a very capital-intensive industry. Canada must maintain our industrial competitiveness and provide matching tax and economic policies to compete against the benefits that are being offered elsewhere and to recognize that it costs more to produce drugs here in Canada than it does in countries like India and China, where labour costs are so much lower.

Third, and I can't believe I'm saying this, access to pharmaceuticals can be weaponized and supply intentionally disrupted as a war measure. In addition to shipping disruptions caused by conflict, the blockade of the Strait of Hormuz where ships from India pass is an immediate cause for vigilance.

We recommend that the Department of National Defence treat domestic pharmaceutical producers as critical infrastructure within homeland defence planning. Mechanisms such as reservation contracts and dual-use technology should be explored with Canadian producers.

The next pillar builds on Canada-first procurement. By directing even a portion of public drug plan expenditures to medicines made by Canadian producers, governments—federal and provincial—can reduce dependence on imported medicines without incurring any additional costs.

● (1615)

Finally, we recognize that we cannot make everything we need and that we must have global partners, as others have said.

Canadians are very good at making medicines, and we are ready to expand our facilities, invest in new technologies and work to defend Canada's pharmaceutical sovereignty.

Thank you.

The Vice-Chair (Dan Mazier): Thank you very much.

Our last presenter, from Innovative Medicines Canada, is Bettina Hamelin. Welcome.

Bettina Hamelin (President and Chief Executive Officer, Innovative Medicines Canada): Thank you, Mr. Chair, and good afternoon. Good afternoon, committee members.

I am Bettina Hamelin, president and CEO of Innovative Medicines Canada.

Your study on Canada's pharmaceutical sovereignty comes at a pivotal moment for Canada's life sciences sector, for our national security and for Canadians.

Canada's access to new medicines is increasingly at risk. Recent global developments, including the introduction of the most favoured nation drug pricing in the United States, is already disrupting access to existing medicines, delaying or halting the launch of new medicines and undermining confidence in Canada's pharmaceutical market. For Canadians waiting for a new cancer therapy or a rare disease treatment, these aren't abstract policy debates: They have real consequences for patients and families.

The U.S. administration has argued that global pharmaceutical pricing needs to be rebalanced, and recent policy changes reflect that view. These developments are contributing to a broader global reset in how medicines are priced and valued, and they will have implications for markets like Canada. Canada must respond strategically and think creatively to ensure that our system is resilient and globally competitive and safeguards the dual-use biomanufacturing capacity that underpins our health security and defence readiness.

For too long, Canada has undervalued and underinvested in pharmaceutical innovation. We have world-class research institutions and a strong regulatory system, yet we lag behind peers in ensuring timely access to new medicines.

Canada faces a clear choice: wait and hope global changes spare us, or act now to strengthen our pharmaceutical sovereignty so that Canada remains a competitive market for innovative medicines and a reliable partner in the global life sciences ecosystem.

Inaction carries risk. A less competitive market leads to delayed launches, fewer clinical trials and decreased investment. This affects not only patient access; it also affects our economic security.

IMC member companies have made significant investments in Canada's life sciences sector. Sanofi's $800-million state-of-the-art vaccine manufacturing facility, AstraZeneca's $820-million expansion into a global clinical research hub, Roche Canada's $130-million global informatics hub expansion and Merck's digital sciences studio helping Canadian start-ups harness AI are just a few examples. The list goes on.

These are votes of confidence in Canada. They create high-value jobs, strengthen our health security through global partnerships and bring advanced manufacturing capacity to our economy. We need policies that keep them coming.

The impact of innovative medicines on health system sustainability is compelling. A 2025 study by Dr. Frank Lichtenberg at Columbia University shows that sustained investments in innovative medicines reduced hospitalizations in Canada by 55% in 2022, saving close to $80 billion. Lichtenberg also found that pharmaceutical innovations between 2002 and 2022 reduced premature mortality by 49% when compared to a scenario without those drugs.

Other countries are actively strengthening their life sciences strategies and investment environments. Canada must do the same. The U.K. has already reached a bilateral agreement with the U.S. Now is the time for Canada to act with clarity, with purpose and with a plan that protects patients, supports innovation and strengthens our partnerships. Canadians are counting on it and deserve nothing less.

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

● (1620)

The Vice-Chair (Dan Mazier): Thank you.

That summarizes the testimony. Now we'll get into asking questions.

To kick off the first round, it will be the Conservatives. That will be me. I'm in the chair today, which is a little different, but away we go.

Mr. Watson, you are here today representing Apotex. Is that correct?

Jeff Watson: Yes, that's correct.

The Vice-Chair (Dan Mazier): Mr. Watson, I have a copy of the public settlement agreement from the opioid litigation in the United States involving Apotex Corp. According to the settlement, Apotex agreed to pay over $72 million U.S. to resolve opioid-related claims brought by the U.S. states.

Just so we're clear with the committee, Apotex Corp. referenced in this settlement is part of the same Apotex corporate group that you are representing today. Is that correct?

Jeff Watson: Yes. It's a U.S. subsidiary.

The Vice-Chair (Dan Mazier): That is correct?

Jeff Watson: That's correct.

The Vice-Chair (Dan Mazier): Mr. Watson, I also have here the original lawsuit filed by the Province of British Columbia against opioid manufacturers. It seeks to recover health care costs related to the opioid crisis. In this lawsuit, Apotex is listed as a defendant. That is the same Apotex that you are representing today. Is that correct?

Jeff Watson: Yes, that's correct.

The Vice-Chair (Dan Mazier): Mr. Watson, Apotex manufactures opioid medications, including hydromorphone. Is that correct?

Jeff Watson: That's correct.

The Vice-Chair (Dan Mazier): Are you aware that hydromorphone is one of the most prescribed drugs in the safe supply programs across Canada, yes or no?

Jeff Watson: I'm aware that it's a well-prescribed product. To indicate whether it's the most prescribed, I wouldn't know.

The Vice-Chair (Dan Mazier): You don't know?

Jeff Watson: I would know that it is an actively prescribed product.

The Vice-Chair (Dan Mazier): Those programs are designed to address addiction. Given that your company manufactures—

John-Paul Danko (Hamilton West—Ancaster—Dundas, Lib.): I have a point of order, Mr. Chair.

I don't know who takes the point of order, because you're asking questions as chair. You should have handed the chair over.

The Vice-Chair (Dan Mazier): That's not a point of order.

What standing order are you referring to?

John-Paul Danko: My point of order—

The Vice-Chair (Dan Mazier): What standing order are you referring to?

John-Paul Danko: Relevance, sir. You're asking questions that have nothing to do with pharmaceutical sovereignty. I'd ask someone other than yourself to rule on the point of order and to bring your questions in line with the point of this study.

The Vice-Chair (Dan Mazier): Duly noted.

John-Paul Danko: You can't rule on it as chair.

The Vice-Chair (Dan Mazier): You're out of order. Yes, I can.

Moving back to Mr. Watson, those programs are designed to address addiction. Given that your company manufactures this drug, does Apotex have any scientific evidence showing that hydromorphone is an effective treatment for addiction?

Jeff Watson: I'm not in a position to speak to that, Mr. Vice-Chair. I'd be happy to take any questions from the committee and respond back to your questions.

The Vice-Chair (Dan Mazier): That would be great. If you could table those documents, that would be very helpful.

Dr. Somers, it is my understanding that Mark Tyndall served as deputy public health officer under the provincial B.C. government until 2018. Is that correct?

Julian M. Somers: It sounds about right. To the best of my knowledge, yes.

The Vice-Chair (Dan Mazier): After leaving the government, Mark Tyndall launched a vending machine company called MySafe, which dispensed opioids to drug users. What can you tell us about this vending machine company?

Julian M. Somers: Well, I can confirm that I've seen the machines in action. At the time that they were being developed, at the concept stage, I suggested that there were much more effective priorities and, in fact, that taking the step of responding to people who are living in poverty.... It's important to note that these machines were installed in what are referred to as low-barrier housing developments. From prior research, one of the things that was most urgently needed among people who were socially estranged, including those in low-barrier housing, was the opportunity to be engaged in meaningful relationships and on a path to social reintegration, which, by the way, is something that harm reduction interventions are capable of initiating.

I thought it was exactly the wrong type of message to take, as we were in the first year of a declared public health emergency, in that rather than engaging alienated people interpersonally, we would instead be pouring our energies and attentions into an interface that involved a machine, but my view was fairly forcefully outvoted by people in positions of authority.

● (1625)

The Vice-Chair (Dan Mazier): I have some follow-up questions on that as well.

According to Health Canada's website, the federal government gave this company over $3.5 million. Is this correct?

Julian M. Somers: I've seen that, and an additional tranche of funds as well. I think that's a low estimate of what we've invested collectively.

The Vice-Chair (Dan Mazier): Okay.

Dr. Somers, did Mark Tyndall advocate for policies like decriminalization and safe supply in his former role within the government, yes or no?

Julian M. Somers: Yes, he did.

The Vice-Chair (Dan Mazier): How is this not financial conflict of interest?

Julian M. Somers: You're asking me....

Maggie Chi: I have a point of order, Chair.

I'm wondering what the relevance is, because we're just starting out on the study on pharmaceutical sovereignty, and the line of questioning hasn't been even close to the intent of the study.

The Vice-Chair (Dan Mazier): I guess when we're done with all my questions, it will be very clear.

Dr. Somers, it is also my understanding that Perry Kendall served as the public health officer in the provincial B.C. government until 2018. Is this correct?

Julian M. Somers: It's either 2017 or 2018, yes.

The Vice-Chair (Dan Mazier): After leaving the government, Perry Kendall co-founded a company called Fair Price Pharma, which distributed injectable heroin. Is this correct?

Maggie Chi: I have a point of order, Chair.

It's the study we're focused on, and to this point, I have not heard a relevant question to the intent of the study.

The Vice-Chair (Dan Mazier): Okay.

Julian M. Somers: I'll answer. Yes, Dr. Kendall co-founded a company that was positioned to distribute heroin, diacetylmorphine.

The Vice-Chair (Dan Mazier): Okay.

Is it fair to say that both former government officials advocated for policies like decriminalization and safe supply in their former roles, yes or no?

Julian M. Somers: Yes.

The Vice-Chair (Dan Mazier): Thank you very much. That's the end of my time.

We'll go to Ms. Chi.

Maggie Chi: First of all, thank you to all the witnesses who are here today as we start this very important study.

We're looking at our pharmaceutical sovereignty and all the things having to do with the security and sovereignty of our medical system. In lots of the readings and notes, we've seen that Canada relies heavily on foreign imports of APIs on a lot of the drugs.

My question is for either Jim or Jeff.

What does this dependence mean in practical terms for Canada's pharmaceutical sovereignty? Specifically, what are some of the challenges, but also some of the opportunities that you see?

Jim Keon: I think it is true that Canada relies heavily on foreign imports of active pharmaceutical ingredients, as well as final dosage products. We commissioned a study a couple of years ago, which showed that the percentage of products made in Canada has been declining. Our solution to that is to try to make Canada as attractive a place for investment in generic and biosimilar medicines as possible. I think some of the framework policies that we've mentioned today are very important.

We're very concerned about Health Canada, which lacks resources. They're not able to review and approve medicines in any kind of predictable way. Companies that want to invest in Canada have no idea right now when their products are going to be approved. We are making a strong campaign to encourage Health Canada to get the resources necessary to have the ability to approve products so that Canada can be seen as a leader in pharmaceutical regulatory approvals.

The other thing that has happened is there's been a race to the bottom in terms of pricing, both at the hospital level and at the retail level. When you're looking to support investment—and Jeff can speak to Apotex—you need to have sustainable pricing. We are working with our partners at the provincial level through the pan-Canadian Pharmaceutical Alliance to try to get sustainable pricing that would support more domestic production.

Those would be two things right off that I think we could do to improve the situation.

● (1630)

Jeff Watson: What I would add is that as you build out the pharmaceutical supply chain, I think we probably don't speak enough, as an industry, about building out capability in the market. As you develop API resources in the market domestically, you also develop broader international supply chains so that you end up having sourcing hubs around the world globally. As you build that expertise, you are able to utilize that global network.

It's a complicated supply chain. You're not going to fix it overnight. However, what you can do through investment is start to build in-market resourcing, which then strengthens the supply chain, as I mentioned, globally. It's important to have those resources here domestically, the scientific staff, etc., and engineering that's required on this side of the industry.

Maggie Chi: Yes, Terry, please comment.

Terry Creighton: This is a national security vulnerability, as you've pointed out, but it's something other countries are looking at too. In fact, most of our allies are looking at this as well, and how there can be integrated supply chains where we support each other's API production.

There are API producers in Canada. Apotex is an API producer. There's a company called Minakem in Quebec, which is Canada's largest API producer. We can support our own API producers to begin with.

There are many sources of API production in Europe. Also, as I understand, there are discussions taking place between the Mexican government and the U.S. as part of their bilateral agreement, because the Mexican industry is building out their API production.

It's not something just for Canada to consider, and we probably should be discussing, as part of our trade talks with Mexico as well as with the United States, how we can support each other through API sharing.

Maggie Chi: Thank you.

With the understanding that it is a very integrated supply chain and that obviously it's not going to happen overnight, I want to get your take on what you see as challenges and opportunities to build our own domestic manufacturing capacity and what you see as the way forward here.

Jim Keon: We would like the policy environment to be as attractive as possible for generic and biosimilar manufacturing. We think that having the right regulatory system, sustainable pricing and fair intellectual property laws is the basis for all investment. Companies need to have a stable, predictable and sustainable market. We don't have that right now in Canada. We have proposed a number of measures that would improve that.

I think I also said in my remarks that we're never going to make all of the medicines necessary. There are thousands of medicines sold in Canada for Canadian patients. We can't make them all. We need to have secure arrangements with other partners, and we would certainly support Canada entering into supply commitments with other countries and supply agreements to ensure the free flow of pharmaceuticals.

Maggie Chi: I think that's my time.

Thank you.

The Vice-Chair (Dan Mazier): Thank you.

Mr. Blanchette-Joncas, you have six minutes.

[*Translation*]

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

I'd like to welcome the witnesses who are with us today for this important study.

My first question is for Mr. Bouvier.

Canada has excellent researchers, and many important biomedical discoveries come from our universities. However, these innovations are often developed and commercialized elsewhere, unfortunately.

In your opinion, what is still preventing Canada from turning its discoveries into drugs developed, tested clinically and produced here?

● (1635)

Michel Bouvier: Thank you for your question.

There are a number of barriers that limit the ability to fully produce and commercialize the drugs discovered here. I'll give you just a few examples.

The first is the ability to generate enough capital to ensure that discoveries can be developed here in Canada with Canadian actors. Too often, discoveries are directly licenced abroad. That can be an attractive source of revenue and acceleration, but it cannot be the only source of innovation. We also have to be able to keep our capacity at home, not only to innovate, but also to transform innovations into commercial products.

In Canada, we very often don't have enough capital to establish companies with the depth needed to fully accomplish that. Even when a company is set up, it is very often sold to foreign interests quite quickly. This is happening, once again, because of a lack of Canadian capital to be able to support the development of these companies in Canada for the benefit of Canada.

The other limitation was mentioned by our colleagues. It has to do with the challenges of assessing and approving drugs in Canada. I could cite the example of drugs that were discovered here, by our colleagues at the Université de Montréal, to treat a very rare disease. Those drugs were accepted and approved for reimbursement in Europe and accepted in the United States, but they are still not accepted in Canada.

These are barriers that prevent, in many circumstances, the full development and commercialization of drugs invented here.

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

Based on your experience in commercializing research, is intellectual property from universities sufficiently captured in Canada, or is it often harnessed elsewhere?

Michel Bouvier: That's a complex issue. Some of the intellectual property is actually captured here when the valorization structures attached to universities are able to properly negotiate knowledge transfer. Universities are able to grant licences abroad while providing the parameters necessary for a significant, fair share of revenues to be returned to Canadian institutions.

Unfortunately, this type of structure is not necessarily as widespread as it should be in Canada. That was more or less the vision the federal government had when it created the centres of excellence for commercialization and research program. The idea was to provide Canadian universities and high-level research institutes with a structure that enabled them, among other things, to advance their discoveries as far as possible. There's a myth that an academic discovery necessarily leads to a product or a drug.

In reality, there are a lot of steps, usually referred to as the valley of death, between discovery and commercialization. We need to have the means to bring a discovery to a stage of maturity that will enable it to be commercialized. Also, there are structures that will help either start up a spinoff company, which keeps the intellectual property in Canada, or grant operating licences to foreign companies while ensuring that the licencing conditions allow for the value generated to be fairly shared.

Unfortunately, Canadian universities are not always very well equipped to ensure the two parts of the equation that I've just described.

Maxime Blanchette-Joncas: You said that the centres of excellence for commercialization and research program supported platforms such as the Institute for Research on Immunology and Cancer and IRICoR, but that it was discontinued in 2018.

In your opinion, what tangible impact has this decision had on Canada's ability to develop drugs that come from university research?

Michel Bouvier: Locally, it had an impact on IRIC and IRICoR, where we had to greatly reduce the development of new projects. We had to focus on a few projects with the own-source revenue generated by valorization. It prevented a virtuous cycle where even more valorization revenue could be generated and reinvested in research.

On a larger scale, the centre of excellence in commercialization and research wasn't the only one in Canada. Other centres have also been impacted nationally and have had to scale back or curtail their expansion. Some even completely halted both.

I think that has had a very significant impact, not only on the development of new drugs, but also on the innovation needed to produce drugs. That includes methodologies and drug synthesis techniques.

Developing new biologic drugs requires significant innovations, and when innovations are not supported here, they are not easily used locally in the various sectors of the life sciences and biopharmaceutical sciences ecosystem.

● (1640)

Maxime Blanchette-Joncas: In your opinion, was it essential to bridge what is often referred to as the valley of death?

Michel Bouvier: Absolutely.

The program worked very well. I think the strategic decision not to keep it going was not based on the program's performance, but rather on a new vision of how Canada should invest in research and major initiatives.

[*English*]

The Vice-Chair (Dan Mazier): Thank you. That's the end of that round.

We'll go into the five-minute rounds with Ms. Konanz.

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

My question is for Mr. Watson.

Can you confirm that Apotex is involved in the production of the opioid apo-hydromorphone and have you had any contracts for apo-hydromorphone with the federal government in the last decade?

Jeff Watson: I can't confirm a contract with the federal government, but I'd be happy to provide that information to you.

Helena Konanz: If you could table that for the committee, that would be great. Thank you.

Mr. Watson, as I'm sure you're aware, my province of British Columbia has seen enormous damage to human health because of opioid addiction. You've asked us to trust you and include you in the buy Canada component—

John-Paul Danko: I have a point of order, Mr. Chair.

The Vice-Chair (Dan Mazier): Ms. Konanz, we have a point of order.

John-Paul Danko: Once again members of the committee are asking questions that are completely irrelevant to the issue at hand of pharmaceutical sovereignty.

I would ask you, Chair, to ask members to please make their questions relevant to the study we are here to discuss.

The Vice-Chair (Dan Mazier): Ms. Konanz.

Helena Konanz: I think everyone here would agree that the manufacturing of opioids is part of pharmaceutical sovereignty, so I will continue.

You asked us, Mr. Watson, to trust you and to include you in the buy Canada policy, but it's widely agreed upon that this crisis began with the oversupply of prescription opioids dating back to the 1990s. It has obviously cost many lives and caused tragedies.

Will Apotex take responsibility and agree to a settlement with my province, B.C., and provide compensation for these harms?

Mr. Watson.

Maggie Chi: I have a point of order, Chair.

Again, I'm struggling to see the relevance of the line of questioning here. I think the member may have even referred to lawsuits.

I would request that the chair ask members to stay on topic and ask questions relevant to the study. We're doing a study here.

Thank you.

Helena Konanz: I can imagine why members around this table might get upset by this line of questioning, because it is a very upsetting subject. In order to understand whether we can trust the companies and the representatives who want us to buy Canadian, we need to find out whether they are trustworthy.

One of the things I'm asking about is the class action that was brought by my province, B.C. You've been opposing that in court for seven years now, even all the way to the B.C. Supreme Court. You want Canadians to support your efforts in domestic drug-making today, and you want us to trust you. Canadians, obviously, would like to trust you, but you won't take accountability for these past failings.

Can you speak to this?

Jim Keon: I'd like to provide an answer to that, and provide some context.

I am the president of the Canadian Generic Pharmaceutical Association, representing all companies, including Apotex.

Helena Konanz: I'm sorry, Mr. Keon, but I asked Mr. Watson this question. I just want to know whether he can answer that.

Jim Keon: I represent Apotex and all generic companies. The—

Helena Konanz: Are you representing Mr. Watson? I'm sorry. I didn't realize that. I'm sure you'll have questions going to you.

I am going to ask Mr. Watson, because he is the one who spoke to us about—

Jim Keon: I was just going to provide some context.

The Vice-Chair (Dan Mazier): I'm using the chair's prerogative.

The question was for Mr. Watson. If Mr. Watson decides to hand it over to you, that's the way it will work.

● (1645)

Jeff Watson: I'm not in a position to talk about part of your question.

I will tell you that we recognize the tragic circumstances that these products have caused for Canadians.

However, as a reminder, as a generic company and part of the generic association, we do not promote generic products to physicians. We don't sell products to physicians or patients. We sell our products to pharmacists through a wholesale chain.

I will defer to Jim because this is an—

Helena Konanz: I will follow up with another question.

We know Apotex agreed, under a national multistate opioid settlement in the United States, to a compensation package of $72 million.

I want to understand why your company, Apotex, is willing to compensate Americans but not.... Why won't you end the legal battle here in Canada and compensate British Columbians? It's a very important question, I'm sure, for everybody watching online and in this room today.

Jeff Watson: Once again, we recognize the importance of this. We have been working productively, but I'm not in a position to...nor will I be commenting on any ongoing matters.

Helena Konanz: Further to that, I understand it's a difficult subject, but you've been working on this for seven years. In order for Canadians to trust your company and trust you, we need to understand why they aren't being compensated for the destruction caused by these drugs in British Columbia, which I represent, and throughout Canada.

Jeff Watson: Once again, it's an ongoing matter.

Helena Konanz: Okay.

I have a final question on this.

As CEO of Apotex, do you take any responsibility for the Canadians who lost their lives to, or have been ruined by, opioid addiction?

Jeff Watson: As the CEO of Apotex, I take the importance, maintenance and impacts of these drugs extremely seriously. Once again, Apotex, like other generic companies, sells products to pharmacies. We do not promote our products. We fulfill existing demand in the marketplace.

However, we do take this topic extremely seriously.

Helena Konanz: I'm glad to hear that, because I know that you did have a settlement with Quebec. I'm wondering why this company cannot settle with B.C. It's been seven years.

Thank you.

The Vice-Chair (Dan Mazier): Ms. Jaczek, you have five minutes.

Hon. Helena Jaczek: Thank you so much, Chair.

To reorient the discussion and remind all our witnesses, the study is to develop recommendations on how Canada can best promote pharmaceutical sovereignty.

To return to that subject, my first question is for Mr. Keon.

Canada is responsible for direct health services for the armed forces and for indigenous populations. Would you recommend that Canada look directly at Canadian manufacturers in terms of procurement for its pharmaceutical requirements for those particular responsibilities?

Jim Keon: It absolutely should look to Canadian suppliers. I think the procurement process should also look for reliability, sustainability, good cost and good value. All of those things should be part of the contracts.

Hon. Helena Jaczek: Ms. Creighton, would you like to comment on possible procurement practices?

Terry Creighton: In fact, procurement policies are one of the five action plans we have put together. We have thought about this a lot. We think there is great opportunity in Canada to support domestic producers through procurement. Between the federal and provincial governments, governments in Canada spend over $18 billion a year reimbursing eligible Canadians under the drug plans.

As it stands today, none of that is directed to support Canadian producers, yet the federal government has adopted, or is in the midst of adopting, a buy Canadian policy, which we certainly support. One of the components of that is to direct federal purchases to Canadian suppliers. We are strongly in favour of that including medicines. Through the programs you mentioned, there is an opportunity through formulary management to direct even a portion of those current expenditures to give preference to Canadian-made medicines.

The most important part of that is it would not cost any additional money because those expenditures are already being made. This would be a matter, in the case of generics, of directing some of that to the companies that are here in Canada, have invested in Canada, are making these medicines in Canada and are incurring the cost to do so as a way to support Canadian producers.

● (1650)

Hon. Helena Jaczek: Thank you.

Ms. Creighton, I think you made some comments, or expressed concerns, about our government's new initiatives for regulating Health Canada, trying to modernize the whole regulatory process and speed it up, and moving towards greater international collaboration and reliance, including the ability to rely on assessments by foreign regulators while maintaining Canadian standards for safety, effectiveness and quality.

You viewed this with some trepidation. Can you elaborate on how you think this might be improved?

Terry Creighton: The reliance program is in the midst of consultation. It is a program that is intended to speed up approvals of submissions to Health Canada for sponsors—drug companies—by relying on the approval they have received from other foreign regulatory authorities, such as the FDA in the U.S. or the European Medicines Agency in Europe. The intention of it is to speed up approvals.

Logically, you have to believe that those applications received by Health Canada will get priority review, because the whole point is to speed it up. We are very concerned that, as Jim pointed out, there are already tremendous delays in approving submissions for generic products from Canadian companies as well, and we're concerned that Canadian submissions will inadvertently go to the end of the line.

We know this is not the intention of the reliance program. It is an unintended consequence that we have brought to Health Canada's attention, but it's very concerning to us if it delays the approval of Canadian products.

In the case of generics, we compete against those imported products, and we're concerned that they would gain access to the Canadian market faster and our products would stay in the same queue that currently exists, which is not being addressed and is not being improved, and that we would be subject to the current pathway as opposed to this expedited pathway.

We have recommended, in addition to the reliance program, that Health Canada consider a priority pathway for submissions from Canadian companies and speed up those approvals in a different way.

The Vice-Chair (Dan Mazier): Thank you, Ms. Creighton.

Mr. Blanchette-Joncas, you have six minutes.

[*Translation*]

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

I'll continue with Mr. Bouvier.

This year, the federal government also announced a significant cut to the college and community innovation program.

In your opinion, what impact can this lack of predictability in federal programs have on Canada's ability to build a strong pharmaceutical ecosystem?

Michel Bouvier: You mentioned a particularly important word, predictability.

One of the major difficulties we've encountered over the years is the inability to know to what extent a program that's been put in place will be supported and maintained for a number of years so that we can establish partnerships, either with other university partners or with industrial partners, to ensure the sustainability of the programs and research we're undertaking. Sustainability is an important issue.

That said, the budget cuts that are being made to training programs, whether at the college or university level, have a major impact on our ability to train the next generation of innovators, both in the pharmaceutical field and in other fields, particularly in the life sciences. We need to train these people here so that they can contribute to the next discoveries and innovations here.

If the climate is not conducive to this training, young people will either choose to leave Canada or choose other career paths, which will jeopardize our ability to innovate in the future.

Maxime Blanchette-Joncas: Mr. Bouvier, have you heard from research centres that have had to scale back their activities or even close their doors following the elimination of the Centres of Excellence for Commercialization and Research Program?

Michel Bouvier: Those centres have definitely had to cut back on their activities. In our case, for example, while IRIC and IRICoR continue to operate and generate successes, our ability to invest in new projects has been significantly reduced. As a result, these innovations won't see the light of day quickly, due to a lack of investment.

Other CECRs have also had to cut back a great deal. I'm thinking, for example, of adMare in Montreal, formerly NÉOMED, which had to significantly reduce its activities, particularly in terms of developing a new company and research programs. It had to limit itself to certain sectors, only for investments, and stop almost all development.

● (1655)

Maxime Blanchette-Joncas: I understand.

From your perspective, is national drug discovery and development capacity an essential condition for ensuring true pharmaceutical sovereignty?

Michel Bouvier: I think it's essential. The ability to innovate makes it possible to use those innovations. When a country or an organization stops innovating, it also hinders its ability to adopt innovations, even if it imports them from elsewhere.

In addition, if we are forced to import innovations from elsewhere, we can't contribute to them ourselves. We leave ourselves vulnerable to crises such as the one we experienced in public health or those linked to major geopolitical changes currently taking place.

It is essential to have a strong and vibrant biopharmaceutical sector here in Canada to continue collaborations with other foreign organizations. Collaborations with large pharmaceutical companies have been very important for us. It speeds up drug discovery, as long as we have the right structures in place to capture the value of what has been generated here and maintain this virtuous cycle.

Maxime Blanchette-Joncas: To your knowledge, if a new global health crisis were to occur tomorrow, which we obviously don't want, would Canada have the necessary capacity to develop and produce new treatments quickly, or would we still remain largely dependent on foreign countries?

Michel Bouvier: Unfortunately, I think we would still be largely dependent on other countries. There have been improvements, but the difficulty, in my opinion, is in targeting certain very specific sectors.

Human beings are pretty bad at predicting the next problems they're going to encounter. Of course, viruses and bacteria are real problems, but they aren't the only problems that we may have to deal with. Providing a broad base of innovation and knowledge would increase our response capabilities.

It also takes infrastructure that enables us to pivot quickly and with the necessary agility. That's what I was describing in my opening remarks. We must be able to reorient existing, efficient infrastructure based on needs. If we lose this infrastructure, and if we don't have a broad base, we'll once again find ourselves in serious trouble when faced with the challenges ahead.

Maxime Blanchette-Joncas: I understand.

To recap, Mr. Bouvier, if you had essential recommendations for the government to strengthen its pharmaceutical sovereignty, what structuring measures would you prioritize?

Michel Bouvier: I would say that we need to invest in existing innovation and research infrastructure that is already working well, in order to strengthen it and encourage the local development—and this is key—of structures necessary for value creation.

There is often a perception that this can be done globally by superstructures. Unfortunately, research and innovation are contact sports. There really needs to be proximity between the people who make the discoveries and the people who will turn them into value. The goal is to build trust and ensure that things are done in a very efficient and agile way. Those two things are absolutely critical.

Maxime Blanchette-Joncas: Thank you very much.

[*English*]

The Vice-Chair (Dan Mazier): Thank you.

Mr. Strauss, you have five minutes.

Matt Strauss: Thank you, Chair.

Thank you, everyone, for coming to committee today. Your testimony is really interesting.

Mr. Watson, I hope you understand that the Conservatives' line of questioning is in good faith, and I hope you've been reassured prior to coming that you benefit from parliamentary privilege while you're here. Nothing you say at this table can be held against you or your company in a court or any other proceeding. Have you been briefed that way?

Jeff Watson: No, but I appreciate your comment.

Matt Strauss: I have a point of order, Chair.

Could the clerk confirm to the witnesses here that they benefit from parliamentary privilege, and could future witnesses at the committee be briefed about the benefits thereof?

● (1700)

The Vice-Chair (Dan Mazier): What did you...? I'm sorry.

Matt Strauss: It's just notable to me that the witnesses here today haven't been briefed about parliamentary privilege and that they're able to speak with immunity here. I'm wondering if the clerk could confirm to them now that they benefit from that immunity and if future witnesses to the committee could be reminded of that.

The Vice-Chair (Dan Mazier): Do they have parliamentary immunity while they're testifying to the committee?

A voice: [*Inaudible—Editor*]

The Vice-Chair (Dan Mazier): That is confirmation of yes.

Matt Strauss: Thank you. I just wanted the witness to be reassured by that.

Part of what intrigues me, Mr. Watson, about pharmaceutical sovereignty is the opportunity for a higher level of trust and safety of Canadian drugs made for Canadians by Canadian manufacturers. Would you agree with me?

I see a lot of heads on the panel nodding. That would be an important part of pharmaceutical sovereignty, the opportunity for higher trust and safety standards. Thank you.

This question is still for you, Mr. Watson.

Dr. Somers claimed that in Canada—though it might be different in other countries—drug manufacturers don't have to disclose the amount of opioids or other potentially addictive drugs that are given to any particular provider or in any particular situation. Is that your understanding of the regulations? If a safe supply provider is asking for a bunch of your meds, do you take an interest in that? Does it have to be reported anywhere?

Jeff Watson: I'm not in a position to talk about a safe provider, but I can tell you once again that on the generic side of the business, we would ship either to pharmacies or to wholesalers. If it were a wholesaler, we would have to track the amount. We would be able to track the units sold to a unit pharmacy.

We're not involved in any way with the promotion of the products.

Matt Strauss: Got it, but you do track the amounts. Do you have to report the amounts to any government agency?

Jeff Watson: We have other.... I'm not aware of reporting.

Matt Strauss: Thank you.

Would you say in general that as a Canadian manufacturer, you take an interest in how your drugs are used? If you became aware....

What's interesting here is we have Dr. Somers saying that there is not good evidence for using hydromorphone in safe supply and not good evidence for using it in general as a treatment for opioid use disorder.

Is that of interest to your company? If providers are using your drugs in a way for which there is not good evidence, is there any way by which that is fed back to either your company or the government?

Jeff Watson: Once again, we're not in a position to have a relationship with the providers. We do not have a relationship with prescribers or with providers.

Are we interested in the general category of pain management and the fact that we participate in that to ensure that there's a safe supply of product in the marketplace? Yes. Do we have an awareness of the product? Yes. Do we have ongoing frontline knowledge of emerging information on the product? We might not have that, as other parts of industry might be exposed to that information.

Matt Strauss: Would you be interested in taking an interest in that? I'm asking you in good faith, with parliamentary privilege, could your company, as part of a pharmaceutical sovereignty strategy, take an interest in making sure these drugs are not misused in Canada?

Jeff Watson: Of course.

Matt Strauss: Okay, thank you.

Dr. Somers, I was excited that you came to speak to us today. You said a number of very interesting things. The first thing I'll ask you is whether I got your comments correct when I put them to Mr. Watson that, to your knowledge, Canada is a bit peculiar and that the reporting requirements for opioid manufacturers are different than in other jurisdictions.

Julian M. Somers: The key point I made was not related to volumes of drugs and that tracking, but rather the fact that providing funding, direct funding to universities, to clinicians, to researchers is disclosed only on a voluntary basis, and so a fraction of the money that is allocated by pharmaceutical companies in Canada for those purposes—

Matt Strauss: I'm sorry if I misrepresented your comments, and I'll just put those back to Mr. Watson.

Does Apotex give money to universities for research in the way that Dr. Somers is describing, and is that not tracked or declared?

Jeff Watson: Once again, we're a generic pharmaceutical company. We don't fund research. Whether we have any relationships related to a generic portfolio, I'm not aware of that, but we are not....

Matt Strauss: Thank you. Is that time?

The Vice-Chair (Dan Mazier): You have 15 seconds.

Matt Strauss: Dr. Somers, I read in the news about your being ordered to destroy your research data by the B.C. government. Is that true, and is that even legal for them to ask you to do that?

● (1705)

Julian M. Somers: It's an extraordinary step, and yes, that was correct. We had some over 20 years of research data collected over pharmaceutical trials, randomized trials, other studies involving addiction drug treatment court, a whole variety of interventions designed with collaborators around the world. One week after the B.C. government learned that we had those data and were mobilizing to evaluate their current drug policies, we received a letter ordering us to destroy everything, effectively undermining our ability to do that work that had already been funded and approved.

The Vice-Chair (Dan Mazier): Okay, thank you very much.

Julian M. Somers: Can I shoehorn a clarification in?

I had to think about this term “sovereignty” before appearing here today. My understanding is that the committee's interest is both in the meaning of sovereignty as it relates to internal autonomy and agency, as well as security of freedom from external actors and threats and that meaning of sovereignty. From my perspective, knowing that Canada is—

The Vice-Chair (Dan Mazier): Sorry, but we do have time limitations here.

If you want to submit a paper on that, please by all means submit that to the committee and we'll take those comments under consideration.

Julian M. Somers: No, I've made my point. Thank you.

The Vice-Chair (Dan Mazier): Thank you.

Ms. Sidhu.

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

Thank you, witnesses.

My question is for Mr. Watson.

If the federal government were to adopt a national strategy of pharmaceutical sovereignty, what three priorities do you believe should be at the centre of ensuring Canadians have reliable, affordable access to essential medicine? You already talked about sustainable pricing, but give three priorities, if you can speak to that.

Jeff Watson: First of all, we do have a backlog of products waiting for approval, and I would say bringing new products to market sooner is one. By the way, a couple of years ago, three years ago maybe, I think Health Canada was leading the way on time to market and approvals to the point where you had regulators like the FDA trying to understand what were some of the key processes that Health Canada was using. This is something that the country definitely knows how to do and has done. I think there's unleashing that backlog, which would once again continue to bring more innovation from the generic side into the market and all of a sudden continue to offer more affordable medicines out to the marketplace.

The second thing would be to prioritize Canadian local manufacturers and find ways to incentivize local manufacturers to continue to invest in Canada, continue to bring products here in Canada and manufacture in Canada and be given credit for domestic manufacturing for those products.

Sonia Sidhu: To follow up on that, from an industry perspective, what types of tax incentives, such as tax credits or regulatory reforms or direct investments, would most effectively encourage companies to expand pharmaceutical manufacture in Canada?

Jeff Watson: I would defer to Terry, but I'd be happy to comment after Terry from a company perspective.

Terry Creighton: We've looked at this quite closely, and we have developed a list of tax incentives and depreciation incentives that we have submitted to the Department of Finance as part of our budget submission, which I think you will be receiving as part of this deliberation. These are things like a refundable tax credit for the manufacturing of medicines in Canada.

The premise here is we are suggesting that pharmaceutical production be treated as a critical industry similar to other critical industries that receive tax and favourable economic support from the federal government as part of a broader strategy. It's something that's desirable in Canada. We should support it.

We have also recommended that the depreciation allowance for equipment be increased. We have recommended that the tax deductibility for investments not be capped.

There was, in the past, a tax credit given to drug companies for donating medicines for charitable purposes. That tax credit was removed a few years ago. We think that should be restored.

Sonia Sidhu: I just want a clarification.

I'm hearing here that Health Canada's approval of any drug is done in 180 days. I think there are major delays in approvals after that, after Health Canada's approval. I think there is more procedure on that, but Health Canada's record for the approval of any new drug is 180 days.

● (1710)

Terry Creighton: That is the target, but it's rarely met. I think that's what my colleague, Jim, was referring to in particular. Although there are targets and a process in place that are covered by the user fees that drug companies submit to Health Canada, there is a mechanism that enables Health Canada to send it back on the 179th day. That's the concern we have, that they are not reaching their own milestones.

Jim Keon: I think their failure to reach their milestones costs Canadians and the health care system substantially. Generic medicines come on the market at much lower pricing, so when they're delayed, the programs have to pay the higher brand prices for longer.

The other thing it does is.... A company invests in developing the product. It does the formulations, the studies and the clinical trials. It submits it to Health Canada. The company is waiting to get an approval. It's trying to plan its production processes, etc. Health Canada now is unable in many, many cases to tell a company when it might get a final decision. This does affect investment and the ability to produce these products in Canada and make them available to Canadians.

I've talked quite a bit today about Health Canada. It is critical that they have good resources, expert resources, and that they review products and give good decisions on time.

The Vice-Chair (Dan Mazier): Now we'll go to our third round.

Mr. Bailey.

Burton Bailey: Thank you, Mr. Chair.

My question is for Ms. Hamelin.

Earlier, we talked a little bit about the approval process. I don't want to hear it from start to finish, but could you outline some of the things you haven't heard that you think would be beneficial in this process, things that we need to improve so that Canadians can get access to treatments more quickly and reliably?

Bettina Hamelin: That is an excellent question, Mr. Chair.

There are numerous duplicative processes that are applied in Canada between the submission of a new innovative medicine to Health Canada and that medicine actually coming onto a public formulary so that Canadians have access to it. On average, that time frame—between the beginning of the regulatory review and the formulary listing—is three and a half years after a medicine is launched, for example, in the U.S. or in Canada.

The process starts with regulatory review at Health Canada. That is followed by what is called a health technology assessment by Canada's Drug Agency, followed by lengthy negotiations around pricing with the pan-Canadian Pharmaceutical Alliance. That is followed by negotiations with each of the provinces and territories. Many of the processes are duplicative, and they are not happening in parallel. They are sequential, and that adds a tremendous amount of time. For a patient with cancer who is waiting for this new cancer medicine, it can be a question of life or death.

That really needs to be addressed. It becomes a much more pivotal issue in the context of the U.S. highlighting the pricing in Canada. Canada is one of the eight countries with most favoured nation pricing, and the U.S. is really putting that in the limelight. That puts a great amount of risk on medicines being launched here because we don't have this clear, predictable, supportive policy environment that is needed to actually launch medicines here.

We actually have some numbers from our membership which suggest that already at least 10 medicines have not been launched in Canada in the past few months because of the uncertainty that is created by the most favoured nation pricing policy that's triggered by the U.S. That is significant for Canada. It involves mostly cancer medicines.

● (1715)

Burton Bailey: You mentioned price reform. How can we be assured that the pharmaceutical companies are engaging in transparent communication with Canadian-based innovation, so that we are getting the best prices for Canadians?

It will have to be a very short answer.

Bettina Hamelin: The innovative pharmaceutical industry is very interested in working together with government to find the right policy solutions that work for Canada and for Canadians and that assure Canadians get the medicines they need when they need them.

It's important to note that Canada has underinvested in innovation for a long time. That is why we find ourselves in a situation where we are rather dependent on the global supply chain. On the other hand, that is also a good thing, because that is how Canada has access to the most innovative discoveries that are tackling cures and tackling prevention.

Burton Bailey: Thank you.

Dr. Somers, your commentaries have criticized Liberal narcotic policies, like the so-called safe supply. I dislike the term “safe supply”. I think it's a terrible term. I think it should be “controlled supply”.

How has government censorship or data suppression prevented effective strategies for addictions treatment within a sovereign pharmaceutical framework to protect Canadians' health and well-being?

Again, I'm going to have to ask you for a short answer, please.

The Vice-Chair (Dan Mazier): You have 10 seconds.

Burton Bailey: How about 15 seconds?

The Vice-Chair (Dan Mazier): Hurry up. You have 15 seconds.

Julian M. Somers: The ability to flow money without disclosure into points of influence—universities, researchers and clinicians—distorts the appeal of pharmaceuticals—

The Vice-Chair (Dan Mazier): I'm really sorry. We're way over here.

Burton Bailey: Chair, could we get him to table that for me, please? Thank you.

The Vice-Chair (Dan Mazier): If you could table your response, that would be fantastic.

Mr. Danko, you have five minutes.

John-Paul Danko: Thank you, Chair.

I have a couple of questions for Ms. Hamelin and maybe Ms. Creighton.

Ms. Hamelin, you started your initial remarks by bringing forward a number of Canadian success stories. I just want to highlight a few in my riding in Hamilton West—Ancaster—Dundas. Life sciences is the largest employer in Hamilton.

OmniaBio is a CAR-T cell therapy pharmaceutical company that is developing pediatric brain cancer medications. Fusion Pharmaceuticals is developing medical radiation isotopes and therapies and was recently acquired by AstraZeneca for over $2 billion, I think. AtomVie is also in the radiopharmaceutical industry.

Ms. Hamelin, how can we help those Canadian success stories scale and grow to be able to compete on the global market?

Bettina Hamelin: We need to create an environment for these companies to be successful and to go beyond the discovery and development to reach Canadian patients.

It's quite shocking to hear that many success stories in Canada.... We have seen several. Michel Bouvier has spoken to some. The medicines are not getting onto our formularies because of the lengthy delays. It is about the processes that need to be modernized to create an environment that set positive market signals. The industry is now competing globally. We can look to China, for example. A third of pharmaceutical innovation today is coming out of China. Why? In 2015, China invested in regulatory reforms, R and D, clinical research infrastructure and partnerships, and now we see this accelerated growth of innovation in China.

We need Canada to be strategic and to think not only in the short term but in the medium and long terms to build an ecosystem that sets the right market signals. What that needs is clear, predictable, supportive policies to bring innovative medicines to patients.

● (1720)

John-Paul Danko: Thank you so much, Ms. Hamelin.

In this context as well, you talked about the risk at the border. Those three pharmaceutical businesses that I mentioned make very time-sensitive products, and they have mentioned the uncertainty at the U.S. border in getting their medications back and forth as a constraint on their business.

Ms. Creighton, do you have anything to add on how we help those Canadian businesses succeed?

Terry Creighton: I think Bettina is right. We need an environment that supports the continuum from innovation through to production. Innovation is certainly important, and vaccine production is certainly important, but that's not what Canadians take every single day. Those are not the drugs you find in your medicine cabinet. Those are not the ones on your bedside table every night.

If we don't have access to essential medicines that are made here in Canada, we are very vulnerable, and we are beholden to the rest of the world for our supply. If we don't have a healthy environment for drug production, and that is what we are talking about, then all of the innovation can go on, but it's going to end up somewhere else anyway.

John-Paul Danko: Thank you. I'm sorry to cut you off. I have about 45 seconds seconds left.

I want to switch gears and go to the labour market. What is part of Canada's commercial advantage in science and research technology? I represent a riding that has three post-secondary institutions, McMaster, Mohawk, and Redeemer. How important is it to have access to the best talent in the world, Ms. Creighton?

Terry Creighton: I said in my remarks that Canadians are very good at making medicines. The companies that I represent have deep Canadian roots. They have been here for decades, from the 1960s and 1970s, and they have created a workforce in Canada that is particularly skilled at making medicines.

In my opinion, there is not enough support for that end of the spectrum, workforce support. Many of the people who work in these facilities are recruited from elsewhere in the world. They come to Canada. They've had experience in drug manufacturing in places like India. You walk around a facility in Canada and you see many of those people, new Canadians, contributing greatly.

We should be able to train people here in Canada to do that as well, because workforce is an issue. There are always job postings in all of these companies, and they have difficulty filling those roles.

The Vice-Chair (Dan Mazier): Thank you.

Now we'll go to Mr. Blanchette-Joncas.

[*Translation*]

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

Ms. Hamelin, the pharmaceutical industry said it wanted to invest in research and development to the tune of about 10% of its sales revenue in Canada. According to the data from the Patented Medicine Prices Review Board, that percentage varies between 4% and 5%.

How do you explain this discrepancy?

Bettina Hamelin: This is related to the business environment in Canada, an environment that does not allow pharmaceutical companies to bring drugs to market in order to have them listed on formularies accessible to patients and physicians.

As a result, that environment is not very open to innovation or to the commercialization of innovative medicines. This prevents companies from investing. The situation will soon get worse, given the presidential decrees issued by the President of the United States, who asked not only Canada but all the countries of the world to contribute more to innovation.

Maxime Blanchette-Joncas: If I understand correctly, you're not meeting your commitments because the investment environment isn't favourable. Let's get this straight. Canada represents about 2% of the global pharmaceutical market.

Do multinationals today see Canada as a market to sell drugs or as a place to invest?

Bettina Hamelin: The two go together. The industry invests $3.2 billion a year in research and development in Canada. It has 110,000 employees, and generates $18.4 billion in economic benefits. We have to acknowledge the investments that the industry makes.

However, the government is delaying drug approvals and reimbursement. The two go together. It's not one or the other. You have to approve drugs for patients, and that's tied to an investment. Now, with the most favoured nation clause—

● (1725)

Maxime Blanchette-Joncas: What you're saying, Ms. Hamelin, is that it's the government's fault if you don't meet your commitment to invest 10% of your sales revenue in research and development.

Is that correct?

Bettina Hamelin: It's a partnership between the government and the industry. The industry is investing heavily in Canada.

Should we do more? Yes.

Maxime Blanchette-Joncas: Whose fault is it, Ms. Hamelin? Who is responsible?

Bettina Hamelin: It's the fault of an environment that is changing—

Maxime Blanchette-Joncas: Who is part of the environment?

Bettina Hamelin: Let's not go backwards. Let's look forward and find solutions together.

Maxime Blanchette-Joncas: We need to understand the past in order to move forward, Ms. Hamelin.

Thank you very much.

[*English*]

The Vice-Chair (Dan Mazier): Okay. That's the end of that round.

We have Mr. Strauss for five minutes.

Matt Strauss: Thank you, Chair.

Mr. Watson, I have a couple of final questions.

Are you aware if any of the opioid products you manufacture are currently accessible through vending machines in Canada?

Jeff Watson: I'm not aware.

Matt Strauss: Would you be able to table that with the committee in written form?

Jeff Watson: Yes, I can come back to you with that.

Matt Strauss: Would you be able to tell us in general how much revenue is generated from opioids in vending machines?

Jeff Watson: I couldn't tell you that.

Matt Strauss: Okay.

Dr. Somers, I'm still terribly alarmed by this story of your being ordered by the B.C. government to destroy data. Who ordered you to destroy the data, and why do you imagine that they ordered you to destroy your data?

Julian M. Somers: The order came precisely one week after I delivered a briefing to provincial deputy ministers. I was told directly by one of those ministers in that meeting afterwards that my remarks had angered him and some of his colleagues, because I implied that the provincial government was not optimally handling the so-called addiction and homelessness file. I was surprised by his remarks, but I could understand in hindsight why he might have reached that conclusion. I thought after our years of working together that he wouldn't be so easily offended, but that was the explanation.

Matt Strauss: To my understanding, you're a full professor at a Canadian university. You did this research study for 20 years. You gathered the data. You published the data as randomized control trials. This seems like an incredible departure from normal scientific practice, to have published data being destroyed. Do you have any comment on that?

Julian M. Somers: Well, there's no question it's an extraordinarily heavy-handed tactic by a government. It definitely caught me by surprise, and it amounts to significant overreach.

The research in question included randomized trials, data collected with individuals' consent and pharmaceutical comparisons.

Matt Strauss: Knowing that you benefit from parliamentary privilege, can you say the name of the person who ordered you to destroy this data?

Julian M. Somers: Mark Sieben was the deputy—

John-Paul Danko: I have a point of order, Chair.

It might surprise you that I am very interested in this testimony, but again, it has nothing to do with pharmaceutical sovereignty. Could the member please at least pretend to link his questions to pharmaceutical sovereignty?

Matt Strauss: On a point of order, Chair, I would point out that more Canadians died from opioid overdoses in the last few years than in the entirety of World War II. I think this goes directly to our sovereignty.

John-Paul Danko: Let's do a study on that, then.

Matt Strauss: This is about pharmaceuticals and it's about sovereignty. I don't know how it could be more clearly in the wheelhouse.

John-Paul Danko: I know the chair is not going to put this committee in order, but at least just pretend.

Matt Strauss: Dr. Somers, benefiting from parliamentary privilege, could you please say the name of the person who ordered you to destroy the data?

Julian M. Somers: Yes. The letter was signed by an executive director named Leigh Greiner, and her supervisor who called me was deputy Mark Sieben.

I think these matters actually are directly related to sovereignty in the sense of Canadians being able to exercise due control over the ways that pharmaceuticals are dispensed and knowledge about their effectiveness. First, on the one hand, that's internal. Second are the points I raised about the absence of a need to disclose funding provided to clinicians, universities and others, which is a distorting influence that signifies, to me, an external threat to Canada's sovereignty.

● (1730)

Matt Strauss: Yes. May I say that I absolutely agree with you that if multinational pharmaceutical companies are using big bags of cash to determine British Columbia's anti-scientific policies on this file, then that absolutely speaks to our sovereignty.

Thank you for your bravery in speaking with us about it now.

You said something interesting about not believing there's evidence for the pharma-first strategy that has been employed nationally. Do you include non-opioid pharmaceuticals like gabapentin for alcohol use disorder or buprenorphine like Sublocade for alcohol and opioid abuse in that assessment, or are you speaking mainly of opioids?

Julian M. Somers: I was speaking predominantly of opioids and also stimulants, the major classes of drugs. In relation to [*Inaudible—Editor*]—

Matt Strauss: We're really pressed for time, so I just want to say this. When you have this story of a violation of your academic freedom and open scientific inquiry and the destruction of data, do you think that this problem of government officials maybe not heeding the best scientific evidence available is part of what has caused an entire national obsession with this idea of safe supply for the last 10 years?

Julian M. Somers: Yes.

Matt Strauss: It's incredible.

Julian M. Somers: Part of my confidence in my answer is that prior to the past decade, there was a much more well-rounded base of evidence informing direction and policies in the field of addiction. I'm old enough and my career is long enough that I've lived through more decades of openness and more purposeful forward innovation in Canada than the last decade represents. It's been slightly surreal.

Matt Strauss: Dr. Somers, when you gave that short answer, “yes”, about what you see nationally, what have you observed from the federal government in terms of maybe not heeding the best scientific evidence?

The Vice-Chair (Dan Mazier): Be very brief.

Julian M. Somers: It's a case of belated steps back—a belated step not to renew the safe supply pilot programs last year, a belated step not to renew the so-called decriminalization experiment in B.C., and no statements regarding what we're going to be doing instead.

The Vice-Chair (Dan Mazier): Thank you.

Ms. Chi, bring us home.

Maggie Chi: Thank you, Chair.

My question is for Innovative Medicines.

Health Canada is advancing regulatory modernization through initiatives like the reliance order, as we mentioned before, and a modernized clinical trial framework. From your perspective and that of your members, how important are these reforms for strengthening Canada's life sciences ecosystem? How would they help ensure or translate into more research, investment and innovation in Canada as a whole?

Bettina Hamelin: The reforms at Health Canada are very important to create an environment that is clearer, more predictable and that provides access to medicines faster than currently. The reliance is, as it suggests, on trusted regulatory agencies around the world like in the U.S. and Europe. It is not compromising in any way the safety and the commitments that Health Canada has to Canadians.

What is really critical in this work of Health Canada is to ensure that there is connectivity with the downstream agencies. After it arrives at an approval, then do another round of clinical reviews, a health technology assessment, etc. It's really important that there's a downstream impact of the great work that Health Canada is doing. Our members are applauding the work of Health Canada, and we're working closely with them to help them with any data or evidence they need from us.

● (1735)

Maggie Chi: To your point, Bettina, it does provide a lot of predictability to the sector. As you know, we've also made significant investment in life sciences through research funding, biomanufacturing initiatives and innovation programs.

From your perspective and your members' perspectives, where are we already seeing these investments make a difference in attracting pharmaceutical research and innovation to Canada?

Bettina Hamelin: The federal government has made investments in research, and does this every year through the research councils. There are investments in the biomanufacturing strategy. There was a recent announcement of the defence strategy with the life sciences fund, and a recent announcement of NRC around medical countermeasures. These are all really important investments that help the sector.

I want to emphasize that several of our members are also in the manufacturing space. Organizations like Sanofi have partnered with the federal government to support the development of a vaccine facility that is multi-functional, so that during a pandemic these facilities can actually help out in Canada directly. Gilead is doing APIs in Alberta. GSK is producing vaccines in Quebec.

These investments are really important. We need to make sure that these investments carry the fruit they're intending to be, in that they attract continued investment by our members, by the pharmaceutical industry. What is needed in the context of MFN is that we create these policies that ensure that we decrease the time to the patient, and we make this environment more predictable. Other jurisdictions do just that. They compete. They build out their life sciences infrastructure and strategies, and they create predictable environments for the pharmaceutical industry to launch their medicines here. In Canada, as I cited earlier, that is at risk.

Maggie Chi: I think a number of them were mentioned before. The sector really spurs the economy and creates jobs. From your perspective, how important is our talent attraction pipeline in also attracting pharmaceutical investment?

Bettina Hamelin: Talent is absolutely critical. It is one of the things our members use to sell Canada to their global organizations. We have the highest levels of education in Canada. We have top-notch universities across the country. We have incredible talent. We want the industry to flourish here so that we can hire this talent, and it can stay here in Canada.

Maggie Chi: Thank you. I believe that's my time.

The Vice-Chair (Dan Mazier): Thank you, Ms. Chi.

That brings that segment to the end.

I do have one more question. I'm going to take the chair's prerogative as per section 20.147, for those who are paying attention to those.

Dr. Somers, are the pharmaceutical companies here today making money off safe supply, and is this a conflict of interest?

Julian M. Somers: Honestly, I don't know the answer to that question. I'm sorry.

The Vice-Chair (Dan Mazier): Thank you for that.

Thank you to all of the witnesses for coming in today.

Thank you to the committee.

We'll adjourn until next Thursday.