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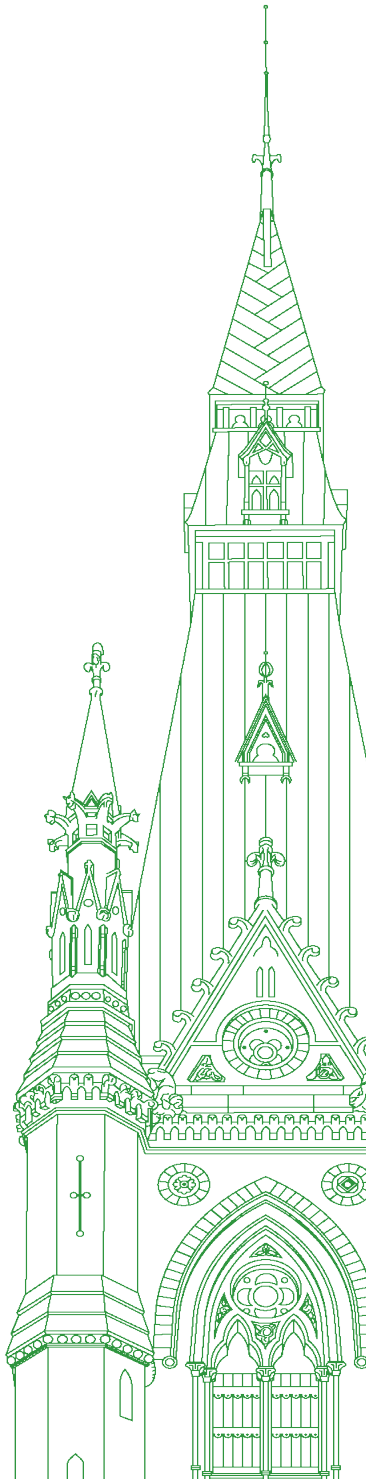

Chair: Hedy Fry

Standing Committee on Health

Thursday, March 26, 2026

● (1535)

[*Translation*]

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

I call this meeting to order.

Welcome to meeting number 26 of the House of Commons Standing Committee on Health.

[*English*]

I recognize that we are meeting on the unceded territory of the Algonquin Anishinabe peoples.

Today's meeting is taking place in a hybrid format, which means that there are those of you here in person and there is a witness who is virtual.

There are some bits of housekeeping that I have to tell the witnesses to remind you of certain things.

Please wait until I recognize you by name before speaking. For those participating virtually, I need to ask you to click on the microphone icon to activate your microphone, but mute it unless you're speaking. At the bottom of your screen, you will see a little round globe. That is to get interpretation. You can choose floor, English or French.

I will remind you that all comments must be addressed through the chair.

For members in the room, you know the drill. If you wish to speak, you have to raise your hand so that I can see you before I see other people, hopefully. Also, remember that the clerk and I will try very hard to manage the speaking order as we sort the hands that are up. We appreciate your patience and understanding in this regard.

Without further ado, we are now on the order of the day.

Pursuant to Standing Order 108(2) and the motion adopted by the committee on Tuesday, September 23, 2025, the committee will begin its study of Canadian pharmaceutical sovereignty.

I would like to welcome our witnesses.

For the first hour, we have the president of the Canadian Medical Association, Dr. Margot Burnell.

Welcome.

I'd like to welcome, from Grifols Canada, Mary Hughes, who is vice-president, sales and commercial operations. Her associate is also here to give her advice should she need it.

We also have, online, Arianne Trudeau, executive director of Médicament Québec.

Here is the drill. Each group will have five minutes. You can pick who is going to speak for the five minutes. I will give you a one-minute shout-out, because I know that sometimes if you're reading, you can't see me. Then I will give you a 30-second shout-out so you can wrap up. You will get to answer questions later on to expand on what you didn't get to say.

That is it.

I shall begin now with the president of the Canadian Medical Association, Dr. Burnell, for five minutes, please.

● (1540)

Dr. Margot Burnell (President, Canadian Medical Association): Thank you, Madam Chair.

I acknowledge with gratitude that we gather today on the traditional and unceded territory of the Anishinabe Algonquin nation and appreciate their stewardship of the land over generations.

My name is Dr. Margot Burnell. As president of the Canadian Medical Association, I have the privilege of representing physicians and medical learners from across this country and, through them, the people we care for.

Thank you for the invitation to share the CMA perspective as part of your study on Canada’s pharmaceutical sovereignty.

I’m sure the committee will agree that the people of Canada deserve a health care system that is modern, high-quality, patient-centred and cost-effective. Prescription medications are essential to achieving this, yet access isn’t always reliable. Every day, physicians see how access to medication can mean the difference between timely treatment and avoidable harm. When we can’t get the right drug at the right time, patients wait. Their treatments have to be delayed, and their surgeries have to be postponed.

When there’s no suitable alternative, patients may not get the full benefit of their treatment or they may have more side effects. Even when alternatives exist, switching medications can be confusing, especially for people who have been on the same drug for a long time.

The effects of these shortages are serious not only for individual patients, but for the health care system as a whole. Patients may need extra appointments to adjust their medications or emergency care that could have been avoided. That added pressure builds up quickly. Physicians, nurses and pharmacists have to spend more time searching for alternatives and adjusting treatment plans, which pulls them away from other patients.

Meanwhile, governments and pharmacies face financial strain when supply chain disruptions drive up drug prices. In the end, though, it’s patients who pay—and pay dearly—through delays, side effects, worsening health and lost confidence in a system that’s supposed to support them.

Canada's vulnerability is clear: 68% of the drugs used here are imported, and 83% of activities related to drug production take place outside our borders, including manufacturing, packaging and labelling.

The CMA has been sounding the alarm for many years. Since 2005, we've called for a comprehensive, well-resourced system to monitor Canada's drug supply. We've also recommended a review of supply processes for drugs and equipment essential to medical practice.

COVID-19 made the stakes clear: Canada didn't invest enough in stockpiles to meet demand. This lesson must guide us now as we look to build our pharmaceutical sovereignty and better protect patients.

First, the CMA recommends that the federal government invest more in producing medications in Canada. Having our own reliable source will help us manage shortages and build a system we can count on.

Second, we're asking for the federal government to partner with provinces and territories to prioritize buying medical products that are made in Canada. This helps strengthen our supply chain and supports Canadian innovation.

Third, we must take steps to strengthen our health care system overall. When drug shortages increase demand for care, we need a health workforce that can manage the impact safely and effectively. That means expanding team-based care, training and licensing more doctors and other health professionals and using technology to make care more efficient.

In closing, I want to highlight the scale of Canada's health industry and the impact our recommendations can have in strengthening it.

The health industry currently employs three million people in Canada, contributes $200 billion annually to our GDP and drives billions in spending on technology, pharmaceuticals and medical equipment. There's a real opportunity to keep more of this investment at home by strengthening domestic innovation and manufacturing.

Yes, let's absolutely keep economic value, jobs and intellectual property in Canada, but as importantly, let's ensure people in Canada can rely on safe, effective and consistent access to medications no matter what's happening elsewhere in the world. The CMA stands ready to work with the federal government, provinces and territories, and partners across the health system to reach this goal.

Thank you for your time. I'd be pleased to answer your questions.

Meegwetch.

● (1545)

The Chair: Thank you, Dr. Burnell. You have 10 seconds to spare, so it was very well done. Thank you very much.

We now go to Ms. Hughes, vice-president, sales and commercial operations, Grifols Canada, for five minutes.

Ms. Hughes, please go ahead.

Mary Hughes (Vice-President, Sales and Commercial Operations, Grifols Canada): Thank you.

Madam Chair and honourable members of the committee, my name is Mary Hughes and I'm the vice-president of sales and commercial operations at Grifols Canada. In terms of academic background, I have a bachelor's degree in genetics, a master's in gene therapy, an M.B.A. and a Ph.D. in hemostasis and thrombosis.

Thank you for the opportunity to appear before you today. I appreciate the chance to tell you about the work Grifols is doing in partnership with Canadian Blood Services to help Canada strengthen the country's self-sufficiency in plasma medicines and improve security of supply for Canadian patients whose lives depend on these medicines.

Plasma-derived medicines treat rare, chronic and life-threatening conditions. For many patients, immunoglobulin therapy is not optional. It is the only effective way to survive and maintain a better quality of life. These medicines can be made only from human plasma, donated by people who help others.

Thousands of patients across Canada rely on these treatments. To treat one patient with primary immunodeficiency for a year, it can take 130 plasma donations, and 465 donations are needed for patients with CIDP, a complex neurological condition.

The availability of treatment depends entirely on a stable, reliable supply of plasma.

The COVID-19 pandemic and a global shortage of immunoglobulins have shown how reliance on external supply for critical health products creates a significant vulnerability for Canadian patients. As a result, Canadian Blood Services made it a national priority earlier this decade to increase domestic self-sufficiency to 50%. Grifols stepped up to support this vision, and in 2022 we signed a long-term renewable agreement with Canadian Blood Services to build a fully domestic plasma ecosystem from the ground up.

Under the agreement with Canadian Blood Services, all plasma collected in Canada by Grifols is for the exclusive benefit of, or on behalf of, Canadian Blood Services. Further, Grifols provides a service whereby it processes all such collected plasma to deliver all immunoglobulin that may result from such collected plasma. As and when directed by Canadian Blood Services, Grifols may process any intermediate products that result from the process of manufacturing immunoglobulins to produce other plasma-derived medicine proteins, such as albumin.

A strong and reliable Canadian plasma supply and manufacturing capacity are vital to avoid the impact of factors outside of Canada's control. As a Canadian, I am proud that Grifols is supporting our country in this effort. Since the start of our partnership together, we have more than doubled Canada's domestic supply of immunoglobulins, going from 15% to 33%. Our progress means fewer imports, greater health care sovereignty and a stronger access to life-saving medicines for Canadians. This is possible thanks to our 800 Canadian employees, whom I proudly represent today, who are focused on helping Canadian patients.

Through Grifols' long-term commitment to Canada's plasma infrastructure and supply chain, we have invested approximately $1 billion to build a domestic plasma fractionation network and a Montreal-based plasma manufacturing facility. This is what self-sufficiency looks like in practical terms: Canadian donors, Canadian collection and Canadian production to create Canadian medicines for Canadian patients.

Our agreement with Canadian Blood Services means that plasma collected through this partnership is used to produce immunoglobulin medicines for Canadian patients. Once all the immunoglobulins are isolated to produce this medicine, the remaining proteins can be used to make another kind of medicine called albumin.

While Canada does not have enough immunoglobulins, our country has more than enough albumin to fulfill patient needs. This leaves the question of what to do with the excess albumin protein. The choice is to throw it away or use the excess to benefit patients in other parts of the world.

Let me be clear: Canadian patients and donors come first—always. For immunoglobulin, this means that every donation is fully and exclusively used to serve Canadian patients. For the by-product albumin, however, Canadian Blood Services has determined that once Canadian needs are met, the excess albumin can be used to provide life-saving medicine for patients outside of Canada. In fact, the proceeds from selling this excess albumin offset the cost of immunoglobulin medicines for Canadian patients.

Together with CBS, Grifols is contributing to Canada's national goal to achieve immunoglobulin sovereignty. We are expanding plasma collection, strengthening domestic manufacturing capacity and reducing reliance on foreign supply, while protecting Canadian patients' access to life-saving medicines.

Thank you very much for your attention. I'll be pleased to answer your questions.

● (1550)

The Chair: I'll now go to our virtual witness, Arianne Trudeau from Médicament Québec. You have five minutes.

[*Translation*]

Arianne Trudeau (Executive Director, Médicament Québec): Madam Chair and committee members, thank you for giving me this opportunity to speak to you.

My name is Arianne Trudeau. I'm the executive director of Médicament Québec.

COVID-19 revealed a number of findings and lessons concerning our dependence on pharmaceuticals. In particular, our ability to prepare and strengthen supply chains depends on our capacity to bring together all stakeholders and to develop a collaborative and flexible system poised to take on new challenges.

At the same time, we must recognize that the pool of technology platforms in Quebec and Canada is one of the cornerstones underpinning this system. University platforms group together a variety of tools, equipment, infrastructure, expertise and services designed to support university research and, to some extent, industrial research.

Médicament Québec grew out of these findings and out of a clear desire to increase the autonomy of Quebec and Canada and to build a real drug supply chain that can ensure a more solid local supply and create innovative solutions for the benefit of society.

Médicament Québec focuses on the development of structuring and collaborative platforms. With support from the Quebec government's department of the economy, innovation and energy, over $24 million was allocated to 20 structuring projects. These projects generated almost $18 million in return in strategic areas such as small-molecule drugs, vaccines and RNA-based therapies.

[*English*]

The Chair: I'm sorry. Excuse me, Ms. Trudeau. I am getting voices. Is there anybody else, or is it just me? I know I'm hearing voices, but there you go.

I'm hearing voices above and beyond the interpreter. I don't know if someone.... Maybe it's you, Ms. Trudeau. Do you have your microphone open? Is there someone else in the room with you?

Arianne Trudeau: No. I'm alone.

The Chair: I don't know where it's coming from. It may be that our members' staff want to tone it down a bit. I don't know. I'm just suggesting it because I'm hearing this sound and it's distracting.

Thank you. I'm sorry. Go ahead. We stopped the clock for this little intrusion, Ms. Trudeau.

● (1555)

Arianne Trudeau: No worries. Thank you very much.

[*Translation*]

These investments helped to boost innovation, create new organizations, attract new partners and strengthen key links in the drug supply chain.

Médicament Québec has made collaboration between academia and the industry its top priority at every level. Médicament Québec drew on the contribution of over 125 partners, including 62 companies in the life sciences ecosystem, to carry out its programs and activities.

As Médicament Québec prepares to roll out the third round of funding over the coming years, I would like to share a few recommendations with you today.

First, it's vital to encourage and require collaboration at all levels—

[*English*]

The Chair: Excuse me, Ms. Trudeau.

Go ahead, Ms. Konanz.

Helena Konanz (Similkameen—South Okanagan—West Kootenay, CPC): I'm having trouble hearing. I wonder if you could turn up the volume.

The Chair: Have you turned it all the way to the top?

Helena Konanz: It's all the way to the top.

The Chair: We've stopped the clock, Ms. Trudeau.

Arianne Trudeau: Can you hear me clearly now?

The Chair: Let's try it again.

Go ahead.

[*Translation*]

Arianne Trudeau: Federal and provincial granting agencies are increasingly encouraging research in partnership with the industry. Yet the university grants available often require quid pro quos from the industry, without these partners having the opportunity to benefit from the grants. In contrast, public funding for the industry requires little collaboration with academia.

Just as certain contracts awarded to defence companies require reinvestment in the Canadian economy, the government could require that a set percentage of any public investment in a life sciences company goes towards research and development activities in partnership with academia. These two-way partnerships benefit all stakeholders in the ecosystem and create real benefits for society.

The second recommendation is to develop clear guidelines and specific objectives for pharmaceutical sovereignty to ensure consistent approaches. Networking requires clear guidelines, in order to strengthen the positioning of certain strategic sectors or critical components of the value chain. The goal is to make a significant contribution to the implementation of government strategies, policies or plans.

Ultimately, the resulting strategies must be implemented by hybrid teams made up of academic and industry players in order to address specific challenges and produce truly structuring results. We must avoid, at all costs, supporting projects or platforms in silos that remain limited to a single organization.

A better organization of the services provided will prevent the duplication of resources and the development of services sometimes unnecessarily split among several institutions. It also helps to secure and optimize the investment of public funds.

[*English*]

Lastly, as Canada works toward achieving its commitment of raising military spending, all eyes are turned to defence-related or dual-use research. Once the primary focus of the COVID-19 pandemic, the life sciences sector has been pushed to the background in favour of uncrewed systems, quantum technologies and AI. However, pharmaceutical sovereignty should be discussed more widely through a health security lens and should not become an afterthought. Ensuring the health of both civilian and military populations is a real value driver for a nation, regardless of geopolitical climate.

Sustained government support, whether it be financial or through public policies, for industry, academia or both, is required to maintain a vibrant and robust domestic life sciences ecosystem that can fully contribute to pharmaceutical sovereignty. Government should avoid buzzword-driven ephemeral approaches and instead strive to implement sustainable public policies and funding supported by evidence-based data and robust risk analysis that reflects an integrated vision of Canada's life sciences sector. Although many—

● (1600)

The Chair: Wrap up, please, Ms. Trudeau. You have gone over time. I wanted you to finish your sentence.

When the question-and-answer period comes, you will get to elaborate on something you didn't get to say in your opening remarks. You can take advantage of this when that happens.

Arianne Trudeau: That's perfect.

The Chair: Thank you very much.

Now we will go to the question-and-answer section. It begins with a six-minute round, including both the questions and answers. I will once again allow a couple of seconds of leeway for people to finish their thoughts, but I will not allow people to go over the time limit.

We'll begin with Mr. Strauss from the Conservative Party.

You have six minutes, please.

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

Ms. Hughes, The Globe and Mail reports that two people died in Winnipeg following donations at a Grifols plasma centre. At least one of the people who died was a young immigrant woman. I believe she was 22. She was an international student from Nigeria.

I'm wondering how your organization, or you personally, would approach the ethics around a case like this.

Mary Hughes: Madam Chair, let me start by saying that the health and safety of our plasma and our donors is our utmost priority. We were deeply saddened by the passing of two individuals in Winnipeg, and our condolences go to their families.

Under Health Canada, we report any serious adverse event that occurs within 72 hours of a plasma donation, irrespective of whether there's potential causality.

Today, there is no correlation between their deaths and plasma donation. I've been with Grifols for 25 years. I am not aware of any evidence-based correlation between plasma donation and death in those 25 years. Plasma donation is a safe, low-risk procedure.

Matt Strauss: I'm sorry to interrupt you, but we're short on time.

As I read The Globe and Mail report, which is what I'm working off of—I'm not an investigative journalist—it sounds as though death occurred in a totally healthy woman. I assume your organization screens folks to make sure they are totally healthy. She died either while hooked up to a donation machine or shortly after being disconnected. This seems to be a correlation. It seems as though we're avoiding the fact that there's an obvious correlation there.

Are you sure you maintain that there's no correlation between the donation and the passing?

Mary Hughes: I will repeat, to be clear: Today there is no correlation between death and plasma collection.

Matt Strauss: Thank you.

News media reports, including in Toronto, document that several Grifols locations in Regina, Calgary and Oakville were found to be non-compliant with Health Canada regulations. Were all these regulatory non-compliances remediated?

Mary Hughes: We operate in a highly regulated environment. We have an excellent track record across our 390 centres.

With regard to the recent inspections by Health Canada, we have submitted and implemented comprehensive corrective action plans.

Matt Strauss: I'm sorry, Ms. Hughes. I'm looking for a yes or no.

Have the regulatory non-compliances that were reported by Health Canada been remediated?

Mary Hughes: Yes, those findings have been remediated. We continue to co-operate fully with Health Canada to reinforce overall compliance.

Matt Strauss: I'm a practising physician. The principle of informed consent is fundamental to my practice.

Are folks who donate at a Grifols Plasma Donation Centre informed of a potential risk of death when they donate?

Mary Hughes: Madam Chair, yes.

Matt Strauss: When somebody donates, are they informed that some of the donation they give may be packaged and sold for profit overseas?

Mary Hughes: When donors consent, they are informed that the plasma collected is intended for plasma-derived medicines for Canadian Blood Services.

Matt Strauss: They are not informed, then, that some of what they donate may be sold for profit overseas.

Mary Hughes: To clarify, we collect plasma on behalf of and for the benefit of Canadian Blood Services, to be manufactured in Canada with immunoglobulins exclusively for the benefit of Canadians in this country.

With the manufacturing process, we have—

Matt Strauss: With respect, it sounds like a no. If I go donate, some of the albumin from my body will wind up overseas, to be sold for profit, and I won't be informed of this.

Mary Hughes: Madam Chair, that's incorrect. If you donate in Canada, the needs of Canadians are met first. All of the albumin needs for Canadians are met in this country. The oversupply can either be thrown away or be used to benefit patients outside the country.

Once again, I'll be clear that all the needs of Canadians are met in this country.

Matt Strauss: I don't think what I said was incorrect, but thank you for explaining that again.

If I donate at a Grifols plasma centre in Canada, is any part of what I donate processed in the U.S.A.?

Mary Hughes: Today we are working on having our Montreal domestic facility finished and available to process medicines in this country. During the transition period, we're processing at a Clayton, North Carolina, facility, which is the same facility we've been using to provide plasma-derived medicines for Canadians for more than 20 years.

Matt Strauss: Am I to understand that, if my donation goes to the North Carolina facility for processing, it's kept totally separate from all the American donations so that 100% of it returns to Canada?

Mary Hughes: Madam Chair, yes.

Matt Strauss: When I donate at a Grifols plasma centre, who is technically responsible for the operation of the machine? Is this person a licensed health professional, and if so, what sort of licensure do they have?

Mary Hughes: I'm sorry. Can you repeat the question?

Matt Strauss: What sort of health professional oversees the donation and hooks me up to the plasma-donation machine?

Mary Hughes: All operations and procedures within our plasma centres are regulated by Health Canada. This regulatory authority is also responsible for Canadian Blood Services centres.

Matt Strauss: What sort of licensed health professional performs that? I'm sorry if I missed it. Is it a nurse or a doctor who hooks me up to a machine when I attend for my donation?

Mary Hughes: I can take the question and provide a written response—

Matt Strauss: You've explained that it is only albumin that would leave the country. Is Grifols currently party to any sort of agreement or undertaking to ensure that this remains the case in perpetuity?

Mary Hughes: We have an agreement with Canadian Blood Services. There are confidentiality terms in the agreement. I cannot speak to the confidentiality of the agreement.

The Chair: Thank you. The time is up.

I now go to Mr. Eyolfson for the Liberals. You have six minutes, Doug.

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

First of all, Dr. Burnell, thank you for coming.

We were talking about clinical trials. We've been talking a lot about how this is one of the essential parts of developing new drugs. They're the first pathway through which patients can access new therapies for things like cancer and rare diseases, and they can attract global research to Canada. We apparently have an opportunity right now, given that in the current political climate, we're looking at medical practitioners and researchers from America who are looking for other places to practise and work.

Health Canada recently launched some consultations on a framework to modernize our clinical trial regulations to make them more flexible with risk-based regulatory oversight. Why are these clinical trials so important? Can you give more detailed answers on why we need this in Canada?

Dr. Margot Burnell: Clinical trials are very important. The reason is that medicines, when they enter into practice, are tested. First of all, are they safe for individuals? What is the appropriate dosing? What is the appropriate interval of dosing? What are the anticipated side effects? We need what we call phase one trials to determine this.

Phase two trials are then tested in patients with the indication that the drug is supposed to benefit. If it's a patient with breast cancer, the phase two trial will take individuals with advanced breast cancer; the drug will be administered to see if it's effective. If it meets the threshold predetermined in the phase two trial, it proceeds to a phase three trial.

A phase three trial compares the new drug with the current standard of care for efficacy and safety, as well as cost-effectiveness, in that order. Safety and toxicity are balanced. If you have a very effective drug but it has a lot of toxicity, then we need to know that. This becomes a discussion about whether you advance the drug and what you describe with patients when you administer or discuss using the drug for their illness.

Phase four is postmarketing studies. They look at reporting adverse events that occur in individuals once you open it up to a larger patient population. Individuals who enter clinical trials are very well screened. They have very tight eligibility criteria. When the drug enters a broader market, other toxicities may come to light.

● (1605)

Doug Eyolfson: All right. Thank you.

Physicians will see gaps in access to medications. We're hearing this a lot. Can you speak to the challenge your members are hearing right now about what's happening in terms of whether we have a relative lack of pharmaceutical sovereignty and how clinicians are saying this is affecting their patients?

Dr. Margot Burnell: We hear from individuals that shortages occasionally happen across this country. In the medical oncology field, which I'm most familiar with, a product may not be available from a given company, and therefore we need to source a similar product from a different company. We may need to adjust a drug dosage that has been determined to be effective in order to conserve on drug availability.

This takes time and effort. We have to adjust what our normal paths of distribution are in prescribing within our clinics and our discussion with patients.

Doug Eyolfson: Thank you.

Madam Chair, how much more time do I have?

The Chair: You have one minute and 30 seconds, Doug.

Doug Eyolfson: Thank you, Madam Chair.

This question is also directed towards Dr. Burnell.

We are hearing a lot about the different changes regarding the economic and political problems, particularly in regard to tariffs and the disruption of trade because of them. Have your members in the CMA been reporting any increased difficulty in access to medications since the recent actions of the U.S. government in their approach to trade?

Dr. Margot Burnell: There have been discussions, I understand, between the pharmaceutical industry and Minister LeBlanc with respect to these issues.

Doug Eyolfson: Thank you.

Is it too soon to tell on the ground, as it were, whether clinicians are seeing any effects on how their patients are being treated?

Dr. Margot Burnell: Drug costs over the course of time increase a given percentage per year, which is budgeted for by health authorities. It is hard to attribute a percentage for any given year to being affected by geopolitical events.

Doug Eyolfson: Thank you.

The Chair: Thank you very much.

I now go to the Bloc Québécois.

Monsieur Blanchette-Joncas, you have six minutes, please.

[*Translation*]

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

I would like to extend my greetings to the witnesses here today.

My first question is for Ms. Trudeau.

In your opinion, is Quebec fully benefiting from the economic spinoffs of its pharmaceutical research, or is it failing to capture a significant portion of this value?

Arianne Trudeau: First, Médicament Québec doesn't necessarily work on promoting innovations that stem from research partnerships or university research. However, a great many studies have been carried out to show that this situation isn't unique to Quebec. This is happening across Canada. We're seeing a certain valley of death.

On the one hand, the pharmaceutical value chain contains a valley of death. It takes an enormous amount of capital to move innovations from one link in the innovation chain to the next. On the other hand, we lack certain links that would enable us to better harness this value and work together more effectively to move projects forward.

When we talk about developing clearer strategies and clear guidelines for pharmaceutical sovereignty, we're also talking about government guidelines for strengthening one key sector versus another. However, we also need to become clients of these innovations. We need to become the first users of innovations made in Quebec or Canada, so that society as a whole can benefit from them.

● (1610)

Maxime Blanchette-Joncas: Ms. Trudeau, in terms of strategy, when public funds support pharmaceutical research in particular, should we impose conditions to ensure that the economic benefits stay here?

Arianne Trudeau: Indeed.

This is one reason why Médicament Québec advocates in particular for collaboration. This collaboration makes it possible to secure and optimize investments in pharmaceutical research. It helps to ensure that, if we invest in a company, an academic partner is also involved. If, for some reason, the company goes bankrupt and gets sold, an academic partner still tends to stay on.

We experienced this in the 2000s, when the big pharmaceutical companies left. The pool of talent and highly qualified employees remained in Quebec and, in many cases, retrained in academia. This would be one way to better reap the benefits of our investments.

Maxime Blanchette-Joncas: Understood. Thank you.

Given your expertise, do you believe that the model that Canada currently uses makes it more dependent on the decisions of foreign multinationals to design and produce its own drugs?

Arianne Trudeau: This is largely the case. Pharmaceutical ingredients often come from China, India or other pharmaceutical companies. As you no doubt know, drug supply chains are extremely complex. Of course, the current geopolitical situation is only making them more complex.

To get the most out of supply chains, we really need to determine the niches to focus on and then develop them. However, we need to make decisions. We can't be good at everything. The Canadian market is too small to be good at everything. We really need to make some strategic choices here.

Maxime Blanchette-Joncas: I completely agree.

I love the strategy of consistency. In your opinion, are Canadian policies consistent in terms of research funding, tax incentives and industrial objectives?

Arianne Trudeau: I think that things are getting better and better at this stage. I think that we're increasingly looking at impact research and targeted research. We're talking about mission-oriented research. We're really talking about generating actual benefits. We're talking less about basic research, and more about applied research.

That said, we mustn't forget basic research either. It fuels the rest of the process.

Maxime Blanchette-Joncas: Understood.

You said that things are getting better and better. As far as I know, Canada is the only G7 country that failed to produce its own vaccine against COVID-19.

What steps have you taken to analyze the benefits showing that things are getting better or that pharmaceutical sovereignty is gaining ground in Canada and even in Quebec?

Arianne Trudeau: Indeed, the current ecosystem is highly fragmented. In other words, there are a significant number of small players. Once again, this stems from the departure of the major pharmaceutical companies. Of course, we can't necessarily compete with countries where the major pharmaceutical companies are well established.

We can't compete with China or India on the price of pharmaceutical ingredients either. Canada must really adopt a differentiation strategy. Once again, public policy must reflect these choices and help to truly support the benefits of research carried out here in Quebec.

[*English*]

The Chair: Thank you. The time is up.

I now go to the second round, which is a five-minute round with Mr. Mazier for the Conservatives, please.

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

Ms. Hughes, in 2022 Grifols signed an agreement with Canadian Blood Services to collect plasma from blood donations. Has the entire signed agreement ever been made public, yes or no?

Mary Hughes: Madam Chair, no.

Dan Mazier: Given that multiple blood donor deaths have occurred at your facilities, will Grifols commit today to tabling the full contract to this committee for a parliamentary review?

● (1615)

Mary Hughes: To repeat what I said earlier today, there is no correlation between plasma donation and death. The terms of the agreement are confidential. I'm afraid I cannot share the details of a confidential agreement.

Dan Mazier: Well, that was the question, so this would be a no.

I'll ask the question again for you. Since there have been two deaths in these facilities, will Grifols commit today to tabling a full contract to this committee? I guess your answer is no.

Mary Hughes: Once again I repeat that the agreement is under confidentiality terms that we're bound to.

Dan Mazier: Okay.

Ms. Hughes, has Health Canada suspended your licences at the Winnipeg facilities where two deaths occurred, yes or no?

Mary Hughes: Madam Chair, no.

Dan Mazier: Has Health Canada seized the collection machines used to collect plasma in the cases of the two deaths in Manitoba, yes or no?

Mary Hughes: I'm sorry, but can you repeat the question? I couldn't hear that.

Dan Mazier: I'll just leave it alone.

Ms. Hughes, has the federal health minister met with Grifols directly to discuss the two deaths in your Winnipeg facilities, yes or no?

Mary Hughes: I'm not aware of any meeting.

Dan Mazier: I'll repeat this question again: Has Health Canada seized the collection machines used to collect plasma in the cases of the two deaths in Manitoba, yes or no?

Mary Hughes: Madam Chair, I don't have the details of the operations. We can certainly follow up, but our quality and medical teams have been collaborating with Health Canada fully in their investigation.

Dan Mazier: Okay. Thank you.

Health Canada authorizes Grifols to extract blood from Canadian donors 104 times per year while Canadian Blood Services allows only 52 extractions per year. Why does Grifols draw from Canadian donors up to twice the amount that Canadian Blood Services does?

Mary Hughes: All of our centres in Canada are regulated by Health Canada, the same authority that regulates Canadian Blood Services. We adhere to those regulations, and our procedures continue to be licensed, with oversight by Health Canada.

Dan Mazier: Do you know of any reason that you'd have twice the amount?

Mary Hughes: I cannot comment on CBS's plasma operations.

Dan Mazier: Ms. Hughes, does Grifols sell any part of the plasma you collect in Canada on the international market, yes or no?

Mary Hughes: Madam Chair, Grifols does not sell plasma. The plasma we collect in Canada is specifically and exclusively for the benefit of and on behalf of Canadian Blood Services and the Canadians who rely on those plasma-derived medicines.

Dan Mazier: I know, and I was asking because, of course, you can make many products out of plasma. The question was, does Grifols sell any part—that is to say any parts—of the plasma you collect in Canada to international markets?

Mary Hughes: To clarify, and from the opening statement once again, Canadian Blood Services has agreed that, with an oversupply of albumin, which is derived from the immunoglobulin manufacturing process, it can be thrown away. Rather than throwing it away, it's being used to benefit patients, and this offsets the cost of immunoglobulin medicines for Canadians.

Dan Mazier: Okay, so immunoglobulin is part of the plasma: That's one product you make. Are there any other products you make out of the plasma that are sold internationally?

Mary Hughes: An oversupply of albumin that is made from an oversupply of by-products, which, Canadian Blood Services agreed, can benefit patients outside of the country, is what Grifols purchases to provide to those patients.

Dan Mazier: Are there any other products that you sell, or any other products that you can make that it would be, actually—

Mary Hughes: Madam Chair, no.

Dan Mazier: No. Okay.

Ms. Hughes, Grifols acquired Canadian Plasma Resources in 2023, which was a Canadian company. Prior to their acquisition, the Canadian company had offered to sell plasma to Canadian Blood Services but was rejected. Do you know why their offer was not accepted but Grifols' was?

Mary Hughes: I can't speak on behalf of Canadian Blood Services. I can say that, in 2022, the independent operator was operating in the country and was selling Canadian plasma, exporting it outside of the country. Grifols acquired the majority stake of the company and continues to work towards a smooth transition to acquire the operational and full control to keep the plasma in the country.

Dan Mazier: Thank you.

The Chair: Your time is up, Mr. Mazier. I'm sorry.

I now go to Ms. Chi for the Liberals.

You have five minutes, please.

Maggie Chi (Don Valley North, Lib.): Thank you, Chair.

Thank you to all the witnesses today.

It's great to see you, Dr. Burnell. Thank you so much for coming to share perspectives from your members.

To continue my colleague's couple of questions, I want to pick your brain from your members' perspectives. What would be the most impactful steps governments can take to increase our pharmaceutical sovereignty?

● (1620)

Dr. Margot Burnell: The two most impactful are really investing in producing those medications within Canada and, when procurement happens, to favour those that are made in Canada whenever possible.

Maggie Chi: Thank you.

In terms of numbers when you're dealing with shortages, would you describe to the committee what the usual steps are in dealing with that? During COVID, we saw a lot of shortages come up, given the unexpected nature of the pandemic. What are some of the lessons learned from your members' perspectives? What actions can we take as a government to increase supply?

Dr. Margot Burnell: The lessons learned are, one, to ensure that tier three drugs have a sufficient supply and that there is capacity to upscale production or obtain increased amounts when necessary. This is a really important part.

The other is to share across the country what the current amounts of drugs are between the provinces, territories and federal government. I would say for the pharmacy network that whenever there's a shortage, especially during pandemics and crises, or when there are specialty drugs, such as oncology drugs, they work together to identify the best sources of drugs and what the best alternative is. Part of this is to standardize what we recommend to patients as a substitute. That seems to work very well.

Maggie Chi: Thank you, Dr. Burnell.

As you know, much of our system is structured around treating illnesses, rather than the preventative side. From your members' perspectives, how should we be thinking about pharmaceutical innovation in the context of prevention and long-term health outcomes?

Dr. Margot Burnell: With respect to medications being introduced into preventative care, as I understand your question, drugs are typically tested in people with more advanced disease to identify whether there is a risk that has not come out through the clinical trials.

In cancer drugs, for example, they'll be tested in advanced disease. If there are no surprises with respect to toxicity, and some evidence of benefit, they are moved up to earlier-stage disease. From metastatic breast cancer, they're moved up to early-stage breast cancer. If they're shown to be effective there, then they're moved to prevention.

The reason for doing this in a stepwise fashion is that when you're trying to prevent something, you want to minimize toxicity. You don't want to have a life-threatening toxicity. Whereas if you are fighting a cancer and a patient's life is on the line, the patient will often prioritize the possible benefit over toxicity.

Maggie Chi: Thank you so much, Dr. Burnell.

I'll share my time with Dr. Jaczek.

The Chair: You have one minute, Dr. Jaczek.

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

Ms. Hughes, you've asserted that the two deaths at the Grifols clinic were not connected to the fact that the people were plasma donors. How do you come to this conclusion? Is this what the coroner or Health Canada has determined? How are you making that assertion?

Mary Hughes: Madam Chair, all internal investigations in working with our quality and medical teams have found no correlation between plasma donation and death. I'm not speaking on behalf of Health Canada, but with regard to the information our quality and medical teams have to date, there has been no correlation.

Hon. Helena Jaczek: That's an internal determination within Grifols.

Mary Hughes: It was internal, as well as information that is shared with Health Canada.

Hon. Helena Jaczek: If you could answer Dr. Strauss's question on how you screen potential donors and the types of questions you ask, even if you gave that to us in writing, I think that would be valuable.

● (1625)

Mary Hughes: Madam Chair, yes, we'll provide it in writing.

The Chair: Thank you very much.

Thank you, Ms. Jaczek.

I will now go to Mr. Blanchette-Joncas for two and a half minutes, please.

[*Translation*]

Maxime Blanchette-Joncas: Thank you, Madam Chair.

My first question is for Ms. Burnell. On March 18, the government announced the creation of a pharmaceutical and life sciences sector task force.

Has the Canadian Medical Association been consulted regarding the creation of this new task force?

[*English*]

Dr. Margot Burnell: I'm not sure we were consulted, but we're pleased to support the establishment of the task force and look forward to seeing the recommendations. I hope the recommendations will result in tangible actions.

[*Translation*]

Maxime Blanchette-Joncas: You said that you aren't sure. Is this because you don't have the information or because you can't give it to us?

[*English*]

Dr. Margot Burnell: We have the information now that it has been established. I'm not sure if we received it prior to the establishment.

[*Translation*]

Maxime Blanchette-Joncas: Could you send us your response later?

[*English*]

Dr. Margot Burnell: We'd be pleased to do so.

[*Translation*]

Maxime Blanchette-Joncas: The government said that the task force will include members of certain national industry associations; representatives of the pharmaceutical industry and biotech companies; and partners in the regulatory, public policy and research fields.

How would you define the criteria?

Is it the government's responsibility to do so, or should the experts also be consulted to ensure a fair membership structure that truly reflects the real issues at stake in Canada's pharmaceutical sovereignty?

[*English*]

Dr. Margot Burnell: The members who have been proposed are from the national industry association, pharmaceutical representation, biotech firms, regulatory policy and research partners. I would leave it to the task force to identify any gaps they feel they need to fill.

I would suggest that the patient voice and lived experience, as well as the voice of practising physicians, be entertained in the task force.

[*Translation*]

Maxime Blanchette-Joncas: Okay.

I gather that you don't have any position on the membership structure of this task force.

Is that right?

[*English*]

Dr. Margot Burnell: The members who have been appointed to date cover a broad spectrum, and I would encourage the group to discuss amongst themselves any gaps to ensure that the lived experience of patients, as well as practising physicians, is included on their task force.

The Chair: Thank you very much.

That's the end of this round.

I will now go to Ms. Konanz for the Conservatives for five minutes, please.

Helena Konanz: Thank you, Chair.

Ms. Hughes, if you walked down any main street in a Canadian city and asked, most Canadians wouldn't be aware of the drugs that you manufacture from Canadian blood donations, but they would be aware, from the news in the last six months, that two donors died not long after donating at two of your blood donation sites.

I appreciate that you've tried to address this today, but I want to ask you this: What can you say to Canadians to reassure them that they can have confidence in your operations, considering these two very unusual and tragic losses of life?

Mary Hughes: Madam Chair, Grifols has been providing life-saving plasma-derived medicines in Canada for 20 years. For Canadians, we have invested significantly in ensuring that there is a domestic security of supply of life-saving immunoglobulins for patients at the Montreal facility, the network of plasma centres and the over 800 Canadian employees working to support these patients. It hasn't changed our mission and our vision to improve the health and well-being of patients.

We are regulated by Health Canada. We continue to work with Health Canada. For any serious adverse event, we report it to Health Canada, irrespective of whether there is a causal link.

Helena Konanz: Thank you.

My next question is, did those operations and staff continue immediately after these deaths, or were the sites and staff subjected to review and retraining before you opened again? Was the facility closed temporarily? What happened? What was the timeline?

● (1630)

Mary Hughes: Madam Chair, I don't have the operational details. I can follow up and provide them.

Helena Konanz: Will you table this?

Mary Hughes: Yes.

Helena Konanz: Thank you.

You don't know whether the two sites in Manitoba were closed at all after these deaths, even temporarily.

Mary Hughes: Madam Chair, I can follow up. I don't have the details for you.

Helena Konanz: That would be great. It would be really good to know. That's very important, I'm sure, to reassure Canadians.

I want to return to Grifols' presence in Canada. You're collecting plasma, through Canadian blood donations, for the purpose of manufacturing immunoglobulins in Canada. However, you're also collecting by-products from those blood donations, which you pay Canadians for, to make albumin and sell it abroad. I'd like to know this, if possible: What's the average payment you make to Canadians for their blood donation, compared to your profit margin? How much does Grifols make from the sale of immunoglobulins and albumin abroad, even a ballpark estimate?

Mary Hughes: Madam Chair, as I noted earlier, the details of the contract are confidential. As a publicly traded company, our consolidated financial statements are available on our corporate website.

Helena Konanz: Okay. To go back to the deaths that happened at the Grifols site in Canada, or in any other countries.... Actually, that would be a question: Have there been any other deaths in Grifols facilities in any other countries?

Mary Hughes: Madam Chair, no.

Helena Konanz: Okay. There haven't been, so these investigations haven't taken place in any other country.

Mary Hughes: Madam Chair, as far as I know...but I can look into that and the details. Our president of plasma procurement oversees plasma globally.

Helena Konanz: If you could table that, it would be—

Mary Hughes: We can certainly table that.

The Chair: You have one minute.

Helena Konanz: Thank you.

How often has Health Canada reviewed your blood collection sites or procedures?

Mary Hughes: Madam Chair, once again, on the operations and for this level of detail, I'll have to get back to you on that particular question.

Helena Konanz: You can table that also. Great.

Has Health Canada been provided the agreement between Grifols and Canadian Blood Services, yes or no?

Mary Hughes: Madam Chair, Grifols has not provided the agreement. I cannot speak on behalf of Canadian Blood Services. The agreement is confidential.

Helena Konanz: Has Health Canada not seen it?

Mary Hughes: Madam Chair, I don't have the answer to that.

Helena Konanz: Okay. You can table that also.

Mr. Mazier, do you have anything?

The Chair: You have 12 seconds. I'm sorry, Mr. Mazier, but I don't think you can ask a question and get an answer in 12 seconds.

Dan Mazier: No, I can't do it in 12 seconds.

The Chair: I now move to the final person in this round.

Ms. Jaczek, you have five minutes, please.

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

It's good to see you again, Dr. Burnell.

The goal of this particular study, of course, is for the committee to ultimately draft recommendations based on expert testimony. It is important that the report be practical and focused on areas in which the federal government can make a real difference. If you were advising this committee on one or two priority actions the federal government should take to improve access to drugs, attract investment and strengthen pharmaceutical sovereignty, what would they be? I know this is difficult, but...one or two real priorities.

Dr. Margot Burnell: I think the main priorities are, really, to invest in drug production and to study the opportunities with respect to that. Supporting the task force to do that will be critically important because they will then be able to do a very complete analysis and bring forth recommendations. Creating the task force and providing the financial and human resources support for that are critical, as is having the ability for data to flow across this country—what the various medications are, what the stockpiles are and what is available to Canadians in times of crisis. My other recommendation is that pharmaceutical companies should be able to create capacity within their procedures and to be resilient in times of crisis.

● (1635)

Hon. Helena Jaczek: During a previous study that this committee engaged in, we looked at antimicrobial resistance. We heard from a number of pharmaceutical companies that they were loath to invest in looking at potentially new antimicrobials, because the market was relatively small and so on.

Do you see antimicrobial resistance as a major issue? Should we be investing in some way in ensuring that we have supplies of new antimicrobials?

Dr. Margot Burnell: Organisms are very smart. They will develop resistance to drug medications. Regulatory bodies such as Health Canada—and the CDC previously in the States—track these organisms with respect to resistance across the world. When you see a particular organism becoming resistant to what is considered standard of care within developed nations, there is an onus and a reason to look at a drug to combat this.

We've seen in several of our organisms that rarely, but not insignificantly, we have had to go to a less-common drug to fight it. With respect to resistant *Staphylococcus aureus*, for example, this is a common organism that can become resistant. We have to stay ahead of the resistance pathway. This won't be a large percentage of any drug development or consumption, but there can be potentially life-threatening illnesses, and we need to be ready to combat them.

Hon. Helena Jaczek: Thank you, Madam Chair. That's all.

The Chair: You have one more minute.

Hon. Helena Jaczek: Oh, how generous. Thank you so much.

Those are practical suggestions in terms of areas to focus on. In terms of some of the things you may have seen in your own practice, are there some particular areas you're aware of in which pharmaceutical sovereignty might help your patients or in which you have personally seen shortages of potential medications for them?

Dr. Margot Burnell: We have seen shortages of medications when production pathways change. When cork was used to seal some vials, for example, the whole industry really had to revolutionize around that. We will see that particular pharmaceutical manufacturing plants cannot accommodate demand or that, for some reason, they've had to shut down part of their production. Then we are looking for other sources of medication to accomplish the same goal with respect to our patients.

The Chair: Thank you very much. Time is up, Ms. Jaczek.

I want to thank the witnesses for coming and sharing their expertise with us and for answering questions so honestly and up front.

I want to ask one question about the CDC, which Ms. Jaczek referred to and you did as well, Dr. Burnell, and about the vaccine policies in the United States. They are now not looking at vaccines as important elements of prevention. We get a lot of our vaccines and a lot of our pharmaceuticals from the United States. Do you think this means it's almost a necessity for us to create our own pharmaceutical sector?

Dr. Margot Burnell: I would separate the recommendations that come from those organizations from the production standards. The CDC, until recently in the current geopolitical...had very strong and reputable guidelines. From a Canadian perspective, we have the opportunity to fill the gap and to provide guidelines for our physicians and our communities.

With respect to drug production, we'd like as much done in Canada as possible, but I am not aware of anything that has affected the quality of drug production within the States.

The Chair: Thank you very much.

I want to remind the witnesses before they leave that there have been some requests for written documentation. Please send those to the clerk. She will distribute them. Thank you very much.

I now—

Dan Mazier: Chair...?

The Chair: Yes?

Dan Mazier: Thank you.

I'm seeking unanimous consent for this motion: That the committee order the complete and fully unredacted agreements between Canadian Blood Services and Grifols announced on September 7, 2022, and that this be deposited with the clerk of the committee no later than April 10, 2026.

I'm asking for unanimous consent.

● (1640)

The Chair: Do we have unanimous consent? We do.

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

The Chair: I thank the witnesses.

We will suspend so that the witnesses can leave and the new witnesses can come in for the second hour.

Thank you.

● (1640)

_____(Pause)_____

● (1646)

The Chair: The meeting is resumed.

I want to welcome the witnesses joining us for this second hour on the study of pharmaceutical sovereignty in Canada.

I'd like to introduce our witnesses.

As individuals, we have Dr. Martyn Judson, who is an addictions specialist, and Dr. Mina Tadrous, associate professor, University of Toronto. From the Canadian Pharmacists Association, we have Dr. Sadaf Faisal, interim vice-president, public and professional affairs.

I will give you a quick rundown. Each of you has five minutes to speak. I will give you a one-minute shout-out so you can start wrapping up and then a 30-second shout-out so you can finish wrapping up. We will then go to a question-and-answer period. I will time everybody for that period, giving people a few seconds here and there to finish their thoughts. I want to suggest that if you wish to respond, you should speak only when the chair recognizes you.

Dr. Tadrous, you know that you have a “raise hand” function. Please mute your microphone when you're not speaking. When the question-and-answer period comes up, if a question is directed to you, go ahead and unmute and answer it. There is an interpretation service designated by a little globe at the bottom. You can get English or French or floor. You can use that if you wish to.

Once again, all questions and comments should be made through the chair.

I want to begin by welcoming Dr. Judson.

You have five minutes, please, Dr. Judson.

Dr. Martyn Judson (Addictionist, As an Individual): Thank you, Madam Chair, for this opportunity to speak before the committee.

I, Martyn Judson, was licensed by the College of Physicians and Surgeons of Ontario to practise medicine for over 50 years, until I retired in April 2025. I engaged in general practice for 10 years and then specialized full time in addiction medicine in 1984.

Over the last 40 years, I've studied the theories of addiction and attended numerous educational seminars pertaining to the management of substance misuse. I achieved certification in the management of substance misuse from the Royal College of General Practitioners in the U.K. and from the International Society of Addiction Medicine. I remain familiar with current suggestions and recommendations for addiction management and continue to teach students at Western University.

In 1991, I was the first physician to prescribe methadone for the management of opioid dependence or addiction west of Toronto. The introduction of methadone was in part a harm reduction strategy intended to minimize the spread of HIV and hepatitis C by contaminated injection equipment. It also combatted the overuse of prescription opioids such as Percocet and OxyContin. Methadone and, latterly, Suboxone are well-recognized opioid replacement therapies that have been significant influences in stabilizing the neurochemistry and neurophysiology of the addicted brain. The consequences achieved are the almost complete eradication of withdrawal symptoms, curbing cravings to use opioids and, most importantly, blocking the access of other opioids, such as hydromorphone and fentanyl, to brain receptors. These receptors, when stimulated, cause damage and harm, which are experienced by the user and society.

It is well known that the pharmaceutical industry, particularly Purdue Pharma, deliberately promoted the use of short-acting opioids in an attempt to induce addiction for those recipients, all the time denying that such a disorder would develop. Opioid agonist therapy had significant success in London until what is best viewed as the introduction of an abundance of short-acting, destabilizing opioids into the community. It is the result of poorly educated, misinformed physicians who do not fully understand the neurochemistry of addiction and therefore over-prescribe. This surfeit of overprescribing has been aggravated by seemingly substandard medical care, which has not been adequately reviewed by the appropriate licensing authorities.

It is recognized that opioid replacement therapies, such as methadone and Suboxone, do not meet every patient need. Alternative opiate prescribing is acceptable, necessary and sometimes indicated, but this should be in the format of a long-acting opioid. The use of short-acting opioid preparations that do not comprehensively block the opioid receptors significantly increases the risk for patient destabilization, overdosing, homelessness and crime.

Physicians working in safe supply clinics are seemingly unaware of the harm caused to the majority of their patients and the community, not to mention the contribution to drug trafficking. Perhaps they choose to deny it—and this is understandable, considering the lamentable absence of education about addiction in most medical schools, which is limited to about one hour over a four-year course.

In London, there are five safe supply clinics located within pharmacies, in which physicians interview patients and prescribe short-acting addictive opioids by video link. There is infrequent interpersonal contact. The patients then visit the attached pharmacy to collect their prescriptions. The ingestion of medications such as hydromorphone is not appropriately witnessed. This is a recipe for diversion. The more patients attend these clinics, the greater the profits for the physicians, pharmacists, pharmaceutical companies and drug traffickers. All the while, the regulatory colleges, such as the Ontario Ministry of Health and Health Canada, take seemingly little or no action.

● (1650)

My 40 years of experience and accrued knowledge attained by listening to those who successfully became healthy have taught me that the essential components of recovery are the development of responsibility and supportive psychosocial connections to other humans. Many addicted persons have difficulty assuming these prerequisites for recovery, but they must be encouraged to try. The government must stop focusing on the short-term solutions. Physicians need to be better educated about addiction management and academics must move on from putting so much emphasis on harm reduction strategies, which are only part of the management. We must promote holistic well-being by moving away from the disease model of addiction and we must, as a society, not ignore those other components of treatment, prevention and enforcement.

The comments provided in this summary can be well encapsulated in the vernacular by stating that we should adopt a policy of providing a hand-up, not a handout.

I'll attempt to answer any questions you may have.

The Chair: Thank you very much.

I will now go to Dr. Tadrous for five minutes.

Dr. Mina Tadrous (Associate Professor, University of Toronto, As an Individual): Thank you, Madam Chair and honourable members of the committee, for the invitation to appear before you today and for bringing focus to this important topic of pharmaceutical sovereignty.

My name is Mina Tadrous. I'm an associate professor at the Leslie Dan faculty of pharmacy at the University of Toronto. I hold the inaugural Canada research chairship in pharmaceutical policy and real-world evidence. I'm also the founding director of the Toronto Centre for Real World Evidence, and I am co-director of the Ontario Drug Policy Research Network.

My research largely focuses on using data to support pharmaceutical policy decision-making in Canada and globally. A large portion of the work I've been doing has examined Canadian and global drug supply chains to better understand the causes and consequences of drug shortages and how to build systems that can help predict and prevent them.

My team has developed world-class tools and technologies that are already being used to help make decisions across Canada today. Our research has been published in some of the world's top scientific journals and has been commercialized by the university to maximize our impact. Most importantly, our work is actively being used today by decision-makers and health system leaders in Canada and around the world.

Today, I would like to communicate to the committee one central message: True pharmaceutical sovereignty begins with precision and data. We cannot secure what we do not measure, and we cannot secure every medicine in the same way, nor should we try to.

In my view, the core issue is not whether a policy exists; it's whether we know how, when and where to apply it. This is the challenge before us as Canadians.

When it comes to pharmaceutical development, we live in what I describe as an era of abundance. This is both a blessing and a curse. We have thousands of medicines, sourced through deeply interconnected global supply chains, that save and improve Canadian lives every single day, but this abundance also means no country can secure and make every drug themselves. It's simply not possible. Thus, we are forced to choose and prioritize.

The fundamental lesson from my work is not simply that shortages are common and growing, which they are. The fundamental lesson is that shortages are not all the same. Our work has found that not every drug has the same chance of having a shortage. We've also found that not every drug carries the same degree of clinical consequence. To be very direct, not having some drugs will kill patients, while not having others won't.

For example, a shortage of epinephrine, a life-saving medicine used in hospitals daily, happened a few years ago. This was associated with increased mortality when it was not available. In contrast, a shortage of valsartan, a common blood pressure medication, didn't show any mortality signals.

That doesn't mean those shortages don't matter; it means they don't all demand an equal response, and this is why we need a targeted, data-driven approach to pharmaceutical sovereignty.

The potential policy responses are numerous. Many witnesses will propose some very smart options today and in future meetings, as they have in past ones—things like strategic stockpiles, domestic production, procurement reform, essential medicines lists and even friendshoring. They can all play an important role, but no system can, nor can it afford to, apply every policy to every product when managing thousands of medicines.

That's why a one-size-fits-all approach will fail. This is too complex a problem. What we need to help bolster Canada's pharmaceutical sovereignty is a framework.

Here's a thought experiment to illustrate this. If Canada could build one factory today to manufacture only one drug, what drug should it make? In my view, we should ask ourselves four critical questions: First, which medicines are most critical for Canadians' lives? Second, which are at the highest risk of shortages, and what do we already produce? Third, where can Canada gain economic value? Fourth, what can or should Canada do well?

We must also be honest that this is not just a domestic issue. Canada sits within a complex global market.

● (1655)

It's not only the price a country pays that affects resilience; it's also how its market and regulators function and where it sits in this broader supply chain. For this reason, I urge the committee to think beyond crisis response and towards proactive resilience using evidence and data to identify the medicines that are clinically critical, structurally vulnerable and most likely to fail.

Pharmaceutical sovereignty does not mean making everything in Canada, which is neither realistic nor necessary. If Canada is serious about pharmaceutical sovereignty, it must build a precision-based national resilience strategy, which would position Canada to contribute where it can lead globally.

Thank you very much.

The Chair: Thank you very much.

I now go to Dr. Faisal for five minutes, please.

Dr. Sadaf Faisal (Interim Vice-President, Public and Professional Affairs, Canadian Pharmacists Association): Good afternoon, Madam Chair and honourable members of the committee. On behalf of the Canadian Pharmacists Association, I'm pleased to be here today to talk about the important issue of pharmaceutical sovereignty and how we can strengthen Canada's drug supply chain.

CPhA represents more than 40,000 pharmacists across Canada. Pharmacists are among the most accessible health professionals in the country and are often the final point of contact before medications reach the patient. As such, pharmacists see first-hand the impact that drug shortages and supply disruptions have on Canadians.

In late 2022, Canada faced a crisis as shelves sat empty of children's fever medications. Parents were forced to ration doses, travel long distances or improvise care at home. For many, a routine illness became a moment of real concern.

Drug shortages are becoming increasingly common. Each year, more than 2,000 shortages are reported in Canada, with somewhere between 1,500 and 2,000 active shortages at any given time. Pharmacists are on the front lines of managing these shortages. Our research shows that pharmacists can spend up to 20% of their day managing drug shortages—time that would otherwise be spent providing care to Canadians.

In the past few years, we have seen the number of drug shortages increase as the COVID-19 pandemic and geopolitical changes have resulted in significant disruptions to global supply chains, revealing weaknesses in Canada's manufacturing capacity. At the same time, new policies under the Trump administration, including most favoured nation policies and the threat of tariffs on pharmaceutical products, threaten to impact drug pricing in Canada and around the world.

Pharmaceutical sovereignty does not mean complete domestic self-sufficiency. Rather, it means building a resilient, diversified and reliable supply chain that reduces overreliance on a limited number of global sources. Before we can invest more into Canada's pharmaceutical manufacturing industry, we need to understand where Canada sources its drugs and raw material from.

Canada relies almost exclusively on imports for active pharmaceutical ingredients. Most of them are imported from India, followed by China, Mexico, Italy and Spain. Only 2% of APIs are manufactured in Canada. The U.S. is Canada's top trading partner for pharmaceuticals, representing 31% of Canada's imports. Around 50% of Canada's pharmaceutical imports originate from the European Union countries.

From a pharmacy perspective, six key priorities stand out.

First, Canada must strengthen domestic pharmaceutical manufacturing. There is a clear opportunity to reduce reliance on both imported drugs and raw materials. To support this shift, the federal government should strengthen relationships with diverse trading partners to ensure reliable access to APIs, while also providing targeted investment and incentives for companies to manufacture in Canada. These incentives could include expedited regulatory review processes for drugs made with Canadian-sourced ingredients and reduced review fees for domestically produced products.

Second, Canada should establish and maintain a list of medications at high risk of shortage. This action would support federal, provincial and territorial governments in planning and maintaining appropriate reserves, ensuring preparedness and continuity of care.

Third, there is a need to invest in tools, data collection and technologies to strengthen drug shortage monitoring and response. Improved data systems would enable earlier detection of supply disruptions and more effective coordination across jurisdictions.

Fourth, Canada must examine procurement practices that prioritize lowest cost over supply resilience. More balanced procurement models that value reliability, redundancy and supply security will be critical to prevent further shortages.

Fifth, we need a coordinated pan-Canadian approach, which is essential to ensure alignment across federal, provincial and territorial governments in managing supply risks and responding to shortages.

Finally, an inconsistent scope of practice across jurisdictions limits pharmacists' ability to respond to drug shortages in a timely and effective way. Enabling pharmacists to practise to the full extent of their training, including adapting prescriptions and performing therapeutic substitutions independently, would improve continuity of care and ensure more timely access to treatment for patients.

Pharmaceutical sovereignty is ultimately about ensuring Canadians have reliable, timely and equitable access to medications. Achieving this will require a balanced approach that strengthens domestic capacity, diversifies global supply, reforms procurement practices and improves coordination across jurisdictions.

Pharmacists play a critical role in managing shortages and ensuring continuity of care and must be supported to practise to the full extent of their training. CPhA looks forward to working with government and other partners to strengthen Canada's drug supply and ensure pharmacists can continue supporting patients across the country.

Thank you for the opportunity to appear today. I welcome any questions.

● (1700)

The Chair: Thank you, Dr. Faisal.

We now go to the question-and-answer period. In the first round, each questioner has six minutes, but this includes the question and the answer. I will try to be very tight in sticking to that timeline.

We'll begin with Mr. Bailey for the Conservatives for six minutes, please.

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

I'd like to thank the witnesses, and I'd like to take a special moment to thank Dr. Judson for five decades of service.

Thank you.

A new peer-reviewed study examined the closure, Dr. Judson, of the Red Deer, Alberta, drug site using statistically significant health data. Are you familiar with this study, yes or no?

Dr. Martyn Judson: Yes. I'm a member of the society.

Burton Bailey: Thank you.

The study found that, after the site closed, opioid agonist therapy among former site users increased significantly and exceeded levels at the comparison site that remained open.

Does this data support your view that removing supervised consumption sites can increase the uptake of real treatment?

Dr. Martyn Judson: It's not easy to answer simply.

Opioid safe consumption sites have an advantage in preventing overdoses and give an opportunity for staff to engage with patients and hopefully encourage them to move down the continuum of care to get into treatment and to make some radical changes.

Unfortunately, the closure of some centres will inevitably, depending on where they're located, lead to the movement of patients from those centres to other areas in the town where they were previously located, so you've just moved safe consumption sites to perhaps an unsafe consumption area in the city. However, with regard to whether there are going to be fewer people seeking treatment, I think this particular study was conducted over a short period of time—maybe 26 weeks—and this is probably not long enough to see the long-term effects of a closure.

● (1705)

Burton Bailey: Thank you.

Another thing to note in the Red Deer situation is that when the safe consumption site was removed, a nursing station was put in its place so that people were encouraged to go for treatment and not migrate to other sites.

I think you said that so-called safe supply keeps people locked in addiction. In your opinion, has the Liberal government's expansion of safe supply simply perpetuated addiction rather than treating it?

Dr. Martyn Judson: Well, safe supply was really pioneered in B.C. in about 2012. As I said in my opening remarks, the ideal treatment for opioid dependence or addiction is to use a long-acting opioid agonist—namely, methadone. However, it has its risks and has now really been replaced by Suboxone, which is much safer, particularly for less-experienced physicians to use, because there's less risk of overdose.

Latterly, safe supply has shifted from giving three injections of an opioid in the course of a day to the patients' being dispensed a day's supply of short-acting opioids to take by mouth. They take the first daily dose when the pharmacy opens at eight o'clock in the morning, and then they're given a bottle of hydromorphone, which is short-acting, to take home. They promptly sell it or divert it in some way in order to procure a stronger-acting opioid, such as fentanyl, and that's what's causing the harm.

I can see from my own work in London that in the clinic I used to work at—which employed 22 doctors and had 1,400 patients before the abundance of these safe supply clinics came about—we were containing the use of opioids. However, now the clinic is down to six doctors and 480 patients because the majority of the patients have migrated to an office at which they can get the short-acting opioids, which effectively encourages people to keep on using euphorigenic opioids. In other words, it's keeping them locked in their addiction.

Burton Bailey: Thank you.

In the past, you've stated that these so-called safe supply clinics exist to make money, with patients selling their prescriptions to buy fentanyl. Has the safe supply model basically created a system that pays doctors to churn out pills and flood the street with diverted drugs?

Dr. Martyn Judson: In my opinion, yes, it has.

Burton Bailey: Thank you.

The Chair: You have one more minute.

Burton Bailey: Given the emerging Alberta evidence and the real-world harms you and many others have observed, do you believe the Liberal government's safe supply policies have failed and should be replaced with a recovery-focused model like Alberta's?

Dr. Martyn Judson: I think their policies have been an unmitigated failure.

Burton Bailey: Thank you.

Should the study that was conducted in Red Deer be expanded to cover more areas?

Dr. Martyn Judson: Yes. Then we'll truly know about the benefit of the safe supply and whether they are redundant or not.

The Chair: You have 30 seconds.

Burton Bailey: I'd like you to expand on the things you've heard or seen on the ground at these sites.

Dr. Martyn Judson: Many of the patients who have been stabilized on methadone or Suboxone for many years intimated, when they came to see me before I retired, that they found it a frightening experience to come down to what was once a safe haven and tread over patients who were accessing the safe supply clinics. They were encouraging some of my patients to purchase opioids that had just been dispensed at the pharmacy.

● (1710)

Burton Bailey: Thank you.

Thank you, Chair.

The Chair: Time is up.

I want to caution and ask members of this committee to consider their line of questioning. We're dealing with a study on pharmaceutical sovereignty, not addiction and mental health or how to treat addiction. Be careful about phrasing your questions so that we stay in order on the study we're doing today. Thank you.

We now have Ms. Chi for five minutes, please, for the Liberals.

Maggie Chi: Thank you, Chair.

Thank you to all the witnesses.

The Chair: I'm sorry, Maggie. You have six minutes.

Maggie Chi: Thank you, Chair.

I'd like to thank all the witnesses who have come today to provide testimony and support us on this very crucial study.

My first question is for Dr. Tadrous online.

First of all, your testimony was excellent. I really found it informative and intriguing at the same time. You described how we're in an “era of abundance”. This struck a chord with me. Your approach, your proposed action plan, I find really reasonable.

I want to pick your brain and ask you to maybe help us expand on this framework. You outlined a more targeted approach to pharmaceutical sovereignty, focusing on critical supplies, higher-risk medicines and economic values in this country. What would this type of precision-based national resilience framework look like in practice? How should we decide which medicines fall into which category?

Dr. Mina Tadrous: Thanks again for the opportunity to be here.

This area of work is something that I've been thinking about for a very long time. Canada is not the only one grappling with this. You heard Dr. Faisal speak eloquently about the different components and how every country is largely dependent on somebody else. For drugs to end up in Canada, some of them will go through four or five or even eight different countries before they end up on a shelf in a pharmacy here. This is true for the United States, the world's largest consumer of pharmaceuticals. This is true for Europe and many of our allies that do this work.

What they're all grappling with is that, let's say you want to invest in and build a factory. One factory can cost anywhere between half a billion dollars and $1 billion, depending on what you want to do, and it can take many years. It's a large investment, but it may produce only a small number of products. I'm not saying it's not very important, because domestic production is critical, but the issue becomes this: If you have thousands of drugs, which ones are you going to pick to do this for? Even the United States has admitted they cannot produce all of their own drugs. However, we know that we want to produce some of them.

In terms of what we have produced, what we've proposed in a lot of our research and our work is that, to think about what the most important drugs are, you need to think about two factors.

First, which drugs are at the highest risk of a shortage? We can predict this based on a variety of different factors. How much domestic production do we have? How many products are in it? Is it an IV? What kind of drug is it?

Second, what is critical for an acute clinical situation? I laid out two examples in my opening statement. You have epinephrine, a medication that is needed when someone has an anaphylactic shock or they're in the hospital and they need it at that moment, versus a blood pressure medication for which we have other options. It's preventative. It's important, but you can do with other options there.

That's the kind of thing you can think about. It can help you fine-tune and bring it down from thousands. You can probably pick your top 50 or top 100, depending on which policy you want to implement.

Maggie Chi: As a follow-up to that, how do you see putting this into practice? When we're looking at frontline physicians, pharmacists and nurse practitioners, will it be immediate, or do you see more training happening in between?

Dr. Mina Tadrous: That's a really great question. Some of these proposed frameworks are more about what is preventative. When we think about drug shortages and supply chains, there are preventative and there are reactive things. We want to minimize anything reactive, because this is when things go awry. For the preventative, there are things like building factories and developing stockpiles, but that means an investment from the Canadian government.

If you have a limited amount of funds and you want to put it towards a certain place, you would implement the list and think about, “Okay, let's pick the 50 drugs that we want to make sure we control the supply of.” We ensure that they're made in Canada, and that's what we're going to invest in. We can then apply the same list and use it slightly differently to say, “Let's make sure we get the next 50 important ones from friendly allies.” You can imagine that this helps prevent future shortages, because we know that, even by going from one manufacturer active in the market to two, it can reduce shortages with a 20% probability. This is a big deal when you have hundreds of shortages happening within a single year.

Reactively, at the ground level, there are a lot of different policies that I want to flag. We need to empower pharmacists to respond, and we need to empower ourselves to respond quickly. I will note that we've done research in this space, in which we compared a shortage that hits Canada versus one that hits the United States. What we found, and it is something I am pretty proud of, is that Canada responds better—40% better, actually. The reason for this is that we empower some responses: We have tables and task forces. When you have policies that help you respond, you can do better in the way you respond to these shortages.

● (1715)

Maggie Chi: Thank you so much.

The Chair: You have one minute.

Maggie Chi: Maybe I'll wrap up by asking, if you were to make a recommendation to the federal government—you talked about the supply incentivizing side—are there any actions...? Within the short 30 seconds you have, do you have anything to add to what you just said?

Dr. Mina Tadrous: I think that domestic production, friend-shoring, supply chain resiliency and regulatory agility in responding are essential. However, again, all of those policies need to be backed up by data.

One last point I'll make is that we have a data scarcity. We don't even know how much of a drug is inside our country at a single time, and we need to fill that gap immediately.

Maggie Chi: The ability to track and have the real-time data would help.

Dr. Mina Tadrous: It would help incredibly, yes.

Maggie Chi: That's really great. Thanks so much.

The Chair: Thank you very much, Ms. Chi.

I now go to Mr. Blanchette-Joncas for six minutes, please.

[*Translation*]

Maxime Blanchette-Joncas: Thank you, Madam Chair.

I would like to extend my greetings to the witnesses here for the second hour of the study.

My first question is for Ms. Faisal.

Is Canada still heavily dependent on imports for essential drugs?

[*English*]

Dr. Sadaf Faisal: Yes. As I mentioned in my remarks, we rely heavily on a lot of pharmaceutical.... Active pharmaceutical ingredients are required to produce any drugs, and only 2% of them are domestically produced in Canada. Most of them we import from other countries.

[*Translation*]

Maxime Blanchette-Joncas: According to your analyses, despite the lessons learned from the COVID-19 pandemic, why does Canada still not have the capacity to produce certain critical drugs in the event of a crisis?

[*English*]

Dr. Sadaf Faisal: That's a really good question. There are many factors. Manufacturing a drug is not easy. We need to have the manufacturing plants, the workers to work in those plants, the active pharmaceutical ingredients and the machinery. This is a good time for Canada to consider domestic manufacturing, but as I said, domestic manufacturing is not the only solution, because it will take time. There could be some preventive strategies for drug shortages. There are many other things that we need to consider when we are talking about pharmaceutical sovereignty at this stage.

[*Translation*]

Maxime Blanchette-Joncas: Can we really talk about pharmaceutical sovereignty if Canada doesn't have enough local capacity to produce essential drugs?

[*English*]

Dr. Sadaf Faisal: As I said, producing essential medicine is just one part of pharmaceutical sovereignty. It is one part of the whole approach. The other approach is that we need to have a critical list of medications that we really need. Right now there are more than 9,000 prescription medications that are Health Canada-approved, 2,000 non-prescription medications and more than 30,000 medical devices and parts. We can't just start producing everything together, so we really need to come down to making an important critical list of medications. We can then look into the feasibility for us to produce them.

However, during that time—because you can't just start a manufacturing plant overnight—we need to look at other resources. We may try to expedite some of the review processes for drug manufacturers so that they can bring their products into Canada.

[*Translation*]

Maxime Blanchette-Joncas: Thank you.

In terms of feasibility, is there a formal and up-to-date assessment of the risks posed by our dependence, for example, on major foreign supply chains?

[*English*]

Dr. Sadaf Faisal: Not that I'm aware of. I haven't come across any for supply chain feasibility.

[*Translation*]

Maxime Blanchette-Joncas: Do you think that the government should carry out a risk assessment of our dependence on foreign supply chains?

[*English*]

Dr. Sadaf Faisal: It would be a really good start to look at the supply chain. It would give us some information and data to look at what points we need to invest in if we really want Canada to be resilient when it comes to drug supply chains.

● (1720)

[*Translation*]

Maxime Blanchette-Joncas: Do you know whether other comparable countries in the G7, the G20 or the Organisation for Economic Co-operation and Development, or OECD, carry out this type of analysis?

[*English*]

Dr. Sadaf Faisal: Not that I'm aware of, but I can check it for you.

[*Translation*]

Maxime Blanchette-Joncas: In your opinion, is Canada currently a real match for the United States, for example, when it comes to attracting pharmaceutical investment?

[*English*]

Dr. Sadaf Faisal: I'm not aware of that landscape, so I don't think I can talk about it.

We are in a really good position to explain that there is an opportunity for people to come and invest in Canada, but as I said, that's not the only solution for pharmaceutical sovereignty.

[*Translation*]

Maxime Blanchette-Joncas: I just want to fully understand the situation.

Canada accounts for 2% of the world's drug market. When you talk about opportunities, what do you mean?

Rolling out the red carpet for pharmaceutical companies is all well and good, but it comes at a cost. I'm trying to see how we can strike a balance and make sure that we remain as autonomous and sovereign as possible when it comes to pharmaceuticals, without necessarily taking risks with public funds and ultimately getting nothing in return.

[*English*]

Dr. Sadaf Faisal: We also need to ensure that we have enough supply within Canada. The supply we are manufacturing in Canada shouldn't go out of Canada. It should be for Canadians first. That's what our policies should focus on: anything being made in Canada.

We need to have those incentives for manufacturers. If they are coming to Canada, there should be some guidelines or guardrails around that.

[*Translation*]

Maxime Blanchette-Joncas: In your opinion, is Canada currently getting good value for the investment of public funds?

I'm thinking in particular of our ability to secure help from the world's major pharmaceutical companies to produce certain drugs and take care of the public.

[*English*]

Dr. Sadaf Faisal: I'm sorry. Can you repeat the question?

[*Translation*]

Maxime Blanchette-Joncas: Are we really getting our money's worth in terms of the public funds invested—people's tax dollars—and the contribution that we receive from the pharmaceutical industry in terms of access to certain drugs, prices and availability?

[*English*]

Dr. Sadaf Faisal: I'm not sure I will be able to answer that question.

[*Translation*]

Maxime Blanchette-Joncas: Okay.

Do you know whether the drug prices in Canada are competitive with the drug prices in other countries?

[*English*]

The Chair: The time is up, Mr. Blanchette-Joncas.

Dr. Faisal, you can't answer the question Mr. Blanchette-Joncas just asked now, but could you get the information and send it to the clerk of the committee so that we can get the answer? It's an important question.

Dr. Sadaf Faisal: Yes, I can.

The Chair: Thank you very much.

I now go to the second round, which is a five-minute round, and I'll begin with Mr. Strauss. He's not here. Who's going to do it? Is it Mr. Mazier?

Dan Mazier: No. It's Ms. Konanz.

The Chair: It's Ms. Jaczek. I'm sorry. It's Ms. Konanz. There are two Helenas and I get confused. Both are blond.

I am going to start with Ms. Konanz for five minutes.

Helena Konanz: Thank you, Chair.

My question is for Mr. Judson. In this study of pharmaceutical sovereignty, we're looking at existing public investments in and purchases of Canadian-made pharmaceuticals. The Canadian government significantly increased its purchasing, supply and distribution of pharmaceutical-grade hydromorphone, particularly during the period of the failed B.C. decriminalization experiment.

Do you consider the federal government's purchasing of hydromorphone for so-called safe supply purposes to be public money well spent?

Dr. Martyn Judson: No, it's not money well spent at all. The hydromorphone that has been stockpiled is to be dispensed in pharmacies where patients are getting prescriptions for inordinately high concentrations of hydromorphone. Because it is short-acting, it effectively destabilizes the nervous system, making recovery virtually impossible. It's locking the patients into their addiction.

The fact that there is an abundance of hydromorphone available in Canada, even before it makes it into the pharmacy, means that the present policy is to keep on feeding pharmacies and encouraging doctors to prescribe hydromorphone. That is not the best recommended treatment. Safe supply is not safe when you look at the big picture. It may be pharmaceutical-grade hydromorphone, but it's not safe for the community with this amount of hydromorphone being diverted from patients when they leave the pharmacy.

● (1725)

Helena Konanz: Okay. You're saying that there are definitely risks with increasing the supply, and it's not—

Dr. Martyn Judson: I can't say that it's the supply causing risk. It's because there are physicians who are prescribing it, and it's not the recommended line of treatment. In B.C., when safe supply first came in, it was for the administration of either tablets or injections of morphine under witnessed, supervised conditions three times a day.

Now, particularly in Ontario, it has degenerated into a daily dispensing of a day's supply of hydromorphone tablets, supposedly to be taken by the patient over the 24 hours, but we know full well, just by observation....

We can see that patients get their prescription of hydromorphone, take the first dose as a witnessed dose in front of the pharmacist and take the balance home. They're meant to take it throughout the day to prevent withdrawal and cravings, but instead, that is what they sell. It is diverted. That's where the danger is. It's not so much the supply that's then supplied in turn to the pharmacy; the problem stands with the physicians who are prescribing it.

Helena Konanz: Would the investments made by the Canadian government in the distribution of pharmaceutical hydromorphone have been better invested in the production and distribution of pharmaceutical methadone and Suboxone, to be used for more opioid agonist therapy?

Dr. Martyn Judson: The drugs that are best used in the treatment of opioid dependence or addiction—it's the same thing—are methadone for severely addicted people and, perhaps a safer drug, Suboxone. Suboxone is now available in injectable form and can be administered once a month, but this means the patient goes into the physician's office once a month, gets an injection and leaves. With methadone they were perhaps attending the clinic twice a week, and that encouraged the buildup of an interpersonal relationship, which is perhaps the most therapeutic tool when it comes to treating addiction. It's not in a chemical. It's in developing a human connection and starting with that.

The Chair: You have 40 seconds.

Helena Konanz: The key is that the government needs to want to help people quit drugs as opposed to continuing on them. That would be the bottom line.

Dr. Martyn Judson: That's correct. If the money were spent not in the pharmaceuticals, but instead—

The Chair: Ms. Konanz, you have 16 seconds, but you're skirting close to—

Helena Konanz: We only have a few seconds, if he could finish that—

The Chair: The questions you're asking are not about the study we're undertaking.

Dr. Martyn Judson: It would be better if the money were spent developing treatment programs rather than making it more readily available to prescribe hydromorphone.

Helena Konanz: I'd like to see that in our communities.

Thank you.

The Chair: Next is Ms. Jaczek for the Liberals for five minutes, please.

Hon. Helena Jaczek: Thank you, Madam Chair.

I would like to start, Dr. Tadrous, by saying that I was really impressed with how you emphasize data-driven, evidence-based approaches to drug policy, as well as with your ideas for a framework in terms of prioritizing where we put our efforts when it comes to Canadian pharmaceutical sovereignty.

I'm wondering if you are aware of some of the changes Health Canada is making to the clinical trial process. We have heard in this committee, not only in this study but in previous studies, that at the present time many researchers find that clinical trials take way too long and that they're perhaps not as useful as they should be. Have you had any involvement in Health Canada's developing a more streamlined approach to clinical trials?

● (1730)

Dr. Mina Tadrous: Some of my work relates to the growing field of real-world evidence. The idea is to use and leverage existing data routinely collected from health care visits and other data that can be drawn from the real world. That's been seen as an opportunity to bolster the ability to rapidly allow trials to exist and do studies.

One issue we're facing in drug development today is that a lot of the drugs coming to market are rare drugs that treat rare diseases, such as rare cancers. They are really innovative things, but the problem is they don't have a lot of people, so it becomes challenging to do these clinical trials in the robust way we've been used to and Health Canada has been used to.

What we're seeing from a lot of regulators around the world, such as the FDA, the EMA and Health Canada, which all work together to develop guidance and international standards, is that we need to bolster how we can do those clinical trials to allow ready access to do that. One space in which we're able to do that and unleash the data capacity of Canada is real-world evidence.

We haven't met that promise yet. Something many of us are trying to work towards is how we tap into the data that's part of our amazing health care systems in Canada—which do require some improvement—as a power for Canada, making it more involved in these global studies. This means we could get earlier access to treatments, study Canadians in these studies who might not always be included and then get access to medications earlier.

I want to make one comment that has to do with some of the comments that came before. When you're thinking about sovereignty, it's really important to consider that there are two pathways for conversations around branded, novel and new treatments and generic drugs. Clinical trials and those pieces are really important to get us new, novel treatments, but some of the things around essential medicines and capacity involve generic drugs as well. Both are important for sovereignty.

Hon. Helena Jaczek: Thank you so much.

Dr. Faisal, to pick up on what Dr. Tadrous just said, you talked about developing a list of essential medications, and I was wondering how you might see this happening.

Actually, there was an attempt at this. Dr. Eric Hoskins, former Ontario minister of health, was charged by the Trudeau government—I think in 2015 or so—with coming up with such a list.

Could you elaborate on how you see that we might do this?

Dr. Sadaf Faisal: We have been discussing this for some time now.

We can't manufacture every drug. There are a lot of drugs, so we need to pick the ones that are really essential.

There could be two approaches. We can look at the drugs that are essential in the sense that there are no alternative treatments available for them if they ran out due to a shortage. For example, right now we are seeing an oncology medication for which there is no alternative treatment available, so this would be considered something that needs to be on the essential or critical drug list.

Then there are certain drugs that people use for chronic disease management and that they have been on for a long time. It is not easy for a physician or a prescriber to switch them from one medication to another. We need to pick and choose the ones that can give us the opportunity to cover most Canadians. We can also look at the usage of the drugs, so the drugs that have been very heavily used in Canada are ones that should be included on the list as well.

The Chair: Thank you very much.

I'll go to Monsieur Blanchette-Joncas for two and a half minutes, please.

[*Translation*]

Maxime Blanchette-Joncas: Thank you, Madam Chair.

My next question is for Dr. Judson.

In light of the opioid crisis, does our dependence on imports place patients directly at risk?

[*English*]

Dr. Martyn Judson: It depends on what medicines you're referring to.

[*Translation*]

Maxime Blanchette-Joncas: In general, could our lack of the drugs needed to treat people's problems and illnesses adversely affect their health or make it impossible to treat them?

[*English*]

Dr. Martyn Judson: I'm not aware of it interfering with the management of people who are addicted. The drugs used primarily for management of addiction, particularly opioid addiction—methadone and Suboxone—are readily available in Canada. As for where they're manufactured, I cannot answer.

● (1735)

[*Translation*]

Maxime Blanchette-Joncas: Thank you.

Does Canada currently have the capacity to secure the supply of drugs and treat people suffering from addiction in the event of a crisis?

[*English*]

Dr. Martyn Judson: As far as I'm aware, they do have the ability to secure them. In fact, in my 40 years of prescribing methadone, I was never aware of any pharmacy running short of such medication.

[*Translation*]

Maxime Blanchette-Joncas: Thank you.

As far as you know, does Canada have a strategic stockpile or minimum production capacity to handle a crisis, for example?

[*English*]

Dr. Martyn Judson: I'm not aware of that. I can't answer the question.

[*Translation*]

Maxime Blanchette-Joncas: In terms of sovereignty, again, should we be doing or implementing things to ensure as much stability as possible, particularly when it comes to the opioid crisis?

[*English*]

Dr. Martyn Judson: The best way to manage the opioid crisis is to reduce the amount of addictive drugs prescribed to addicted people. It's the same thing as offering alcoholics free alcohol.

[*Translation*]

Maxime Blanchette-Joncas: That's a good image. Thank you.

[*English*]

The Chair: Thank you very much.

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

Dan Mazier: Thank you, Chair.

Dr. Judson, Health Canada gave $4.5 million to an organization called MySafe Society, and the money was used to operate vending machines that dispensed opioids to people struggling with addiction. As a physician, what is your assessment of the federal government's directly funding opioid vending machines as a health and addictions strategy?

The Chair: I would like to comment quickly. Let us be careful. This is not a study on addictions. Let's stick with the order of the day, which is a study of pharmaceutical sovereignty. Again, I ask members to exercise caution.

Thank you.

Dan Mazier: On that, Chair, one of the previous witnesses here today talked about sovereignty, and there are two streams: new treatment and traditional treatment. This is directly talking about sovereignty and how we deal with addictions in Canada. This is what we're getting at, but thank you for the clarification.

Dr. Martyn Judson: Effectively, supplying vending machines from which patients could access their daily doses or several daily doses of opioid replacement therapy didn't last very long, as far as I know, because those people were coming in the night, smashing the machines and accessing the drugs. I think they didn't get very far. I think it was a waste of money. Again, it would have been much better to be investing the money in treatment.

It's this obsession with harm reduction. Harm reduction has been very effective in reducing the spread of HIV and hepatitis C, but it has ignored the need for what is the basis of recovery. The healthiest people in the process of recovering from drugs and alcohol are found in fellowship meetings such as Alcoholics Anonymous and Narcotics Anonymous, which are not religious—they're spiritual—and those people do not take any drugs at all. Recovery is possible without prescribing addictive substances.

Dan Mazier: Thank you.

Dr. Judson, there's growing evidence that drugs obtained through safe supply programs are being diverted from patients onto the street and into the hands of young Canadians. Is diversion a problem with safe supply? What are the consequences when this happens?

The Chair: I would again ask Mr. Mazier to be careful with his questions.

Thank you.

Dr. Martyn Judson: Diversion is a significant problem in my own town of London. I've witnessed it myself.

When patients have been given a daily dose of their medication in the pharmacy, they take it out and then are swarmed immediately by people on the street. They sell what they're meant to be taking for the balance of the day. Increasingly, there are a lot of younger people coming into the clinic seeking treatment for the management of their opioid dependence. This invariably started as a result of accessing street drugs in the form of hydromorphone, which had obviously been diverted.

Dan Mazier: Thank you.

I have another question, Dr. Judson. Over the past decade, federal policy has moved toward decriminalization, government-funded drug supply and opioid vending machines. Many Canadians would call this a “normalization” of hard drug use. From a clinical standpoint, what impact does normalization have on addiction rates and treatment uptake?

● (1740)

The Chair: Once again, I caution Mr. Mazier that we're not discussing addiction therapy. We're discussing pharmaceutical sovereignty. I'd like him to keep to the agenda.

Thank you.

Dan Mazier: Okay.

I have another question for you, Dr. Judson. This one is on sovereignty. The most commonly used drugs at supervised consumption sites are fentanyl and meth. As a physician, can you tell us what happens to the human body when somebody perpetually uses hard drugs with no exception of treatment or recovery?

Dr. Martyn Judson: The cycle of addiction continues. The patient administers the fentanyl. They have a few minutes of contentment. Then the drug is metabolized. They go into withdrawal, only to have to come and repeat the process. They go and get more drugs, bring those drugs in and inject them. It would be much better, when they attended safe injection sites, if there was a greater emphasis on trying to encourage people to seek long-term recovery.

Dan Mazier: Would you say that the policies built around drug enablement are holding people with addiction hostage?

Dr. Martyn Judson: Yes.

Dan Mazier: Thank you.

The Chair: Thank you, Mr. Mazier.

Mr. Eyolfson, you have five minutes, please.

Doug Eyolfson: Thank you, Madam Chair.

I'd like to thank all the witnesses for coming. This has been very useful testimony.

We've heard a lot of testimony about how we need to improve our own manufacturing capacity. It's not the be-all and end-all—every nation has to rely on other nations for some—but we have severely limited capacity. One thing we learned during the pandemic was that we didn't have the ability to make our own vaccines.

Now, I'm going a little far through the mists of time, but some of us may remember Connaught Labs. This was a publicly owned laboratory. It produced a large portion of Canada's vaccines. It was sold in the 1980s by the federal government of the day to private industry, to a private company. This company decided that the best business case for them was to close the Canadian branch, formerly Connaught Labs, leaving us without any vaccine capacity.

Dr. Tadrous and then Dr. Faisal, does this occurrence, as long ago as it was, make a case for publicly owned pharmaceutical manufacturing that would not be at risk for being sold out of country due to a business case?

Dr. Mina Tadrous: Thank you very much. That's a really interesting question on the balance of this. It speaks to what I'm trying to present to the committee, which is the need to be targeted. We should be bolstering domestic production in some way.

Let's say we went to a company today, told them we'd give them money to make a drug and allowed them to pick whatever they wanted. They would pick the thing that's most profitable. I'm not saying there's anything wrong with that, but as Canadians, we should be selecting on this, or at least working hand in hand: We want to pick a drug that's critical to us and important to Canadians, whether it's vaccines or drug products. We may also want to lean into how we can be valuable to the global economy and where Canada can lead. There are drugs that the United States is unable to produce. They've made this a national security process. There's a really good opportunity in working with other allies. These are the things we can make.

On the public space, there is a really great opportunity to be thinking about some public-private partnerships and different models in which we produce certain products. We've seen this in Alberta. There's a manufacturing site called API that's being produced. There need to be supports in what they can make and how they make it, but there is an opportunity to be thinking creatively about how we can both bolster domestic production and be very pointed on what we make and what Canada needs.

Doug Eyolfson: Thank you.

Dr. Faisal, would you care to add to that?

Dr. Sadaf Faisal: Yes. Just to pick up on what Mina was talking about, there is an opportunity, but whomever we partner up with in a public-private partnership, we need to make sure that we include some expedited regulatory review processes for these drugs. One of the issues is that a lot of the time, we do not get drugs in time. We also need to make sure that if we are asking them to produce something domestically, they get some incentives so that Canada can be a better market for them. Why would someone invest in Canada if they don't see that we are giving them some kind of incentive?

We could be leading. We are the ones who produced insulin. There is a big opportunity over here in which we can work together—maybe not as a whole public company; maybe a public-private partnership would be a better option.

● (1745)

Doug Eyolfson: Thank you.

My final question, I'll put to both Dr. Tadrous and Dr. Faisal.

In regard to this, you mentioned that you had to have your top 50 be domestic and then the next top 50 be from a friendly ally. I'm not asking you to answer this right now. That would be absurd. Would either or both of you be among the sources who could help to tell us the top 50 and the next 50?

Dr. Tadrous, I'll start with you.

Dr. Mina Tadrous: That's exactly what we've been doing in our work. We've developed frameworks and mechanisms to do that. I want to point out that Health Canada has been leading a proposal to develop a critical vulnerable drug list. It's related to bolstering the supply that would be held inside of Canada, to increasing the amount that should be held.

There's a lot of work happening in this space and a lot of really smart people working towards it. We need to have the vision whereby all of this work is linked with policy. That's where the people on this committee can really play a leadership role.

Doug Eyolfson: Thank you very much.

Dr. Faisal is next.

Dr. Sadaf Faisal: Mina just mentioned the critical and vulnerable drug list. Health Canada is working on it. We are working very closely with them. It's a great opportunity for us to collaborate on that. We really hope that this committee can move the work forward.

Doug Eyolfson: Thank you.

I have no further questions.

That's my time. Thank you very much.

The Chair: Do you have anything else to say, Mr. Eyolfson?

Doug Eyolfson: No. Those are all the questions I had.

The Chair: I thought you told me that you had a question to put to the committee.

Doug Eyolfson: Oh, yes. I'm sorry. I have no more questions, but I have a motion that I would like to bring up at this point.

This is a routine motion regarding the distribution and access to documents to three associate members per recognized party, adopted by various committees in November. This expired on January 26. There's agreement among whips for committees to adopt a new routine motion extending the provisions of this motion until September.

The following motion is available, printed in English and French. It reads:

> That, notwithstanding the usual practices of the committee concerning access to and distribution of documents,
>
> 1. up to three associate members of the committee per party be authorized to receive the notices of meetings and notices of motion and be granted access to the digital binder;
>
> 2. the associate members be designated by the offices of the whips of each recognized party and sent to the committee clerk; and
>
> 3. the provisions of this motion expire as of September 25, 2026, unless otherwise ordered.

The Chair: Is there anyone disagreeing? I gather that all the party whips have agreed to this.

We have unanimous consent on this.

(Motion agreed to)

The Chair: Thank you, Mr. Eyolfson.

I now want to thank our witnesses, Dr. Faisal, Dr. Judson and Dr. Tadrous, for sharing their expertise on an extremely important issue.

I adjourn the meeting.