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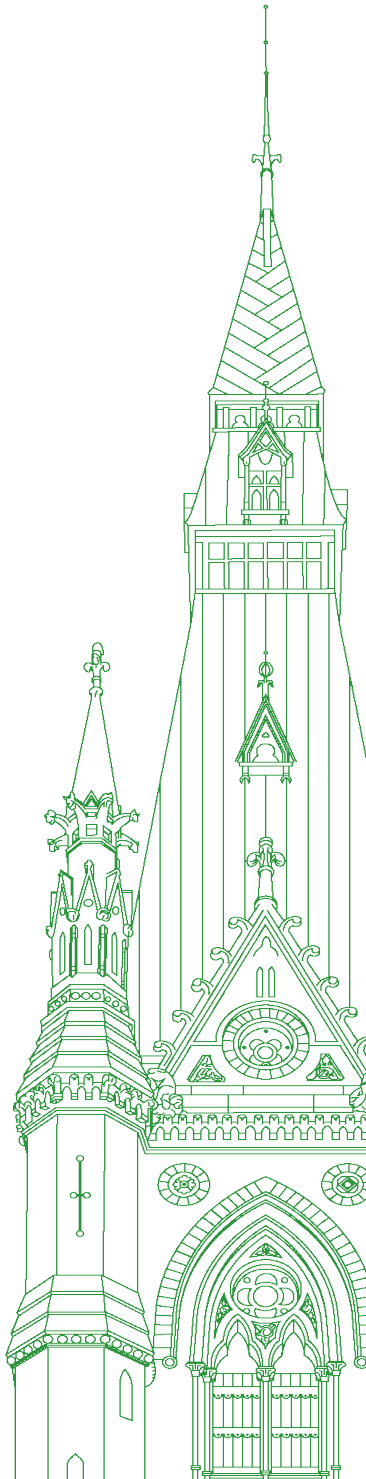

Chair: Hedy Fry

Standing Committee on Health

Thursday, April 23, 2026

● (1530)

[*Translation*]

The Chair (Hon. Hedy Fry (Vancouver Centre, Lib.)): I now call the meeting to order.

Good morning, everyone. Welcome to meeting number 30 of the House of Commons Standing Committee on Health.

[*English*]

We meet on the unceded territory of the Algonquin Anishinabe people.

Today's meeting is taking place in a non-hybrid format for a change.

I want remind participants of the following points.

Wait until I recognize you by name before speaking. For those participating, please mute your mic so we don't have interference. On the console in front of you, you will see that there is English and French, so you know what to do there.

All comments should be addressed through the chair. For members in the room, you know the drill: If you want to speak, put up your hand. The clerk and I will try to figure out whose hand was up first, and we will go ahead with it in that order.

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

I want to welcome the witnesses who are here to speak to that. From Diabetes Canada, we have Glenn Thibeault, executive director, government affairs, advocacy and policy. From HealthPRO Canada, we have Christine Donaldson, president and chief executive officer. From VaxSynergy, we have Denis Leclerc, director and full professor at CHU de Québec, Université Laval.

Each of you will have five minutes. I will shout out “a minute” when you have a minute left, and then “30 seconds” to give you a chance to wrap up. If you cannot finish what you've said, you will be able to expand on it during the question and answer session, so do not panic.

We will begin with Monsieur Thibeault for five minutes.

Glenn Thibeault (Executive Director, Government Affairs, Advocacy and Policy, Diabetes Canada): Thank you, Chair and members of the committee, for the time to speak to you today.

Millions of people in Canada wake up every morning dependent on diabetes medications, which include insulin, a life-saving medication discovered here in Canada. Sir Frederick Banting, alongside fellow Canadian scientists Charles Best and James Collip, changed the world from a lab in Toronto.

Banting House in London, Ontario—I extend an open invitation to all of you to come for a visit—stands as a national historic site marking the place where Banting first thought of taking insulin from a pancreas to treat diabetes. Sir Banting is a Canadian hero, yet today, we do not manufacture a single vial of insulin domestically. That is not a failure of science; that is a failure of will. Despite insulin having been discovered here, Canada remains entirely dependent on foreign manufacturers, and when shortages occur, we have no enforceable mechanism to prioritize Canadians.

In 2024, for example, Canada faced a critical shortage of injectable glucagon, a life-saving emergency treatment for severe hypoglycemia. Emergency importation from the United States was required, and still is. That is a short-term workaround, not a resilient strategy. That shortage was a warning—a stress test we failed.

I have another example. As recently as last month, a small group of Canadians living with type 1 diabetes was about to lose access to animal insulin—the only kind their bodies can tolerate—as the foreign company that manufactures and distributes it in Canada was about to discontinue it altogether. It took those families going public with their story in the media for a solution, albeit still a temporary one, to be reached.

A federal government program, one we all know, is pharmacare. It has helped improve access and affordability, and that matters, but affordability policy is not the same as availability policy. Pharmacare does not secure upstream supply, it does not manufacture medicines and it does not guarantee availability in global distribution.

Pharmacare is a pillar program of the federal government, and its success depends on a stable domestic supply of the medicine it covers. A national pharmacare program cannot function effectively if we remain entirely dependent on foreign manufacturers for its most fundamental input. Supply disruptions or allocation decisions made abroad could undermine the entire program's credibility and leave vulnerable populations without access to covered medications. The bottom line is that, in matters of health security, availability must come first.

Let me be clear that pharmaceutical sovereignty is not about isolation. It is about resilience, it is about preparedness and it is about the duty of a nation to protect its people. Without domestic manufacturing capacity, Canada has no mechanism to prioritize its own population's needs over international demand. We have no control, we have no leverage and we have no guarantee that when the next crisis hits, our patients will have access to the medications they need.

With President Trump’s threats of tariffs on pharmaceuticals, his most favoured nation policy and the U.S. state importation programs, the U.S. is actively competing for Canadian medications. As U.S. states seek lower-cost drugs from Canada, they can create competing demand for products manufactured through Canadian channels, diverting supply away from our patients and creating unpredictable shortages. Global supply chain fragility means that decisions made in foreign boardrooms during crises we do not control directly impact the health of Canadians.

However, here is what gives me hope: We are not starting from scratch. For example, Canada's new defence industrial strategy explicitly recognizes life sciences as a critical sector. The Canadian defence industrial strategy can be a policy instrument in helping us with domestic pharmaceutical manufacturing.

● (1535)

The irony is that insulin was discovered by Canadian scientists in 1920, profoundly changing the lives of every person living with diabetes globally thereafter. We have an opportunity here to really work together to protect our own sovereignty, protect our own supply and make sure that the diabetes community continues to work with Parliament to solve this issue.

Thank you very much, Chair.

The Chair: Thank you very much, Monsieur Thibeault.

Now I'll go to HealthPRO Canada and Christine Donaldson for five minutes, please.

Christine Donaldson (President and Chief Executive Officer, HealthPRO Canada): Madam Chair, vice-chairs and honourable members of the committee, I thank you for this opportunity to appear today.

My name is Christine Donaldson, and I am the president and CEO of HealthPRO Canada. We are a national, member-owned, group-purchasing organization that serves more than 2,100 hospitals and health care organizations across the country. We help procure approximately $1 billion in pharmaceuticals each year, partnering with 50 pharmaceutical suppliers across the globe on behalf of the Canadian health care system. In addition, I am a hospital pharmacist, so I have a very strong investment in what we're talking about today and have experienced many medication shortages first-hand.

The recommendations I am bringing to you today are informed by my experience, by my role at HealthPRO Canada and by the over 20 pharmacy leaders from across the country who gave their input for our recommendations.

I am sure we would all agree that any conversation about pharmaceutical needs should be grounded in uninterrupted patient access to essential medicines. It is our position that today Canada is not currently well positioned to pursue full pharmaceutical self-sufficiency.

Thus, a sustainable and realistic pharmaceutical strategy must prioritize pursuing domestic manufacturing—but it has to be strategic—for critical medications; updating public procurement to prioritize both reliability and redundancy; creating more regulatory agility to incentivize pharmaceutical manufacturing here in Canada; enhancing coordinated data sharing on a national level; and aligning policy across manufacturing and innovation.

In recent years, Canada has experienced repeated shortages of many medications, including those that are hospital-based. These are not theoretical risks. When supply becomes unpredictable, hospitals are forced into buying alternative products and rationing them, which obviously brings increased risk and can compromise continuity of care. Think back to the shortage of pediatric Tylenol that caused risks to our most vulnerable patients—children—and undue stress for parents across the country.

HealthPRO's experience shows that Canada currently relies heavily on global supply and has limited redundancy. Pharmaceutical manufacturing is capital-intensive and depends on sufficient scale across multiple product classes. Replicating end-to-end capacity across all medicines would require substantial investment and volumes that Canada simply does not have with our relatively small population.

Thus, domestic manufacturing must be strategic and must focus on medicines that pose the greatest clinical and system risk. They include sterile injectables, antimicrobials, emergency and critical care medicines and high-volume hospital products.

Health Canada's recently published critical and vulnerable drug list provides an important evidence-based foundation for this prioritization. This targeted approach both strengthens and builds resilience where it matters most, without introducing inefficiencies or escalating costs.

Traditional procurement models have often emphasized immediate savings, but the price alone does not reflect the true costs across the whole system. Procurement can and should incorporate risk-adjusted criteria such as reliability, redundancy, sustainability and domestic capability. These criteria can remain fully trade-compliant, while encouraging manufacturers to invest in more resilient production to strengthen our supply chain overall.

Manufacturers consistently cite that regulatory uncertainty and long approval timelines are barriers to investing in Canada or bringing alternatives to market. Priority review of clinical, critical and shortage-prone medications would align with our trusted international regulators and help bring forward expedited pathways for alternative suppliers during these disruptions.

We know that data is fragmented across jurisdictions and many supply chain actors, limiting our ability to anticipate shortages before they escalate. We believe that improved standardized data sharing across all stakeholders, including organizations such as HealthPRO Canada, would enable earlier intervention, better forecasting and more proactive mitigation.

Finally, pharmaceutical sovereignty requires alignment among manufacturing, health policy and innovation. We see that investment in domestic capability is far more effective when it's paired with predictable procurement signals, regulatory agility and a clear understanding of those clinical priorities.

In closing, pharmaceutical sovereignty is not about choosing domestic production over global sourcing. The most resilient and cost-effective path is a balanced one, combining both strategic domestic capacity and diversified global supply supported by a coordinated national policy.

Thank you.

● (1540)

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

We'll now go to VaxSynergy.

Monsieur Leclerc, you have five minutes.

[*Translation*]

Denis Leclerc (Director and Full Professor, CHU de Québec, Université Laval, VaxSynergy): Good afternoon, everyone. Thank you for inviting me here today.

What is VaxSynergy? It is a network of researchers funded by Médicament Québec and the Canada Foundation for Innovation. It spans three sites—in Montreal, Shawinigan, and here in Quebec City—and possesses cutting-edge expertise in vaccine development.

Our mission is to meet the preclinical development needs for vaccines and therapeutic proteins. Our clientele consists primarily of small and medium-sized enterprises or researcher-entrepreneurs in the academic sector. All our services undergo rigorous quality control in accordance with the good laboratory practices necessary to meet industry needs and regulatory requirements. This is, in fact, one of the aspects that sets us apart from most other academic laboratories and brings us closer to the industry's way of doing things. I won't go into further detail on this subject.

To help you understand what VaxSynergy does within the ecosystem, I will present four concrete examples of our work and explain how they are useful.

The first example is that of Dr. Sauvageau, a clinician interested in the human papillomavirus, or HPV, who used to rely on the services of the Centers for Disease Control and Prevention, or CDC, based in the United States, to perform serological testing on patients vaccinated in Canada. Recently, the CDC discontinued its collaboration with Canadians. The problem is that Dr. Sauvageau can no longer access these services, yet there is no recognized HPV serology centre in Canada. So we have a problem.

We then worked in collaboration with Dr. Sauvageau and took steps to ensure that VaxSynergy becomes the reference centre for HPV serology in Canada. We hope that good news will be announced shortly regarding the funding of this program. Our intention is to offer these services internationally as well, and even to Americans, since the CDC is completely overwhelmed. So, here is a concrete example of a VaxSynergy initiative that helps improve Canada's self-sufficiency in the field of serological monitoring of vaccinated patients.

The second example involves an SME, Glycovax Pharma, which consulted VaxSynergy to resolve a purification process issue with its vaccine platform. Joint funding from Glycovax Pharma and the Natural Sciences and Engineering Research Council of Canada enabled the financing of VaxSynergy's research activities and the simplification of the purification process. The benefit for Glycovax Pharma is affordable access to experts without having to hire additional staff. Furthermore, VaxSynergy's involvement led to a reduction in production costs for Glycovax Pharma's vaccine platform.

The third example involves another SME, but in a different context. Recently, an expression of interest was submitted for Canadian government funding under a program linked to the Biomedical Countermeasures Initiative. Under this program, VaxSynergy is expected to be responsible for elucidating the mechanisms of action of an adjuvant and evaluating its potential for preventing viral and bacterial respiratory diseases. This project lies at the heart of VaxSynergy's expertise and will enable the SME to find new applications for its adjuvant, including for combatting respiratory diseases in a pandemic context. Thus, in this case, if the program is funded, VaxSynergy's involvement will help a Canadian SME develop new products.

Finally, the fourth example involves a researcher-entrepreneur from Laval University, Dr. Tessier. He discovered a protein with promising anti-cancer properties. However, Dr. Tessier faces a major problem: production of the protein is far too low to consider commercialization. He therefore consulted VaxSynergy. Together, we developed a new production process that increases output by a factor of 1,000 compared to the initial process. Consequently, a new patent application was filed, a new biotechnology was created, and a licensing agreement was negotiated with Laval University to commercially exploit this invention. Here, VaxSynergy's involvement facilitated the transition of a new drug from the academic sector to the private sector.

That's not all. VaxSynergy also contributes to the training of highly qualified personnel, as we train—

● (1545)

[*English*]

The Chair: You have 30 seconds.

[*Translation*]

Denis Leclerc: Very well.

I was saying that we train students, and that is one of the reasons why companies working in the field of vaccination, such as GlaxoSmithKline or Aramis Biotechnologies, are able to remain in Quebec City.

So, this is just the beginning. VaxSynergy was created just a few months ago, and we anticipate that it will play an important role in facilitating the development of new vaccines and therapeutic proteins in Canada. Our survival will depend on government funding and the revenue generated by our activities. We hope to become financially self-sufficient within four or five years.

[*English*]

The Chair: Thank you very much, Monsieur Leclerc.

I'll now go to the question and answer session. Just as an explanation, you have a six-minute question and answer to start off, and then there are five-minute question and answers. The six minutes and the five minutes include the question and answer, so please be as succinct as you can.

I'll begin with the six-minute round, starting with Ms. Konanz from the Conservatives.

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

My first questions are for Ms. Donaldson. Thank you so much for being here today.

You were quoted last week in a BNN Bloomberg article entitled "Why Canada's health care system is eyeing the global helium shortage closely". Helium is vital for its use in MRI scans, and there's no hospital in the country that can go without medical imaging.

Shipping constraints through the Strait of Hormuz and damage to helium production facilities in Qatar have essentially cut off one-third of the world's helium supply. You told Bloomberg, "There is no system-wide shortage", yet you said that there seem to be "targeted pressures". This is now the fifth worldwide helium shortage in two decades.

My question is twofold. What are those "targeted pressures" you mentioned, and, if the conflict in the Middle East persists, how long will it take for Canada to see shortages of helium?

● (1550)

Christine Donaldson: HealthPRO Canada has certain helium contracts for hospitals. Some of them are used for medical gases, and as you said, there is a product used in MRI machines.

At this point, one of the producers has put out a notice that says there is a 50% allocation for a certain type of liquid helium. We have been working with that producer very carefully to ensure that the medical usage of helium is being prioritized. In other words, there are many uses of helium, and all recipients or users of helium receive the same notice.

Secondly, we have a diversification strategy with helium. At HealthPRO Canada, we often try to do a very unique strategy with contracts called the multi-supplier strategy. That allows us to award a contract to more than one producer, which keeps them healthy in the Canadian market. In this case, we have two producers. One is based out of Qatar, as you mentioned, and one in North America. That is one of our strategies, and we've been working to diversify and prioritize medical gases here in the country.

I do not have a strict answer for you about the timing. It is still something we're working very carefully on with suppliers to determine.

Helena Konanz: What you are saying is that at this point there hasn't been a noticeable change in the availability of helium for medical imaging, but this could change in the near future.

Christine Donaldson: I do not have any line of sight as to when that could change.

Helena Konanz: Canada has the world's fifth-largest helium resources, estimated at seven billion cubic feet. However, we have no liquidation facilities in Canada, so we are completely reliant on shipping helium to the United States. Provinces like Alberta and Saskatchewan want to change this, but federal taxes and red tape are limiting companies' willingness to invest in liquidation plants.

Would having helium liquidation plants help to end our reliance on Qatar and the United States for medical helium? Also, do you support federal tax changes to make that happen?

Christine Donaldson: Unfortunately, I do not have much interaction with the domestically based suppliers. I think your question is a thoughtful one, and I believe that the Minister of Energy and Resources in the province of Saskatchewan is actively looking into those strategies.

We have an open market opportunity within all of our contracts that encourages, wherever we can, domestic production by allowing suppliers to enter into a formal contract with HealthPRO Canada.

Helena Konanz: Thank you.

My next question is for Glenn Thibeault.

Mr. Thibeault, Canada's Drug Agency recently recommended that public health plans should cover Mounjaro for type 2 diabetes. Mounjaro is like Ozempic in that it's being used as a weight-loss drug in other countries. We know that generic forms of Ozempic are currently under review as well.

What challenges should we be aware of, on behalf of the diabetic community's access to the supply of Mounjaro and Ozempic, if these drugs inevitably become used more for weight loss than diabetes?

Glenn Thibeault: There are quite a few concerns that we should be flagging when it comes to even generic GLP-1s, from Ozempic to Mounjaro.

The important thing to recognize here is that I'm very concerned about online pharmaceutical sales and the cost of Canada having a lower cost for these medicines. We've seen before that prescriptions happening in British Columbia are being filled in Nova Scotia, and 17,000 of them are going to the States. When we have this at a lower level, we could see a shortage of those products for Canadians.

If you talk to the pharmaceutical companies involved in this and look at the patient voice.... We're all really concerned and raising the flag here at a committee, asking that we find ways to protect Canadian supply to make sure that the lower cost is then applied to Canadians and not shared globally.

● (1555)

Helena Konanz: Would you say that you're more worried about them being sent to other countries, as opposed to being used as weight loss drugs?

Glenn Thibeault: Yes. Off-label usage is something for the person and their health care provider. The loss of them, I think, is more important.

Helena Konanz: Thank you.

The Chair: Thank you very much.

I now go to the Liberals, with six minutes for Ms. Sidhu.

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

Thank you to all the witnesses for coming here.

My first question is for Mr. Thibeault.

I was proud to help advance Canada's national diabetes framework. Thank you, Diabetes Canada, for supporting this bill. Now it's law.

You raised the question of the life-saving insulin shortage, drug shortage, continuing to affect patients across the country. What are the main factors behind shortages, from your perspective? What should the federal government be doing differently to help prevent them? Can you give any advice on that?

Glenn Thibeault: First off, it's important to say that diabetes is a non-partisan chronic condition. With that, I want to thank you for your leadership in organizing the diabetes caucus and bringing MPs from all different parties to talk about the issue. Thank you for your leadership on that.

When it comes to shortages, we've seen shortages with Ozempic, which came about in relation to plastics—not necessarily the manufacturing of the medicine but that process. Making sure that there is an opportunity for supply to be created from beginning to end in Canada—because we are reliant on having products shipped in from the U.S. or from other places—and looking into having our own domestic supply will be key.

In my opening statement, I talked a bit about Canada's new defence industrial strategy. Everyone is asking me, “Why is a health charity looking at the defence industrial strategy?” It's because there's a life sciences fund in there, and that life sciences fund can do a few things. It can provide capital investment for domestic insulin manufacturing facilities, procurement guarantees and long-term supply contracts that can create predictable demand. Those are the things that we would like to see to ensure that insulin can get to everybody in this country.

We have over four million people in this country who are already diagnosed with diabetes. The number for prediabetes makes that number jump from anywhere between 10 million and 12 million people. There are a lot of things we can do, and I think the government has the tools necessary to act right now.

Sonia Sidhu: Canada has strong research capabilities and a highly skilled workforce, and it is known for having a well-respected regulatory system, yet stakeholders continue to tell us there's room to improve. We are heavily relying on foreign imports for innovative medicines. Can you give us recommendations about which sectors we can improve so that we do not have to rely on others and can be self-sufficient in our own country?

Glenn Thibeault: There's an opportunity for us to align pharmaceutical sovereignty with this industrial strategy to create high-skilled jobs, strengthen domestic capacity and advance Canadian innovation.

It's very important for us to honour the legacy of the scientists who gifted insulin to the world. I'm very focused on diabetes medications, but this can apply to all medications. What we're looking for now is the political will to implement the types of frameworks we've all talked about, let alone the diabetes framework—from the Canadian defence industrial strategy to other kinds of opportunities.

Coming from Sudbury.... We always talk about critical minerals. We really could look at critical minerals and compare them to medicines, and then make sure that the medicines Canadians depend on every single day are actually produced and manufactured here so we can control what happens if and when the next crisis or shortage happens.

There are plenty of opportunities. I think there are frameworks currently in place that we should be looking at and utilizing to make sure that we don't have to go through another shortage here in Canada.

● (1600)

Sonia Sidhu: My next question is for Ms. Donaldson.

From your perspective, what are the biggest supply chain vulnerabilities for Canada right now? What should the government do to improve those?

Christine Donaldson: The vulnerabilities today can be addressed through a national coordinated policy and framework. As I mentioned in my remarks, there is an opportunity to focus on critical and vulnerable medications. Health Canada has had some leadership in this area.

We have a vested interest here, as a provider to hospitals and health care organizations, as many of the products on that list are injectable medications and are life-saving. When you think about it, why do you present to an emergency room? It's because nothing else will help you get through the acute or life-threatening illness you're facing.

We have a very opportunistic time to collaborate to look at what information we have, the experiences we can share and the data. The government could really help us with coordinating and pulling together the key stakeholders that can provide intel on the data we own today. That can point us in the right direction to strategize and invest in the smart procurement strategies.

I always like to say that we use procurement as a gateway. We can use it as a really important economic reason to make the right decisions.

The Chair: Thank you very much.

Now I'm going to the Bloc, with Monsieur Blanchette-Joncas for six minutes, please.

[*Translation*]

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

I welcome the witnesses who are with us today.

Mr. Leclerc, first of all, I want to acknowledge all the work you are doing with your organization. In just a few months, you have accomplished a great deal. You have provided some very concrete examples. You have demonstrated that in Quebec, we are capable of developing expertise and know-how, as well as strategic capabilities of the highest level. You have provided concrete examples of what your team is capable of developing.

In your opinion, what is currently missing to make this capability sustainable and self-sufficient?

Denis Leclerc: It's not complicated; what's missing is funding. The expertise has been there for a long time. Funding a drug in Quebec has helped consolidate this expertise and foster collaboration. However, all of this makes sense only if this funding is maintained. Ultimately, that's how we'll reap the benefits of this investment. If we continue to support this kind of initiative over decades, we'll really see significant benefits emerge for Canadians, and organizations like VaxSynergy will eventually become sustainable and able to fund themselves through their activities. Scaling up this type of initiative will allow Canada to move forward quickly and distinguish itself from other G7 countries.

Maxime Blanchette-Joncas: I completely agree with you.

I'll approach the issue from the other side. Obviously, I am an ally in supporting your funding efforts. However, without predictable and structured funding, what do you think Canada specifically risks being unable to do? What are the risks of not funding you?

Denis Leclerc: The risks are enormous. We cannot work together to address these issues and operate according to good laboratory practices, as I mentioned earlier. It requires a great deal of rigour, but there are costs involved. All of this needs to be implemented. The work of an industry is very different from that of the academic world. Government investment is absolutely essential to implement these initiatives. It's really important.

From what I understand, Canada isn't the G7 country that invests the most in research and development. So there's a significant shortfall. It's no secret: talented people are leaving the country because funding is easier to obtain elsewhere. If we want to keep our best minds here so they can work and develop new technologies, we absolutely have to put money into it.

I speak with some perspective: I've been in this field for over 30 years now, and that's what I've observed.

● (1605)

Maxime Blanchette-Joncas: I'd like to pick up on what you said.

Canada is certainly not the leading investor. It's the only G7 country that, over the 20 years from the early 2000s to 2020, and even up to the present, cut back on R and D investment. We have a lot of potential, but it takes investment because this environment is very competitive, as you know.

Beyond product development, you also talked about your role in training. Without ongoing support, is Canada also at risk of losing strategic capacity to train highly qualified personnel?

Denis Leclerc: Yes. Everything is interconnected, and I think that's what makes it strong.

Let me tell you about Quebec City.

Expertise in the vaccine sector grew in Quebec City for a long time, fuelling vaccination initiatives there. It's no coincidence that the GSK production facility was built in Quebec City. Four or five people who were trained in my lab work there. The same is true of Aramis Biotechnologies, which is also in the vaccine sector.

In order to attract multinationals to set up shop in our country, we need to train people in the vaccine sector. That means doing research and training students. They also need to be taught good laboratory practices. They have to learn to speak the industry's language. When these people get into the industry with this training, I'm proud to say, they very quickly become autonomous and effective.

Maxime Blanchette-Joncas: I would like to draw on your experience. You said you've been in the field for many years.

In the early 2000s, Quebec had the world's biggest biopharmas, many of them located in the greater metropolitan area. They didn't leave because it snowed too much one Saturday afternoon, though. From your perspective, why did we lose them?

Denis Leclerc: I think it comes down to political will.

Let's go back even further. Back in the days of Dr. Armand Frappier, we manufactured our own influenza and hepatitis A vaccines in Quebec. Armand Frappier's vaccine production facilities were shut down in the mid-1980s, I believe.

If we had kept those facilities open, they would have continued to grow and we would have continued to innovate. They probably would have expanded. I have no doubt that we would have been in a much better position to deal with the COVID-19 pandemic we experienced in 2020. We probably would have been an international frontrunner in dealing with it.

With regard to research funding, the key to reaping the benefits is to keep that funding flowing over time. There's no point in investing millions of dollars in a hurry and tens of millions of dollars over a short period of time only to then cut off that funding. That doesn't work.

[*English*]

The Chair: Monsieur Leclerc, you have 10 seconds left, so please wind up and finish what you're saying.

Denis Leclerc: I was finished. Thank you.

The Chair: Thank you very much.

I'm going to Mr. Bailey for the Conservatives for five minutes, please.

Burton Bailey (Red Deer, CPC): Thank you, Madam Chair. Will you be giving me a one-minute warning?

The Chair: I'll give you a warning, yes. I just don't give Mr. Blanchette-Joncas a warning. He told me not to.

Burton Bailey: Thank you to the witnesses for joining us today.

Mr. Thibeault, you started out by saying, “the duty of a nation [is] to protect its people.” That resonated with me because yesterday we learned that in the past 10 years, Canadians have paid over $275 million for health care for people who have had their refugee claim rejected.

Are Canadians experiencing longer wait times for specialist care and routine diabetes management across Canada due to the rise in immigration?

Glenn Thibeault: I don't have that specific answer, but what I can tell you is that across the country, we all know that we don't have enough health care practitioners from coast to coast to coast. Every provincial government and the federal government are working collaboratively to try to resolve that issue. If I had a magic wand, it would be great to solve it.

I am Sudbury-based, and there are people in northern communities in northern Alberta, northern Manitoba and northern Ontario who can't get access to the specialists they need, so we would encourage all governments of every level to work together to try to address that issue.

● (1610)

Burton Bailey: The reason I asked the question is that physicians are charging a higher rate for some of these people. We're seeing it with pressure sores and certain things that people will come with from other countries, and they get better treatment than our own Canadians. That's why I asked you the question.

I'll go to another topic.

Diabetes often coexists with chronic pain. Has the opioid crisis compounded the pressure on the patient population?

Glenn Thibeault: Again, that's not data that I would have access to.

Burton Bailey: I understand that. Thank you.

On pharmacare, Alberta has a really robust diabetes program. Can you tell us why Alberta was so adamant that their program was better than programs in other provinces?

Glenn Thibeault: I think every province that has not had a bilateral agreement just yet will tell you that they look forward to having one with the federal government.

The Alberta government has a number of medications on their formulary that put them ahead of other provinces and territories. Do they do some great things? Absolutely. Do they need to work on other things? Absolutely.

I think my friend from the Bloc would agree that Quebec also has a very good program that's very hybrid in its approach, and it's something we can continue to look at.

We're all-in in supporting universality when it comes to pharmacare. We think everybody in this country, no matter where they live from coast to coast to coast, should have access to the medications they need. We're just not sure if the single-payer approach is the right approach, and Quebec is an example to look at. With hiccups and warts and everything, there are opportunities to do things better, but pharmacare is the right approach in making sure that we can have universality for medicines.

Burton Bailey: Thank you.

Ms. Donaldson, has your industry been able to keep up with the increased demand for pharmaceuticals due to population growth?

Christine Donaldson: At this point, we look at all patients who present to our hospitals as increased demand. I would say that we always have a challenge when it comes to forecasting the actual demand, the true demand, against what we project.

There's a real opportunity here for us to look at any sort of population change or growth. Access to care is vitally important to us at HealthPRO Canada, because we want to be able to reach into the far edges of the provinces, coast to coast to coast, as my colleague here has been speaking about. There's an opportunity for us to make sure that we are actually addressing the pockets of need, wherever they are.

Burton Bailey: Very quickly, I recently learned that due to a commerce law, Quebec and Ontario are the only provinces that can produce generic medications. There's a company in Alberta that would like to, but they cannot. Can you elaborate on that for me?

Christine Donaldson: I'm sorry. I do not have any insight or commentary to add to that question.

Burton Bailey: Thank you, Chair.

The Chair: Thank you, Mr. Bailey.

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

Hon. Helena Jaczek (Markham—Stouffville, Lib.): Thank you, Chair, and thank you to the witnesses for your testimony to date.

As I'm sure you know, the goal of this particular study is to provide the federal government with very practical, focused recommendations on how to improve pharmaceutical sovereignty in Canada. You've given us some hints of this already during your testimony, but starting with you, Monsieur Thibeault, could you give us one or two absolute priority areas from your perspective to assist us?

Glenn Thibeault: Thank you for the opportunity to put forward recommendations.

We've been very clear about the opportunity presented through the life sciences fund and the defence industrial strategy. There is $84 billion, if I'm recalling correctly, and we could utilize those dollars to implement a lot of the things in the recommendations that we're talking about.

We would like to designate insulin, glucagon and other essential diabetes therapies as critical medicines under a formal pharmaceutical sovereignty framework aligned with that strategy and that fund. Leverage the life sciences fund to provide capital investment for domestic insulin manufacturing. Establish public-private partnerships, with government providing strategic investment and guaranteed procurement, which is the same model that already works in defence and in critical minerals. Expand domestic fill-finish and active pharmaceutical ingredient capacity through targeted funding and regulatory support.

We would also like to see the creation of strategic reserves for essential diabetes medicines to buffer against supply disruptions and act as safeguards to protect Canadian supply from competing international demand.

Those are some of the recommendations we would like to bring forward.

● (1615)

Hon. Helena Jaczek: Thank you.

Ms. Donaldson, perhaps you could give us your top two recommendations. I have a feeling you may want to talk a bit about the critical, essential list and the framework. We've heard that a few times. Given your position and what you do, I imagine you have some expertise on that piece.

Christine Donaldson: You did hear me speak earlier about the data strategy, which I think is paramount to many of the other recommendations we have for building transparency and the national coordination of the data that we own.

You're absolutely right that we do not have the capacity to develop a fully sufficient pharmaceutical strategy in Canada. It is targeted. It needs to be a coordinated approach that envelops.... We use words such as “essential”, “critical” and “vulnerable”. Often a medication could be vulnerable just based on the fact that it is sole-source or that limited alternatives are available. We saw shortages with pediatric oncology medications. These are life-saving options and alternatives, but we often do not have good choices beyond first-line therapies. As a health care practitioner, I know the worst possible outcome is to know that there is a shortage that impacts my patients and that I have to go to a patient or caregiver and explain that there is a reason they cannot receive the very best medication for their need.

It's about the criticality and, layered onto that, the vulnerability. We really are getting down to the data piece that can help drive those discussions. Again, make sure the investments in those strategies are very focused.

Lastly, it's all about procurement and the strategies that we use, because again, price alone should not be the driving factor. We are proud that many of the contracts we have for Canada have sustainability, supply resilience and other factors built into the scoring capability so that we make sure that we have a diverse and more sustainable health care supply chain.

Hon. Helena Jaczek: Dr. Leclerc, you've talked already about funding. During our study on antimicrobial resistance, we heard about a push-pull mechanism as an incentive for companies to produce drugs here in Canada when the drugs are perhaps critical but are used only in small quantities. Do you have any comments in that regard?

Denis Leclerc: There is a big advantage for companies that are involved in this to profit from what is currently available at the university. The investment from Médicament Québec that we benefit from allows us to regroup ourselves and really focus on what the company needs. This is where we can make a difference.

Sometimes we don't need to develop a huge process. We can answer very specific questions as needed by a company producing these compounds, and it could allow us to produce a drug faster or more easily or accelerate its development.

The Chair: Thank you, Monsieur Leclerc. That's good.

We will now go to the next person on the list. It's Monsieur Blanchette-Joncas for the Bloc, for two and a half minutes.

[*Translation*]

Maxime Blanchette-Joncas: Thank you, Madam Chair.

Mr. Thibeault, you've explained clearly to everyone here that there is no domestic production of insulin in Canada. If we wanted to take concrete short-term steps toward pharmaceutical sovereignty, which medications should we prioritize for local production? Should insulin be one of the priorities?

Glenn Thibeault: Thank you for your question.

French is difficult for me, so I'll answer in English.

[*English*]

I absolutely believe that insulin and other vulnerable medications—my colleague and I use a lot of the same words—should be produced here in Canada.

How do you tell a small child that the process they're about to go through will lead to death? It means they're going to lose their vision. Their kidneys are going to fail. If they get a cut on their foot, that foot is going to turn into an abscess, which could then mean an amputation. That's all going to happen before they die.

I can't overemphasize it: Insulin is critical for people to survive. Right now, there are 60 to 100 people in this country who rely on animal insulin to survive, and the company in the U.K. started to say, “We're not going to be making that for you anymore.” That was a crisis for those people. We have a small resolution, but unfortunately we can't make it here in Canada yet, and I would like to see that changed.

● (1620)

[*Translation*]

Maxime Blanchette-Joncas: You mentioned the shortage in 2024. Can you explain the effects this had on certain people? We hope no one died as a result.

Glenn Thibeault: Thank you for the question.

[*English*]

In 2024, there was a shortage of injectable glucagon, which is used in extreme cases of hypoglycemia. That means someone who's going through DKA will crash, with all of the complications that come with that. When we had that shortage, Health Canada designated it as a tier three shortage. While we were searching for that, there was panic among the community, and understandably so.

We now get our supply from a company in the U.S. that provides the sole supply for the country. They have yet to meet the standards of having a DIN and using both official languages. It's extremely important. They're not meeting that, but they have us. We don't have any other supply—

The Chair: I'm sorry, but you're going well over time. Can you elaborate on that in the next question, please? I'm sure the next questioner will allow you to do that.

[*Translation*]

Maxime Blanchette-Joncas: Madam Chair, would it be possible to allow the witness to provide a written response? It's a rather complex question, and I think it would be important to have more details.

[*English*]

The Chair: Would you do that, please? Send it to the clerk, and we'll send it on to the members. Thank you very much.

I now go to the next person, who is Mr. Strauss, for five minutes.

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

Mr. Thibeault, it was unknown to me until your presentation that Canada, the land in which insulin was invented, currently doesn't manufacture any insulin. That's a pretty embarrassing fact. I'd like to dive into the root cause of that with you. I think there might be a hint in the second story you told, about animal insulin. Maybe 60 to 100 people in Canada can't tolerate anything else.

After you said that, I looked it up. There's a Globe and Mail article you're quoted in, so I imagine you've seen it. It describes how the former supplier of animal insulin in Canada has modernized by moving from providing it in vials to providing it in cartridges. Health Canada has required them to apply to get regulatory approval to deliver the same medicine in a different package.

Would you agree with me that this seems like something Health Canada maybe should have waived for the benefit of the 60 to 100 people who have been using that medicine for their whole lives?

Glenn Thibeault: There was a follow-up article about Wockhardt agreeing to work with Health Canada in addressing that issue. The good news is that we have a short-term solution.

On a broader scale, we need to start looking at these vulnerabilities and finding ways we can address them here locally. Unfortunately, there is still a lot of red tape, which, in government and politics, we talk about eliminating.

I would love to find ways to support people in getting the medicines they need. Health Canada has rules and regulations, and I understand that they need to follow those. We then have to start listening to the people who are.... This is their lives. There's one family that has a 14-year-old daughter. I know endocrinologists and others will say, “We can find something for you”, but how do you tell someone who lives in northern Saskatchewan who doesn't have an endocrinologist and doesn't have a doctor...? There's a bigger context that we need to discuss.

● (1625)

Matt Strauss: Something that was crazy to me in this story—and I read only the first article—is that Health Canada demands $50,000 to $300,000 as the application fee. The company has to provide the data to show that, yes, it's the same thing in a different package, and has to say, “Here's our $300,000 application fee for you to review our application.”

That seems extraordinary, almost crazy. Would you agree with that?

Glenn Thibeault: I'm sure there are rhymes and reasons that Health Canada has that in place, and we could maybe have that discussion in another study. What I'm happy about right now is that Health Canada did look at finding ways to waive all of those things to make sure that things could come into place.

Matt Strauss: The reason I bring it up is that when I've had drug makers in my office to talk about how we can manufacture more drugs in Canada, they've said that it is this regulatory process that chases them out, because if they have to put all of this money up just to get regulated to sell in Canada, they're not going to put the money up to manufacture in Canada. That's what I'm hearing from them.

I know you spent some time on the Hill as a member and that you were a parliamentarian in the Ontario legislature. Fundamentally, is it the Minister of Health who could waive these onerous red-tape types of things? Is it you, is it me or is it the Minister of Health who has carriage over these sorts of problems?

Glenn Thibeault: That was our next course of action in supporting these people. It was to bring this to the Minister of Health and ask for some assistance in getting this waived.

Very quickly, to your first question about insulin, we're looking at an overall picture, and we need to start looking at domestic supply and at making sure that we can do it here. I'm not able to follow the bouncing ball to answer how we eliminated it, but let's make sure that we bring it back and produce it here.

Matt Strauss: That's fantastic. I hope to hear from her on this topic as well.

Those are all my questions, Chair. Thank you.

The Chair: Thank you.

I'm now going to Ms. Chi for five minutes, please.

Maggie Chi (Don Valley North, Lib.): Thank you to all the witnesses who have come today to testify as part of this very important study.

My first question is for Ms. Donaldson. Thank you so much for coming.

I read online that your organization does procurement for medicine and equipment. You also mentioned that during COVID, our supply was exposed as a big vulnerability for our country.

From both perspectives—for medication and the supply of equipment—what are some of the good lessons and take-aways we have learned in working with partners, governments and hospitals that can help strengthen that chain? As well, what are some of the steps you've seen that have better prepared us for the next round—knock on wood—in case another COVID happens?

Christine Donaldson: You're right that there are many lessons learned through any type of risk to or any type of stress on our supply chain. What we've done is collaborate on a different level.

I think the national agenda has shifted. As a national organization, we work very closely with many provinces, as you said, on all kinds of critical supplies. Today, that could be a medication, but tomorrow it could be an OR product, a medical device. It's about understanding the true source of the issue, number one.

Number two is that as we start to collaborate, it's about understanding how to make things more predictable. We've heard about encouraging domestic suppliers. They need predictability, and this opportunity for us to band together as a national voice and bring our volumes to the market is critical for their sustainability, as well as for the demand forecast that I mentioned earlier. We need that planning. That's often why we run into these issues, even during non-critical and non-crisis time periods.

Those lessons learned can continue to serve us, but only when we have our national strength. Again, a national policy will help us to reinforce that agility and some of that resiliency, and, as we heard earlier, make it a faster and more streamlined process, particularly for the products at risk.

We're talking about pharmaceuticals here, but it can be any of those products as well.

Maggie Chi: On the procurement side, I imagine you probably deal with the regulatory process and the policies on that side quite a bit. As a federal government, we can concretely say that we can take steps now. What are the signals you've received that say there are some positive changes within the regulatory environment?

● (1630)

Christine Donaldson: The positive changes, I think, would be interacting on a coordinated approach. We recently had engagements with HERC, health emergency readiness Canada. It's still in its beginning days, but there's been quite a bit of excitement around that strategy to work with both the Public Health Agency of Canada and Health Canada and to take that forward in a more proactive approach than we have had in the past.

We have tremendous experience and history. We've been in this business for 30 years, so we have data that could help assist us through many of the ups and downs in the pressures within our fragile supply chain.

We are very keen to continue working with the federal government and all the stakeholders we represent. Our suppliers and the manufacturers out there are keen to understand. They really do want a little more stake in the future, and I think the risk perspective and the risk sharing have also shifted.

Maggie Chi: Thank you so much for that.

Mr. Thibeault, thank you so much for coming.

This is part of your core advocacy. As you mentioned, we invented insulin and played a big part in advancing GLP-1, and you mentioned that we don't produce either of those. It's Canadian IP, yet we don't make money off of it.

From your perspective, tell us a bit about what you see as the biggest gaps and what we can do to address those.

Glenn Thibeault: We can continue to talk about how we can work together as stakeholders, patient voices and Parliament to look at the types of policies that will ensure we're protecting people in Canada and ensure that they get the medicines they need.

There's an open invitation for everyone to come out to Peter's riding to see Banting House and see where it started, because it truly is important. We created it and we invented it. Let's make sure we start producing it here in Canada so that no Canadian will ever have to go without medicine that keeps them alive.

The Chair: Thank you very much.

I want to thank our witnesses for coming in and shedding a light on an essential and critical issue for our patients and our constituents in this country.

I also want to thank you for reminding us of our history with diabetes. We talked about Banting and Best, but we have forgotten a very important Nobel Prize winner from UBC, Michael Smith, who created synthetic insulin so that we didn't have to depend on beef and pork insulin.

We are a leader, especially in diabetes, but Canada has always been a leader in biomedical sciences. We've always done the R and D. We did it, and you're right that what we didn't do was take it to the next stage of manufacturing it ourselves, so we didn't make any money. We did the work; other people made money on it.

I want to flag one thing quickly. Two weeks ago, the Minister of Industry delivered money to a small company in my riding called Aspect. They have been able to 3-D print islets of Langerhans cells, and they can now insert them into a type 1 diabetes person at birth so they can make their own insulin. This is what Canada is doing.

I want to thank you for making us feel proud today to be Canadians. We as a committee should point to the next steps to make some money out of what we do and make sure, as you said, to look not just at affordability but also at availability as a core problem.

Thank you so very much for coming.

We will suspend until we get the next witnesses onboarded.

● (1630)

_____(Pause)_____

● (1640)

The Chair: I would like to resume the meeting. Thank you.

I would like to welcome the witnesses joining for the second hour. From BioCanRx, we have Stéphanie Michaud, president and chief executive officer. From the Canadian Association for Pharmacy Distribution Management, we have Angelique Berg and Simona Zar, senior vice-president. Then we have, from the Neighbourhood Pharmacy Association of Canada, Sandra Hanna, chief executive officer.

We have a very hybrid meeting today.

I just want to begin by welcoming you as witnesses. Also, I want to give you a bit of housekeeping.

There are two of you representing one group. You only have five minutes. You can split it, or you can decide who is going to do the presentation.

Each group has five minutes to present. I will give you a one-minute shout-out and a 30-second shout-out so that you can wrap up. If you don't think you got to say everything you wanted to say, there's going to be a question and answer session in which you will be able to expand. I'm sure the members sitting here will feed you questions so that you can expand on what you're trying to tell us.

We now begin with Stéphanie Michaud for five minutes, please.

● (1645)

[*Translation*]

Stéphanie Michaud (President and Chief Executive Officer, BioCanRx): Madam Chair, members of the committee, it's an honour to appear before you today.

I'm speaking in French to emphasize what's already at the heart of my approach, namely that pharmaceutical sovereignty is also a country's ability to tell its own scientific story and to write its next chapter.

I'll continue my remarks in English.

[*English*]

My name is Stéphanie Michaud, and I'm the president and CEO of BioCanRx, Canada's immunotherapy network, a federally funded organization that has spent the past decade doing something that Canada does not do nearly enough: taking world-class Canadian cancer research and turning it into actual therapies for actual patients.

I want to use my five minutes to challenge one assumption embedded in how the study is framed. I say this with respect, because I believe it matters enormously for the recommendations this committee will make.

Pharmaceutical sovereignty is most often discussed as a supply chain problem: How do we ensure Canadians can access medicines when global supply is disrupted? That framing accepts as a starting condition that Canada will continue to depend on therapies created elsewhere. The deeper question, the one this committee has an opportunity to address, is this: Why isn't Canada creating more of those therapies itself?

Between 2002 and March 2026, only 3.4% of cancer immunotherapy clinical trials conducted in Canada were based on made-in-Canada innovations. Canada is the only G7 country without a domestic pharmaceutical company producing novel medicines. It's not because our science is weak—it is world-class—but because we have built a federal funding and governance system that is very good at funding the first chapter of a discovery, and then stops.

In December 2025, BioCanRx commissioned the Institute on Governance to benchmark Canada's translational ecosystem against that of six peer countries. The finding was unambiguous: Canada's underperformance is not a science gap; it's a governance gap.

Advanced therapies—the cell and gene therapies that represent the next generation of cancer treatment and, increasingly, treatment for metabolic and other diseases—fall structurally between federal mandates. The work required to move a Canadian discovery to a clinical trial—the GMP value manufacturing, the toxicology studies, the regulatory dossier—is too applied for federal health research funding and too risky for private capital. It falls into a gap, and nothing catches it.

We lived this problem directly. In 2023 and 2024 federal clinical trial competitions, three BioCanRx projects were selected for funding and could not proceed. They could not file a clinical trial application to Health Canada because the regulatory preparation work had never been funded. These projects sat idle for more than a year, and there was no federal mechanism designed to bridge the gap.

We stepped in as an organization due to our funding in the strategic science fund. One of those projects has now opened a clinical trial offering a CAR T therapy to both pediatric and adult blood cancer patients, a therapy that has not existed in Canada before.

About two weeks ago, the Government of Canada announced a $280-million commitment to support Aspect Biosystems, a Vancouver company developing bioengineered cellular medicines targeting diseases, including type 1 diabetes. That is exactly the model Canada should be building. It's Canadian science and Canadian manufacturing integrated with global expertise, but it is remarkable precisely because it is rare.

BioCanRx is asking this committee for three things.

First, redesign the scope of the study. Pharmaceutical sovereignty must mean the capacity to create novel therapies, not only to secure supply of existing ones.

Second, fill the structural gap. Canada needs a permanent milestone-driven translational health research program that funds the work currently falling between mandates, including the regulatory preparation that federal clinical trial funding currently leaves unfunded. CIHR should not fund a trial that cannot proceed. The IOG has made this recommendation, and we are here to reinforce it.

Third, publish a strategy with real accountability: a framework with milestones aligned across Health Canada, ISED and federal research bodies, and a coordination mechanism so that Canadian innovators are not navigating this alone. The committee's task is to make success the system, not the exception.

Canada discovered insulin. Researchers trained at the University of Alberta pioneered the science behind CAR T-cell therapy. Canadian science is not the problem. The problem is that we continue to invest heavily in the first chapters and leave the rest unfunded. The result is that Canadians with cancer are accessing therapies created from Canadian science in other countries' clinical trials and manufactured in other countries' facilities. That is not sovereignty.

I'm asking this committee to help us build this.

Thank you. I welcome your questions.

● (1650)

The Chair: Thank you very much. That was well within the five minutes.

I now go to the Canadian Association for Pharmacy Distribution Management.

Ms. Berg is going to be the speaker.

You have five minutes, please, Ms. Berg.

Angelique Berg (President and Chief Executive Officer, Canadian Association for Pharmacy Distribution Management): Thank you, Madam Chair.

Thank you to the members of the committee for the opportunity to appear today.

My name is Angelique Berg, and my colleague, Simona Zar, and I appear on behalf of the Canadian Association for Pharmacy Distribution Management. We represent Canada's pharmaceutical distributors, which deliver the majority of medicines across the country to community pharmacies, hospitals and other points of care. With their trading partners, they represent the actors in the supply chain that actually touch the product. The theoretical hits the road in this supply chain.

We believe that the pharmaceutical sovereignty strategy requires a solid understanding of that supply chain, domestically and globally, to anticipate the impact of decisions on Canadians' access to medications. We are pleased to be at your service, and we commend this initiative.

For those who are unfamiliar, pharmaceutical distributors play a critical role in medicine supply. They streamline orders and deliveries between hundreds of manufacturers and over 12,000 points of dispensing. They manage thousands of products, from the most shelf-stable to the most sensitive across therapeutic categories. They hold buffer inventory to absorb shocks. They resolve most disruptions and shortages—if you can imagine—before the patients feel them. They operate in a stringently regulated environment. They serve Canadians in every province and territory, from downtown centres to remote communities, across all kinds of geography and in any weather.

Distributors connect policy to delivery. Distributors ensure physical access to medications. From their position in the middle of the domestic supply chain, they have a national, system-wide vantage point up and down the supply chain in Canada. This affords a view of pressures and opportunities that can help inform the pharmaceutical sovereignty strategy.

Based on that experience and that viewpoint, we offer three recommendations for the committee's consideration.

First, the strategy can view the domestic supply chain as a vital, enabling system, and it is. Policy decisions on pricing, procurement and manufacturing can be strengthened by including consideration of the cost of physical access to medicines. This is especially important for remote and rural communities. I'll give you an illustration. The average distribution funding for a bottle of a cardiovascular protective agent—let's say, atorvastatin—is less than the price of a postage stamp, regardless of whether it is delivered to downtown Ottawa or Moosonee.

There is also great opportunity for public-private collaboration. This could include partnerships on reimagined vaccine distribution and strategic stockpiling initiatives, leveraging not only the formidable existing infrastructure, but also the supply chain's vast expertise.

Second, domestic manufacturing incentives can focus on reducing cost, risk and time to market, with a close eye on the buy Canadian initiative to guard against worsening shortages before things get better. Strategic incentives behind the scenes that enable all of the pharmaceutical supply chain, such as regulatory and licensing streamlining, faster Health Canada approvals and quicker public drug plan approvals, can improve resilience without losing alternative suppliers that are critical in our transition.

Third, Canada imports roughly 70% of its medicines, and new manufacturing facilities can take years to build, so we need a starting point that preserves patient access, as other witnesses mentioned. Canada can focus domestic manufacturing on a targeted short list of imported critical medicines whose interruption poses serious risks to patient health and whose shortages are already common. There are existing, credible resources that offer a good start, including Health Canada's critical and vulnerable drug list.

We see an immense opportunity here for Canada. The pharmaceutical supply chain is a strong, critical part of the enabling support systems for the strategy, and there's a strong foundation in place. We are committed to working collaboratively with government and partners across the system to build on it.

Thank you for the opportunity to share our perspective.

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

I now go to the Neighbourhood Pharmacy Association of Canada and Ms. Hanna, chief executive officer.

You have five minutes, please, Ms. Hanna.

Sandra Hanna (Chief Executive Officer, Neighbourhood Pharmacy Association of Canada): Thank you, Madam Chair and honourable members of the committee, for the opportunity to speak with you today.

My name is Sandra Hanna. I'm the CEO of the Neighbourhood Pharmacy Association of Canada. I'm also a third-generation practising pharmacist and the former owner of an independent pharmacy, where I worked directly with patients and Canadians to manage medication access and continuity of care.

The Neighbourhood Pharmacy Association represents the delivery of care through more than 12,000 pharmacies across Canada, including independent, chain and specialty pharmacies, as well as those in grocery and mass merchandisers. About 95% of Canadians live within five kilometres of a pharmacy. They are Canadians' most frequent and often first and last point of contact with the health care system.

We describe pharmaceutical sovereignty as ensuring a stable and secure supply of medicines for Canada, and that is critical, but from a pharmacy standpoint, sovereignty has to also include and be measured by whether the supply actually reaches patients, because only then do we achieve true access. Access cannot be defined by manufacturing, procurement, funding and coverage alone. It depends on the infrastructure that reliably delivers medicines to patients. That infrastructure is the pharmacy sector, where patients find out whether their medications are available, delayed, substituted or rationed, and where upstream disruptions become real and can cause harm.

In a globally integrated and increasingly unstable environment, pharmaceutical supply is a matter of national security, and pressures are felt most directly at the point of care. Pharmacies are a stabilizing layer of the system when disruptions occur. Pharmacies manage shortages in real time, work with prescribers to adjust therapies, source alternatives, manage inventory to protect the most vulnerable patients and support adherence when disruptions inevitably occur.

In many cases, patients remain on therapy not because the system is completely stable, but because pharmacies are actively stabilizing it alongside distributors, yet this role is not fully reflected in how pharmaceutical policy is designed. We often treat Canada's pharmaceutical supply as though it was centrally managed. In reality, it is fragmented and price-driven.

Medicines flow through manufacturers, wholesalers, group purchasing organizations and pharmacies, with public and private payers shaping demand. At the same time, global pressures are increasing fragility. Manufacturing is centralized in fewer regions, active pharmaceutical ingredient production relies on a limited number of suppliers and geopolitical uncertainty is growing.

Pharmacies sit at the end of this chain. We don't directly control supply, but we are accountable for ensuring that every Canadian receives the medications they need. We use real-time data, understand local demand and continuously adjust inventory to maintain access. We are often the first to see signs of strain, including demand spikes, sourcing challenges and early ripple effects from global disruptions. This is a critical and often invisible part of the system working at its best, yet these insights are not systematically used in national policy, planning or response.

Pharmacies must be a part of the design of an integrated, system-level solution that leverages real-time insights across the full supply chain. These are not individual business tools, but rather coordinated system infrastructure. If pharmaceutical sovereignty is about resilience, pharmacy-level insights must be part of the core system infrastructure. The last mile matters.

Pharmacies are also a core part of Canada's life sciences ecosystem. We operationalize new therapies, support appropriate use and contribute to postmarket monitoring by identifying early issues with new medicines. Despite this, pharmacies are rarely included in pharmaceutical policy or strategy discussions. If Canada is serious about pharmaceutical sovereignty, a whole-system approach must include the delivery layer where access is actually realized.

In closing, I have a few considerations for the committee. In addition to reinforcing domestic manufacturing and redundancies for critical medicines, as others have noted, we encourage you to think a bit more broadly.

First, recognize pharmacies as critical health care infrastructure and include us early and often in pharmaceutical policy, pricing and strategy discussions. Second, improve supply chain visibility, including at the pharmacy level, to build a more integrated and responsive system. Third and last, enable flexibility for pharmacists to manage shortages through therapeutic substitution across all medicines, supported by federal recognition of pharmacists as practitioners.

Pharmaceutical sovereignty and, increasingly, national security are about ensuring that Canadians have uninterrupted access to the medicines they need, and pharmacies are on the front line of that responsibility. We look forward to supporting this work with real-time insights from the front lines and contributing to a system that is reliable, sustainable and responsive to the needs of Canadians.

● (1655)

Thank you.

● (1700)

The Chair: Thank you, Ms. Hanna.

Now we're going to the question and answer session. It starts with six minutes, and the six minutes include the questions and answers.

I'll begin with Mr. Strauss for the Conservatives for six minutes.

Matt Strauss: Thank you, Chair. Could you kindly let me know when I have one minute left on your clock?

The Chair: I will let you know when you have one minute and 30 seconds.

Matt Strauss: Thank you.

Ms. Hanna, thank you for that introduction to your organization and the importance of pharmacies as the last mile of pharmaceutical sovereignty, as you described it.

Our committee has taken an interest in the e-prescription program that the federal government has funded to the tune of $300 million so far, called PrescribeIT. Were you or members of your organization using that program? Was it working successfully?

Sandra Hanna: Yes. Many of our members were using the program and were signed on to the program. I, personally, was also using the program. It was an important tool, yes.

Matt Strauss: Would you say it was contributing to Canada's pharmaceutical sovereignty in that sense?

Sandra Hanna: It was contributing, certainly. It was the right idea. It was certainly the right direction. Unfortunately, we didn't see the uptake that we would have hoped to see with this type of program.

Matt Strauss: Were you paying to use the program?

Sandra Hanna: Towards the end, we were. It was originally funded federally. Towards the end, when federal funding was ceased, funding was moved over to pharmacies with the new model for PrescribeIT.

Matt Strauss: Do you know to whom those funds were flowing?

Sandra Hanna: I can't say for sure. Pharmacies were invoiced by PrescribeIT for a transaction fee.

Matt Strauss: Do you know how much that transaction fee was?

Sandra Hanna: It was 20¢ per transaction.

● (1705)

Matt Strauss: Was this sustainable, in your view or in the view of your members?

Sandra Hanna: The unfortunate thing is that we view PrescribeIT as critical, foundational system infrastructure, not as an operational tool for pharmacies. E-prescribing is a critical tool that delivers value in terms of safety, efficiency and visibility across the system. This is health system infrastructure.

Pharmacies were disappointed by the decision to make them the only funders of a system that benefited so many different stakeholders, including the government, patients, other health systems and other health care providers. I think there were opportunities to rethink that model for more value.

Matt Strauss: Department officials from Health Canada explained that they made the decision at some point to kill the program. They set some time period because they wanted to give physicians and pharmacists time to pivot to whatever was coming next.

Do you know what's coming next? I understand that the program is wrapping up in six weeks.

Sandra Hanna: We understand that standards will be published, but we haven't been privy to any specifics in terms of what is next.

Matt Strauss: Do you imagine that you'll be able to adopt those standards for e-prescribing six weeks from now, not knowing what they are?

Sandra Hanna: I can't really comment. I'm not a technical expert.

To my knowledge, there aren't any currently available tools that could immediately sweep in, according to those standards, and be leveraged easily, efficiently and in a streamlined way by health care providers in this system today.

Matt Strauss: We spoke with a family physician in St. Thomas, Ontario. His name is Dr. Bolzon. He's been quoted in the CBC about this as well. He and his practice partners, as well as other family physician friends of mine who have been using PrescribeIT, are expressing frustration. They feel like the rug has been pulled out from under them.

Does the expression of the rug being pulled out from under you resonate with you? Is that something you or your members might say about this?

Sandra Hanna: There was some frustration for the pharmacy sector for some time towards the end when the funding model shifted to pharmacies being expected to cover the cost of the full program.

The way we view it is that electronic prescribing is not just a nice-to-have; it's core health system infrastructure. Today, our health care system really relies on faxes, which limits safety, efficiency and visibility across the system. As we think about pharmaceutical sovereignty, tools like e-prescribing are not just about convenience. They're foundational to the kind of data visibility and interoperability we need to manage drug supply, anticipate shortages and respond to disruptions in real time. We don't have that today.

Perhaps the tool was treated as an operational tool. There are other opportunities for us to be thinking about tools like this more as system infrastructure.

Matt Strauss: You mentioned faxes and how they're still very much used in health care.

The Chair: You have one minute.

Matt Strauss: PrescribeIT was brought in 10 years ago under the slogan “axe the fax”, which sounds familiar, but we still have faxes. Would you say “axe the fax” turned out to be an empty slogan?

Sandra Hanna: I still have hope.

Matt Strauss: Very good.

I'd like to turn my time over to Mr. Mazier.

Dan Mazier (Riding Mountain, CPC): I'm good.

Matt Strauss: You're good. I feel like I finished on the highest note I'm going to hit.

To wrap up, it seems to me that “axe the fax” sounds like an empty, rhyming, three-word slogan that the Liberal government used when spending $300 million on a program that was not fit for service, because physicians didn't adopt it. Even though pharmacists found it extremely critical and part of Canada's pharmaceutical sovereignty, the government has now put a bullet in the head of the program and pulled the rug out from under the prescribers and the pharmacists who were using it. I can't believe it's putting another $50 million into Canada Health Infoway—

The Chair: Thank you, Mr. Strauss.

Is that “axe the fax” or “axe the tax”? Which is it?

Matt Strauss: This is “axe the fax”.

The Chair: Okay. I'm sorry.

Ms. Sidhu, you have six minutes.

Sonia Sidhu: Thank you, Madam Chair.

Thank you to all the witnesses for your testimony.

My first question is for BioCanRx.

Clinical trials are often the first pathway for patients to access innovative therapies. In your view, how can modernizing Canada's clinical trials framework improve patients' access while also strengthening our domestic life sciences ecosystem?

Stéphanie Michaud: Thank you so much for this question. It's an excellent question.

Being able to execute clinical trials is absolutely critical for providing early access to novel therapies for patients in a variety of different disease areas. What is equally important, however, is to ensure that we support the pathway from the discovery of an exciting new and novel therapy to getting it to a clinical trial.

Most of the molecules and products that we're looking at are known as biologics. They can be viruses, they can be antibodies or they can be modified cellular therapies. Building up the regulatory dossier, especially for a first-in-human study, is the key to entry in delivering a clinical trial here in Canada. This is what my organization is involved in. We're supporting that bench-to-bedside translation to really increase the number of clinical trials in Canada and to increase access of those clinical trials to as many cancer patients in Canada as possible.

Ensuring that we have bench-to-bedside translational support that involves the coordination of biomanufacturing and that really enables our companies and our innovators to build up a regulatory dossier so they're able to knock on the door of Health Canada with a clinical trial application is the critical first step and a necessary condition to being able to execute a clinical trial in this country.

Sonia Sidhu: From a pharmaceutical sovereignty perspective, what steps are needed to ensure that publicly funded research leads to both improved patient outcomes and long-term economic benefits in Canada?

Stéphanie Michaud: I would underscore the importance of being able to support translational research. Some of the statistics I cited in my opening remarks are quite stark.

We carried out a retrospective analysis over the time period from 2002 to March 2026 using a publicly available database, inquiring how many cancer immunotherapy trials had taken place in Canada. The number was well over 1,000, which situates us well, because we're able to attract quite a few pharmaceutical company trials in the country. When we further analyzed that dataset and asked how many of these were based on Canadian innovation, the numbers were quite stark: 3.4%, or approximately 50, over a 24-year period, which is a very poor performance.

BioCanRx has been in existence since 2015. We're responsible for half of those clinical trials, including very sophisticated, advanced therapeutics, such as CAR Ts and tumour-infiltrating lymphocytes, which we're currently delivering across the country.

● (1710)

Sonia Sidhu: My last question follows up on that. After clinical trials, what advice can BioCanRx give to help us be self-sufficient in our country in domestic manufacturing?

Stéphanie Michaud: An initiative that we have focused on at BioCanRx is to examine what hospital-based manufacturing could look like—point-of-care manufacturing where the different products are being made in a closed system that is entirely GMP on the inside. This will require regulatory innovation from our regulators, and this is something we're actively engaging with them on.

This is not at all about lowering the bar of the safety and quality of the products we're making. It's about looking at different and alternative ways of making these products.

Being able to manufacture here in Canada increases the stickiness—if I can call it that—of these types of products. We work with a lot of companies, both large and small companies, but speaking specifically about the smaller Canadian companies, being able to manufacture here and access the expertise of our clinicians is critical to enhancing the capability of these companies to stay here, to continue to develop their products in Canada and to hopefully be able to secure supply in a pharmaceutical sovereignty strategy.

Sonia Sidhu: What are the main barriers to staying for those small companies and big companies? Is there any difference?

Stéphanie Michaud: A large part is investment. It is also about understanding that we need to have the right business conditions in order to support our companies. It means having different types of regulatory support as well.

We commissioned a study at the end of December that looks at governance and the gap of translation that exists in Canada. There really is a need for our innovators and our companies to more readily access Health Canada, for example. One of the recommendations we made in that study is a concierge service where assistance is provided to innovators to provide them with guidance on how to navigate the regulatory ecosystem at Health Canada and the CDA, ultimately to ensure that their products are sold here.

The Chair: Thank you very much.

You have 18 seconds, Ms. Sidhu. Do you have a wrap-up word? No. Thank you.

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

[*Translation*]

Maxime Blanchette-Joncas: I welcome the witnesses who are joining us for the second hour of the hearing.

Ms. Michaud, I'll start with you. You mention that only 4% of immunotherapy clinical trials in Canada are based on innovation developed here. Is this an indicator that research isn't necessarily the problem, but rather, our inability to fund the transition to clinical trials?

Stéphanie Michaud: That's exactly right. When we coordinate bioproduction, along with the investment in the regulatory dossier required to submit a clinical trial application to Health Canada, that's where we're able to support these clinical outcomes. So it's absolutely essential, and it requires funding.

In fact, this type of funding isn't currently managed very well. That's why BioCanRx was created in 2015. It was created to bridge what is known as “the valley of death” that exists between discovery and these early-stage clinical trials, such as phase 1 and phase 1/2 trials.

Maxime Blanchette-Joncas: Thank you.

Speaking of funding, your organization waited nearly two years to receive a response from the strategic science fund. You're now facing a confirmed reduction in funding.

I'd like you to explain the concrete impact this instability or suspension of funding has had on your ability to plan clinical trials, as well as to retain your teams.

Stéphanie Michaud: It hasn't been negotiated yet, nor have we received the agreement. We did, of course, receive a letter from the government informing us that our funding has been reduced by $860,000, which is a very significant amount for us.

At this time, the number of people on my team remains unchanged, and there will be no new hires.

However, we're definitely launching a new competition soon. Here's our plan. For the projects that will enter our therapeutic product pipeline, of which there are several and of different types, we'll likely have to cut one of the programs responsible for introducing new products into our pipeline. Of course, the goal is always to reach a clinical trial.

This will therefore have an impact on the support we're able to provide to our scientific community and the physicians we work with. Ultimately, it could also affect patients who, we hope, will receive these different types of products in the future.

● (1715)

Maxime Blanchette-Joncas: Thank you.

You mentioned a structurally underfunded transnational capacity. Earlier, you spoke of the “valley of death”. At this stage, is Canada losing its innovations, intellectual property and economic benefits?

Stéphanie Michaud: The very short answer is yes.

It has a major impact. If we look at the investment stages of large companies, for example, we see that investments tend to occur after a phase 1 clinical trial.

If, in the end, we remain at the publication stage, or even the patent stage, and are unable to develop the necessary regulatory dossier required to knock on Health Canada's door, then there will most certainly be no clinical trials. This is what we observed while we were waiting for our funding from the strategic science fund. We had run out of money and were funded through the networks of centres of excellence program.

We asked that other funding sources be considered for our projects, and this was a resounding success. All three of our projects were funded at 100%. We weren't surprised, because these are excellent, well-developed projects. However, what those projects obtained was funding for clinical trials. We weren't able to submit an application to Health Canada for a clinical trial because there wasn't enough money to complete the studies required to meet Health Canada's expectations.

What happens as a result is that these funds remain frozen in the system, the clinical trial never gets off the ground, and patients don't receive treatment.

For example, one of these three projects is currently in a clinical trial. We're treating children and adults, very ill patients who have undergone multiple treatments. This is their last-line treatment.

When we talk about translational research, in our case, and especially in the field of cancer, we're talking about patients, we're talking about lives.

Maxime Blanchette-Joncas: Since we're discussing essential matters, BioCanRx's track record shows that every dollar invested generates $3.70 in partner contributions.

In your opinion, is this an expense or a strategic investment?

Stéphanie Michaud: It is an absolutely strategic investment.

Maxime Blanchette-Joncas: Can we talk about pharmaceutical sovereignty in Canada if Canada funds discovery, but doesn't sufficiently support development through to clinical trials and to the patient, in particular?

Stéphanie Michaud: Absolutely. I believe we have clearly demonstrated at BioCanRx what can be achieved when biomanufacturing is coordinated with the support required to submit clinical trial applications to Health Canada. We're seeing a huge increase in the number of clinical trials involving highly advanced therapies—new therapies that aren't yet available. This is new for Canada. First, our cancer patients need them. Second, they help drive investment in research in Canada. Third, they deserve it.

Maxime Blanchette-Joncas: What's the most fundamental measure the government should implement immediately?

Stéphanie Michaud: It should implement a coordinated funding approach that recognizes that translational research currently falls between Health Canada and Innovation, Science and Economic Development, or ISED. We really need coordination. We need to see, as in our case, the impact that funding cuts can have in the end. This is a program led by ISED—

[*English*]

The Chair: Ms. Michaud, you have gone over time. I'm sorry. Thank you very much. Maybe you can elaborate in the next round.

[*Translation*]

Maxime Blanchette-Joncas: Madam Chair, if possible, I'd like to ask Ms. Michaud to provide us with a written response so that it is complete.

[*English*]

The Chair: Ms. Michaud, please send your response in writing to the clerk, and she will distribute it to everyone else.

Now we'll move to the second round. It's a five-minute round.

We'll begin with Mr. Mazier from the Conservatives for five minutes.

Dan Mazier: Thank you, Chair.

Thank you to the witnesses for coming here today.

I'd like to follow up on Dr. Strauss's comments about PrescribeIT.

It's quite frustrating, actually. I don't know if the witnesses are aware that we discussed the program here last Tuesday. We had the CEO of Canada Health Infoway here, and he went about not answering any of our questions. Even the chair got into it, trying to get information about what was spent and where the money went. I am a Canadian taxpayer. I think everybody was quite shocked at how hesitant they were to reveal where the $300 million went.

This was $300 million for a program that went to a volunteer organization. It was just to "axe the fax" and try to get some streamlining going. They had nine years to figure it out. Then they turned around at the very end of it—Health Canada and Canada Health Infoway—and decided they were going to start charging pharmacies because the money was up. The government, I guess, and Health Canada had had enough, so they turned around and started charging you guys, which is absolutely insane. That $300 million has gone away. It is a program that didn't work.

For that reason, I would like to move to resume debate on my motion for the production of documents about PrescribeIT.

● (1720)

The Chair: Thank you.

We now have a motion on the floor that was distributed at the last meeting. I will open debate on this. I will not ask the witnesses to leave just yet, because I don't know whether this is going to be quick and dirty or not.

Ms. Chi.

Maggie Chi: What just happened?

The Chair: We're going to debate this motion, so I'm entertaining a list.

Maggie Chi: Can we pause or suspend for a quick moment?

The Chair: Would you like to suspend?

Some hon. members: Yes.

The Chair: We'll suspend.

● (1721)

_____(Pause)_____

● (1724)

The Chair: We'll resume.

By the way, for the information of the committee, the rules suggest that if there is a motion to resume debate on a motion that's already been tabled, there is no debate on whether that motion should be accepted or not. It automatically begins to be debated.

Dan Mazier: I have a point of order. I think the clerk is trying to explain—

The Chair: Mr. Mazier, I just read it in the regulations. Thank you.

Go ahead, Mr. Fragiskatos.

Peter Fragiskatos (London Centre, Lib.): Thank you, Madam Chair.

Obviously, I'm not a full member of this committee. I'm substituting today. I'll ask for colleagues' indulgence.

I understand that Mr. Mazier has put forward a motion to resume debate on a motion that was already being discussed. What's that regarding?

● (1725)

The Chair: I think everyone has the motion. I will read it, as the chair, for the record. The motion reads:

> That the committee order the production of the following documents, unredacted, for the period from 2016 to the present:
>
> a. Contribution agreements concluded with Canada Health Infoway relating to PrescribeIT.
>
> b. A record of the intellectual property developed under PrescribeIT, including the entity that holds the rights and the general terms of use, licensing or transfer.
>
> c. Annual adoption data, broken down by province.
>
> d. The total revenue generated from the 20¢ per-prescription fee.
>
> e. Viability analyses and program evaluations.
>
> f. Documents that led to the decision to terminate the program, including recommendations and analyses provided to Health Canada and to the minister, where applicable.
>
> g. A list of the principal vendors involved in the program, including amounts paid to each.
>
> h. Documents and analyses related to the costs of terminating the program, including contractual obligations, penalties and transition costs.
>
> That these documents be provided by Health Canada and Canada Health Infoway, in accordance with their respective responsibilities, and deposited with the clerk of the committee within one week of the adoption of this motion.
>
> That any redactions be limited to commercially confidential information and that a summary of redacted content and the reasons for such redactions be provided.

This is what we're debating.

Peter Fragiskatos: I understand, Madam Chair, that if there is no unanimous consent to resume, we would go to a vote to decide that. This is not about the main motion. As I understand it, Mr. Mazier is asking the committee to resume debate.

The Chair: Yes.

Peter Fragiskatos: In other words, if there's no unanimous consent—and I don't believe there is—we would be voting on whether or not to resume debate.

The Chair: I'm going to read out the rule regarding the reintroduction of a motion that has already been put before the committee.

The rule states, “The motion to resume consideration of a motion is a non-debatable motion”. We cannot discuss whether we are going to resume it or not. It is now automatically resumed. The rule continues: “it has the same effect as a motion to proceed to another order of business. See, for example, Standing Committee on Health, Evidence, May 2, 2023, Meeting No. 65”.

We're not discussing whether the motion should be tabled. We're now discussing the actual motion.

Helena Konanz: Could I have clarification, Chair? Did you read that there is no vote?

The Chair: No. It came off the Order Paper because we adjourned the meeting. It's now being resumed. It automatically does not need to be debated.

The motion itself is on the floor. I just read it. I don't know if you want me to read it again, guys. Are you serious? It's a simple sentence. Do I need to read it again? I will.

We are not voting on whether to adopt the motion. That's what this rule says. We're just going to debate the motion. If you don't want to debate the motion, we can just vote on the motion as tabled.

Peter Fragiskatos: Madam Chair, are you opening up a debate on the motion to resume debating the motion?

The Chair: There is no debate on a motion to resume debate. It's non-debatable, as I just read. You are now debating the actual motion—or amending it or doing whatever you want to do with it.

Peter Fragiskatos: We're not giving unanimous consent to debate.

I would suggest that we go to a vote on Mr. Mazier's motion to resume debate.

● (1730)

The Chair: If you want to vote without debating this.... He made a non-debatable motion to resume debate on a motion already tabled, and that's non-debatable. Whether or not to resume debate is non-debatable.

Shall I read the rule again so the committee understands it?

Peter Fragiskatos: No. Our hands are up.

The Chair: Okay. We're debating the motion on the table.

Do I have—

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

The Chair: Yes, Ms. Chi.

Maggie Chi: You mentioned that it's not debatable. What does the green book say? I'm just curious about all dilatory motions. Do dilatory motions require a vote?

The Chair: This is not a dilatory motion. This is just a motion.

Can I read the rule again, guys? It's pretty clear. It is not debatable. If a member asks to resume a motion that was already tabled by the committee, whether to resume it or not is not debatable. It is automatically accepted.

We're debating the actual motion.

Dan Mazier: What this means is that we go directly to a vote.

The Chair: Exactly. If you want to vote on whether you want to accept it, we don't debate it. You just say, “I don't accept this motion coming to the table”, and we get a vote. If “I don't accept” wins, then the motion is gone. If you say, “I accept”, the motion stays. It's that easy. You don't debate it. You just say, “I don't accept this motion being put back on the table”, but the reason you don't accept it is not debatable.

In other words, I'm asking if everybody agrees with this motion. I'm seeking unanimous consent. If it's not there, do you want to go to a vote on whether the motion should be tabled again?

Do you agree to the motion being placed on the Order Paper again?

An hon. member: I don't.

The Chair: You don't, so let's call a vote.

I do not have unanimous consent to have this motion resumed—

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

I think there is some confusion. Are we voting on the resumption of debate? We are not voting on the motion. There is some suggestion on the other side that we are voting on the motion. I just want to clarify that.

The Chair: Whether the motion comes back or not is not debatable. You just go, “I don't agree.” You don't have to debate the reasons why. That's what is meant by “debatable” and “non-debatable”. If you don't want the motion, you can just say so. That's simply what I'm asking.

I don't have unanimous consent to place this motion back on the Order Paper. Because I do not have unanimous consent, do you wish to have a recorded vote, or do you just want to say whether the motion is passed or not passed?

An hon. member: Vote.

The Chair: We'll have a vote.

The Clerk of the Committee (Catherine Ngando Edimo): The vote is to resume debate on the motion.

(Motion agreed to: yeas 5; nays 4)

● (1735)

Helena Konanz: I had my hand up first.

Maggie Chi: No, I put my hand up first.

The Chair: What are you putting your hand up for? Is it for a point of order, Ms. Chi?

Maggie Chi: I have a point of order. My hand was up first.

The Chair: We have to read out the result of the vote first.

Helena Konanz: I put my hand up first.

The Chair: I didn't see your hand.

Look, guys, stop doing this. We're not in school.

I have a list of people, and I am about to read the result of a vote that was just taken by this committee. I will do that, and then I will entertain the discussion.

I will read out the vote. There were five yeas and four nays. The motion to resume debate is carried.

On the list I have Ms. Chi, Ms. Konanz and Ms. Sidhu.

Ms. Chi.

Maggie Chi: Thank you, and thank you to all the witnesses.

Unfortunately, I have a couple of questions for BioCanRx that couldn't be answered, given the disruption—

Burton Bailey: I have a point of order, Chair.

Maggie Chi: —by the motion that was placed on the table. I thought it was dealt with last time, and that's why we resumed the pharmaceutical sovereignty study.

Some hon. members: Oh, oh!

The Chair: Order, please.

A member is speaking. The member should get to finish what she is saying. She's raising a point of order. I cannot determine whether it's a valid point of order until I finish hearing what she has to say.

Continue, Ms. Chi.

Maggie Chi: It's very unfortunate, because it's a Liberal study that we placed on the agenda in September. Due to various reasons, we weren't able to get to our study. We've been very collaborative, giving Conservatives the first study and giving the second study to the Bloc.

It's been almost a year and we've just reached the Liberal study. This is only our third meeting. When we started the study, it was interrupted by various topics. Despite whatever is being brought up, there should be a level of respect to complete the Liberal study before we delve into the other topics.

I feel we've given a level of respect to the Conservatives and the Bloc. We finished the study. We added meetings to the Conservative study. We've been very collaborative, so this is actually very disappointing. I feel bad, because we have witnesses online and in person today and we aren't able to proceed.

Dan Mazier: I have a point of order on that.

The Chair: The member is speaking to her point of order, Mr. Mazier. It's not up to you to decide whether it's a point of order or not. The chair makes that decision. I cannot make a decision until I hear what Ms. Chi has to say. Can we be respectful of each other, please? I have your name down on the roster to speak later on.

Continue, Ms. Chi.

Maggie Chi: Thank you, Chair.

I want to express how frustrating this is. We're trying to complete the pharmaceutical sovereignty study, and I feel bad for the witnesses.

This is not the first time this has happened. Even now, I'm being interrupted as a member. It's something I really want to raise, because this is a pattern I've noticed at our committee. We are unable to get through our Liberal study, for whatever intent and purpose the other side has.

I implore members to let us complete our Liberal study. It would be great if we could. We've given everybody around the table respect regarding their studies. I only ask that the same respect be given to our study.

I believe this is a very important study. We've heard from witnesses about the shortages—

Helena Konanz: Chair, I have a point of order. I don't think this—

The Chair: Ms. Konanz, a member has the floor.

Helena Konanz: They're not respecting your time.

The Chair: This is a point of order.

Helena Konanz: They're taking advantage of your time.

The Chair: Ms. Konanz, can I finish what I'm saying, please?

The point of this meeting was to discuss pharmaceutical sovereignty. We have witnesses who came to do that. We have now moved off that order of the day and onto this motion, so she's speaking to the order of the day. She's saying it's a pity that we've moved off the order of this meeting and onto something else. She's allowed to do that, and she has not finished speaking. I would ask you to please allow her to finish speaking. Thank you.

Helena Konanz: She's not respecting your time.

The Chair: Go ahead, Ms. Chi.

Maggie Chi: I think the chair can be the judge of that.

Thank you, Chair.

We've heard, even during the three short meetings that were dedicated to this study, about the challenges and some of the opportunities within this topic. We saw during COVID all the shortages that were brought upon our nation, the resilience of our nation and how people came together. That was not without challenges, but we came together.

Do we want to be in the same situation again? I'd really prefer to not be, and I'm pretty sure everybody around this table—all members of this committee—would like to see us move forward with a lot more resilience and with more supply of things in this space so that our front lines are not overwhelmed like they were during COVID.

We were caught off guard, but now we've seen the lessons learned, which are the genesis of this motion and this study. I'm gobsmacked that every time we try to talk about this issue, it gets sidetracked and derailed, which really makes me question the intent of—

● (1740)

Dan Mazier: Chair, which standing order is she referring to?

The Chair: She's not speaking to a standing order, Mr. Mazier. She's speaking to the fact that we have now ended the order of the day. We had witnesses come to speak on pharmaceutical sovereignty, and she's speaking to the fact that she would have liked to see that order of the day continue. You all received the notice of the order of the day, and we were meant discuss pharmaceutical sovereignty—

Dan Mazier: Is she debating, or does she have a point of order?

The Chair: It is a valid point of order she's making.

Dan Mazier: What standing order is she referring to?

The Chair: I don't know what you mean by a standing order. Committees meet, and they have an order for what business they're going to discuss that day. You get that from the clerk every time. You received that this time. It said we would discuss pharmaceutical sovereignty, and we therefore invited people to give up their time to come here and discuss that. We have now removed that from the table. The vote was to remove it from the table. Ms. Chi is speaking to the fact that the order of today's business has now been violated, and she is saying why this is so. She's allowed to do that—

Dan Mazier: Is it a point of order, or is it debate? That's my simple question.

The Chair: It's a point of order about what's on the order of the day, which is pharmaceutical sovereignty.

Dan Mazier: If that's your judgment, I challenge the chair on that. It is not a point of order.

The Chair: Mr. Mazier, it is. Do you understand what the order of the day is? Did you get the notice?

Dan Mazier: I'm challenging the chair's decision. That is not a point of order.

The Chair: Mr. Mazier, I will not even ask for a vote on this, because I know that whatever rules are set by Parliament for how committees behave.... I read them out to you. I'm trying to be as transparent as I can, but because you have the numbers, you can vote down a standing order and the rules set by Parliament. That's just because you have the numbers. I don't believe that is in any way democratic.

We are allowing people to speak. Not allowing people to speak is something that I believe.... If you want to challenge the chair, go ahead. I know that you will win the vote, because there are more of you. It's not about order. It's not about rules. It's not about procedure. It's just about having numbers to challenge the chair on something that is actually not procedurally correct.

He's challenging the chair. Is there unanimous consent?

Maggie Chi: I'm sorry, Chair, but before we proceed, out of respect for the witnesses' time, can we please dismiss them?

The Chair: I will dismiss the witnesses.

I would like to apologize to the witnesses for giving up their time, preparing their submissions and coming here to answer questions only to be derailed. I apologize to you, but you may leave, because this meeting can only go to a certain time based on resources. You were asked to come for two hours, so I'm sorry that I'm going to have to ask you to leave. Thank you for your time.

Dan Mazier: For the record, witnesses, I tried to do that 15 minutes ago.

The Chair: Mr. Mazier, please, I don't know what you're saying for the record. You did not say anything to me about letting the witnesses go, because you did not have the floor. Somebody else had the floor.

You can say what you want and mutter it in the corner, but respect means that if somebody is speaking, you allow them to finish when they have the floor. That's called mutual respect. In the House, when somebody is speaking, if you yell and scream, the Speaker will say to you, “I'm sorry, but so-and-so has the floor; that is not a point of order.”

You cannot tell me what you are thinking. I am unable—I'm working on it—to read minds. I'm learning how to read minds without anybody speaking, but at the moment Ms. Chi has the floor. She's speaking—

Helena Konanz: Chair, there's a—

The Chair: Let me finish my sentence.

Ms. Chi—

Helena Konanz: This is a violation of his rights as a member.

The Chair: Ms. Chi has the floor. I said she had it and I accepted her point of order as valid.

You have challenged the chair, and I'm saying to you that we will call the vote, but I'm arguing that I don't know whether it is democratic to violate the rules set for standing committees by Parliament. They're not set by the committee; they're set by Parliament. There are standing orders, and you can always challenge the chair when you know you have the numbers. It has nothing to do with a principle or the procedure.

You've challenged the chair, so I will call the vote.

Mr. Blanchette-Joncas, what's your point of order?

● (1745)

[*Translation*]

Maxime Blanchette-Joncas: I'd like to ask for clarification, Madam Chair.

You're talking about democratic principles. In your view, is a government that secures its majority with floor-crossing MPs democratic?

[*English*]

The Chair: That is out of order, Mr. Blanchette-Joncas. I'm sorry.

[*Translation*]

Maxime Blanchette-Joncas: What do you think?

[*English*]

The Chair: It's a point of order [*Inaudible—Editor*]. We're not discussing that; that's not on our business agenda for today.

Does anyone in this room understand what the point of order is? It is about resuming the order of the day.

Maggie Chi: I have a point of order.

The Chair: Go ahead, Ms. Chi.

Maggie Chi: We've seen a lot of patience from the Liberal side.

First, our study was derailed, and second, I found the question that was asked of you, Chair, was really inappropriate. I do not think that was a fair question. We're the Standing Committee on Health, and asking you a question like that is disrespectful. It's out of the scope of the committee, and it's out of the scope of respecting all the members around this table.

The Chair: Thank you, Ms. Chi. I said that to Mr. Blanchette-Joncas. I do not accept his point of order.

Maggie Chi: I just wanted to share that this is how we're feeling on this side as well.

The Chair: Thank you.

Have you finished speaking to your point of order, Ms. Chi?

Maggie Chi: I have not. I was disrupted; I was interrupted.

Dan Mazier: I challenged the chair. We have a vote.

The Chair: I'm sorry. We have a vote to challenge the chair.

Actually, you don't have to agree with it, but she should be able to finish.

Ms. Chi, continue.

Maggie Chi: Okay.

The Chair: No, I'm sorry, Ms. Chi. I called a vote.

We will vote on whether the chair's decision is sustained. Mr. Mazier called that.

Maggie Chi: Before I vote, I'll say that I'm so sorry, Chair, that things have happened, like comments that—

The Chair: I'm sorry, Ms. Chi. That's not a point of order.

A vote is in order right now, so we will call the vote.

The Clerk: The question is, shall the decision of the chair be sustained?

(Ruling of the chair overturned: nays 5; yeas 4)

The Chair: The chair's decision is not sustained. We knew this was going to be the result. I said it, but there we are.

Because the chair's decision was not sustained, let me say what is going to happen now. We will go back to the motion. Ms. Chi no longer has the floor, because the decision to allow her to speak on a point of order was not agreed on, so Ms. Chi has to stop speaking on that issue.

Is it clear for everybody what we're doing here? Thank you.

Ms. Chi, your hand is up for some reason.

● (1750)

Maggie Chi: I would like to be added to the speaking list, Madam Chair.

The Chair: Is that for the debate?

Maggie Chi: Yes, for the debate.

The Chair: All right.

We have a speaking list on the debate of the motion. We will start with Ms. Konanz, and then go to Ms. Sidhu and Ms. Chi.

Ms. Konanz, go ahead.

Helena Konanz: Thank you.

The Chair: Speak to the motion, please.

Helena Konanz: Yes. I am speaking to the motion of MP Mazier, in which we have an order for papers having to do with the $300-million PrescribeIT scandal.

I'm really surprised that the Liberal members are not supporting it, because they have supported bringing in representatives from PrescribeIT and Canada Health Infoway, which was incredibly supportive. Representatives of all parties here voted unanimously to bring in representatives from those organizations next week. If you look back at the debate, they agreed that something was happening that was not being revealed and that Canadians had been ripped off for $300 million.

I do not understand why they wouldn't want to get the paperwork necessary to prove that the $300 million was misspent. That's all we're asking for.

I'm sure the Liberal members want to see the proof, just as they want to talk to members of those organizations and find out what really happened. I'm sure that the next Liberal member who speaks will speak directly to the $300-million rip-off of Canadian taxpayers; otherwise, they will be called to task. Canadians will want to know why they are filibustering when we need to find out more about this scandal.

I really look forward to hearing the next Liberal member sitting here describe to Canadians tonight why they do not want Canadians, along with the MPs who represent them from across the country, to see the paperwork that will prove there was wrongdoing. I really look forward to hearing why these Liberal members do not want to see proof of this scandal.

The Chair: Thank you very much.

The next speaker is Ms. Sidhu.

Sonia Sidhu: Thank you, Madam Chair.

This is the health committee. We all work together for the betterment of Canadians.

We also have questions for the witnesses. We want to know what happened, and the opposition cannot blame us.

One thing I want to put on the record is that when my colleague Ms. Chi was speaking, there was unacceptable behaviour. We all want to work for Canadians. That was unacceptable. Members said this is happening in our committee. We are not hiding anything. The opposition can say whatever they want.

It's not like they have a different heart and we have a different heart. We all have the same heart. We all want to serve Canadians in a better way. This is about protecting integrity. We don't want to play games with the opposition. This is unredacted.... The only limited exception raises serious concerns. We accepted the other motion, but when the witnesses see what kind of behaviour we are displaying.... When the opposition is speaking, we don't say anything, but when my colleague—

The Chair: We're speaking to the motion on the floor.

Sonia Sidhu: I want to put this on the record, Madam Chair.

It's happening all the time. They interrupted Ms. Chi. They don't want to listen. This is not acceptable. I'm really frustrated to see that.

I want to say one thing. Allowing unredacted documents with only a limited exception raises serious concerns. It's not like we are hiding. We see that, but this is not the time. When they put the motion up, they didn't give us time. There were witnesses. We were asking questions, and it's not like we aren't going the right way.

I just want to discuss part (e) of the motion.

● (1755)

The Chair: Excuse me. I cannot hear because there is disorder in the room from people speaking quite loudly.

Members, if you wish to discuss something, could you allow the meeting to continue and instead go outside in the corridor to speak to each other? If you're going to speak so loudly, it disrupts the proceedings.

I'm sorry, Ms. Sidhu. Continue.

Sonia Sidhu: This is another point I want to put on the record. This is unacceptable behaviour.

What the Bloc member said to you, Madam Chair, was unacceptable.

The Chair: We have dealt with that, Ms. Sidhu. We are talking about the motion on the floor presented by—

Sonia Sidhu: The behaviour of the opposition is not unacceptable. When I'm speaking, I cannot hear. No one is listening.

The Chair: I know, Ms. Sidhu, but let's debate the motion on the floor right now.

Sonia Sidhu: Thank you, Madam Chair.

Let me talk about part (e), “Viability analyses and program evaluations”.

These documents are, by their very nature, part of the internal policy process. They include candid assessments. They include risks. They include recommendations. Those recommendations are meant to inform decision-makers in a way that is honest, true and sometimes critical. If public servants believe that every internal analysis could be disclosed in full without appropriate protections, it makes it harder for them to pull some thousands of thousands of documents.

We want to present some amendments too. This is why we need time. That is what we are saying. We are not saying no, but we need time. This is, frankly, untimely. It makes it harder for the government to make informed decisions.

I come to part (f), “Documents that led to the decision to terminate the program”. This category almost certainly includes briefings to the minister, recommendations, and decision-making records. There are long-standing principles respected by governments of all stripes regarding these types of documents, so we have to see what we are requesting. I don't think the time frame is enough. This is not about avoiding accountability. This is about respecting the framework that allows government to respond to thousands and thousands of unredacted documents. We want to work with the opposition. It's a long motion.

Through investment in the organization, we have supported the development of tools that improve patient safety and enhance data security and have made historic investments through health transfers to provinces in health workforce retention and recruitment. We invest in mental health services....

I have to ask what the objective is. They cannot blame us for that. We also want to be transparent. We already have a mechanism to ensure accountability. If the object is to improve health care delivery, we should be focusing on how to strengthen systems like PrescribeIT, not undermining them through broad and potentially harmful disclosure requirements. If the objective is to support patients, we should be listening to the witnesses in front of us, who can provide insight into how these systems work on the ground. Instead, this motion demands extremely broad document production and imposes an unrealistic deadline. A one-week deadline is not enough and risks exposing confidential, sensitive or protected information.

This is something that takes time away from the very witnesses who are here to help us do our job better. We can do better if we work together. The amendments.... We are not opposing what they are saying. We also want to work together for the betterment of the health of Canadians.

● (1800)

The Chair: Do you have amendments, Ms. Sidhu?

Sonia Sidhu: Madam Chair, I'm not finished. We didn't talk much about this during the questions. I want to let Canadians know that when witnesses are here, this routinely happens. They started reading a motion, and we were not ready. If they give us time, we'll bring amendments. We can work together. We want to work together. They blame us, but we're not hiding anything. I want to put that on the record.

We want to focus on the health of Canadians, too, but the opposition is saying this is unacceptable. They are making scandals. On the last motion, we worked very well. They did the same thing. When witnesses were here, they put up a motion, and then we worked with them. It's happening again. We want to work with them, but we need time.

Peter Fragiskatos: I have a point of order, Chair.

You might find this is not a point of order; however, it is brought up in very good faith.

I understand there are discussions happening among parties. If you found the room disorderly today, Madam Chair, I think it might have to do with the fact that parties have not been on the same page. We're trying to rectify that.

The Chair: Do you wish to suspend while this is happening?

Peter Fragiskatos: Yes, for a few minutes.

The Chair: I suspend the meeting.

● (1800)

_____(Pause)_____

● (1820)

The Chair: I will resume the meeting.

I understand that all parties have been working on a resolution, which is good. We should be able to work together on these things.

When the meeting was suspended, the last person speaking was Ms. Sidhu. I understand that I now have Ms. Chi on my list. I'm going by the list I have, which is the list I must go by.

Ms. Chi, are you prepared to speak, or shall I pass the floor to the next person?

Maggie Chi: You can pass the floor.

The Chair: Thank you very much.

Peter Fragiskatos: Can I proceed, then?

The Chair: Actually, Ms. Chi, your name is the next on the list. If you wish to not use your time, I will go to the next person on the list. Will you use your time to speak?

Maggie Chi: I'm just adding my name to the list, Madam Chair.

The Chair: Your name is already on the list, Ms. Chi. I just called on you.

Maggie Chi: No. I'll go after Peter speaks.

The Chair: Ms. Chi, the list is you and then Mr. Fragiskatos. The clerk and I have set up a list based on when people put up their hand. If you wish to pass, I will go to Mr. Fragiskatos, because he's next, but your name won't be on the list again until later on.

Maggie Chi: Yes, I'm passing it to Mr. Fragiskatos.

The Chair: You are ceding your speaking time. Thank you.

I will go to Mr. Fragiskatos.

Peter Fragiskatos: Thank you, Madam Chair.

I've already alluded to this. I am not a full member of this committee, although I do follow its work because it is among one of the more important committees on Parliament Hill. How can it not be? We're talking about health and health care.

Obviously, sometimes things go in a different path, and politics take over. I would hope that as much as possible we don't allow that. Perhaps tonight is an exception, or maybe it's the rule. Again, I don't know this committee very well.

Regardless, I see in front of me the motion that Mr. Mazier has put forward. It begins by asking that the committee order “the production of the following documents” and so on and so forth. Then it continues with this: “Contribution agreements concluded with Canada Health Infoway relating to PrescribeIT.”

I will take the time after this meeting to make myself more familiar with the issue at hand. I know that Conservative colleagues have raised the issue in the House of Commons a few times now. I think the media has perhaps followed the story. There's material there for me, and for other substitutes, frankly. I see Mr. Grant with me and Dr. Hanley. All of us can take the time to bring ourselves up to speed, and I'm sure we will.

From a procedural perspective, for this first part, I can't comment on that. I can comment that the call for contribution agreements that have been concluded does present a challenge, because there would be—as I think Conservative colleagues know very well—well over 1,000 documents or perhaps thousands of documents.

This is how production orders work. When you call for documents, because the country is bilingual, you need to have translation carried out. That adds an enormous amount of time to the work that public servants are tasked with. They could be doing, in place of that work, other things in service of Canadians. I have not heard in the House of Commons and have not heard today how assigning that responsibility to public servants is going to advance the agenda of health care in this country.

Across from me, I see Dr. Strauss, who comes from southwestern Ontario, the region I'm from. I know he cares about health care. I know that he will perhaps disagree on certain aspects of health policy, but I know he will agree that public servants play a very important role in the administration of our health care system. How can he defend a motion that would absolutely tie up the public service, not just in producing documents—

The Chair: Your name is down, Mr. Strauss.

Peter Fragiskatos: I promise I wasn't baiting him to speak. It was a mostly rhetorical question. If he wishes to get on the record, I guess he's going to get on the record. That's his right.

How can he get behind a motion that calls for, among other things, public servants to spend an enormous amount of time, hours upon hours at the very least, on this? It could be much longer. With production orders, it often is. The result, of course, would be to have them look in another direction when it comes to what their main responsibility is, which is helping to administer Canada's public health system. That's the first point.

There are other things that are unclear to me, such as “A record of the intellectual property developed under PrescribeIT”. Again, I'm relatively new to the committee. I'm not quite sure why that would be of interest, but colleagues across the aisle can share that with me. Also, there's “adoption data, broken down by province”. Where we could get this data from exactly is the question that comes immediately to mind.

Regardless, let me say something else, and before colleagues across the aisle accuse me of trying to distract from the matter, it does relate to the motion at hand. I was very much looking forward to sitting in today in place of Dr. Eyolfson. The reason is that we heard from witnesses, beginning with Diabetes Canada, who were passionate on any number of things.

Mr. Thibeault kindly mentioned London, where I'm from, a city I that have the honour of representing in the House of Commons. He mentioned Banting House. I was glad he did so. Banting House does tremendous work.

● (1825)

The first part of the meeting created momentum for the second part, which was to focus on an issue that is, I think, important to all of us: pharmaceutical sovereignty in this country. This is something coming out of the pandemic that we all need to think much more about. I know the government is seized with carrying out that goal.

The pandemic left us with many lessons. You, with your expertise in medicine, Madam Chair, have been very clear for years now about the need to prepare this country for all sorts of realities from a health care perspective.

The pandemic left us with many lessons, as I said. One glaring lesson is the need to ensure pharmaceutical sovereignty. We saw what happened to other democracies. We saw what happened at the outset of the pandemic.

● (1830)

The Chair: Mr. Fragiskatos, we are debating the motion—

Peter Fragiskatos: Yes, and I'm getting to it.

The Chair: There's leeway in debate, but let's focus on just the motion.

Peter Fragiskatos: I appreciate your brief indulgence, Madam Chair. I will bring it back, I promise you, and I was about to. That was only to say that the pandemic left us with the lesson about pharmaceutical sovereignty.

We were hearing from articulate witnesses who are experts in their fields. I saw colleagues around the table engaged and seized with the issue, but all of a sudden, this motion, which had nothing to do with the second part of the meeting, as I understand it, came up. It could have come up at any other time. There is, I believe—of course there is; every committee has one—a steering committee where that matter could have been addressed.

An hon. member: Not in this one.

Peter Fragiskatos: There's not in this one. Okay. I'm learning as I go. Leave that aside for just a moment.

That could have been raised. The substance of the motion could have been addressed using any other avenue. There are many different avenues that could have allowed for the Conservatives to reach what they're apparently trying to reach, but we lost witnesses as a result. Witnesses took time out of their day to be here. In the case of Ms. Michaud, I'm not sure where she was travelling from, but it took her an entire day of planning.

The Chair: Mr. Fragiskatos, bring it back, please, to the motion at hand.

Peter Fragiskatos: I'm bringing it back. I promise.

The point is, what do we have in front of us? We don't have a meeting in front of us. We have Mr. Mazier's motion in front of us. With contribution agreements concluded, I'm not sure how that advances.... Maybe he can explain it for me. Again, I'm sitting in today on the committee. Maybe he can explain how the production of thousands of documents will advance the public interest for his constituents, for my constituents, for Dr. Strauss's constituents and for all of our constituents. I don't see it, but I hope to be informed on the subject.

I heard Ms. Chi, who has done excellent work as a parliamentary secretary, navigating at this committee a very complex set of priorities that the committee, in its wisdom, has identified as important and vital to take up. She was making a number of points and was interrupted along the way, unfortunately. I hope that in the time we have remaining, we don't have that happen again. That would be my hope. We will see what happens.

I know she's next on the list, Madam Chair, but I'll conclude my initial intervention by simply saying that I would love to hear an answer from Conservative colleagues on how the production of thousands of documents that will tie up the public service—not just for hours and hours, as I said before, but for much longer, if we want to be honest—advances the public interest. How does that do anything to advance what this committee is doing?

This committee has a mandate from Parliament to take up matters of health care and health policy. We will see where things go.

I turn it back to you, Madam Chair. I think Ms. Chi wants to get on the record.

The Chair: Ms. Chi has been on the record already.

Peter Fragiskatos: She wanted to be on the list, and I think she is. There you go.

The Chair: She's on the list. I am keeping a list, Mr. Fragiskatos, with the help of the clerk.

Next on the list is Mr. Strauss.

Matt Strauss: Thank you.

I'm so eager to answer my long-winded friend's questions.

When you blow $300 million, you need to find out how you blew it so you don't blow it again. At the last committee meeting, we found out that the government is planning on giving the same totally incompetent, possibly corrupt organization, Canada Health Infoway, another $50 million for its pivot operation. We'd save $350 million by getting to the bottom of this and not making that sort of mistake again.

As for the time it takes to translate, you have a Minister of Artificial Intelligence. Perhaps he can be made aware that we can do AI translation now. It takes five minutes. It shouldn't take any time at all. Canadians want us to get to the bottom of this.

There are about 50 people in this room. You all have only one life. It's such a crying shame that we're spending it listening to very long speeches in order to prevent the production of these documents. I saw the Prime Minister in a scrum explain that he needs to have majorities on committees so he can prevent filibusters, which his own team is doing right now in order to hide a $300-million scandal.

Thank you, Chair.

● (1835)

The Chair: Thank you, Mr. Strauss.

Before we go any further, I will let you know that we have resources only for the time I told you earlier on. I would like to point out to this committee that we are speaking to the motion on the floor. We have already decided that the motion is in order. It is here. We need to speak to the motion.

The issue of resources was brought up. Is this the best way to use our resources? This committee has spent every single meeting going one to two hours over time just because we have resources. It's spinning its wheels and doing all kinds of things. I would like to see us respect the role of the standing committee, as everyone would. A standing committee is supposed to get work done.

The motion is in order. I would like people to speak to the motion.

Go ahead, Ms. Chi.

Maggie Chi: Thank you, Chair.

I really appreciate my colleague's comments around diverting time away from the study that was on the schedule. It's experienced many forms of delays. Our witnesses came, but unfortunately we couldn't finish the rounds of questioning. It happened again. We've seen it time and time again.

We are the Standing Committee on Health. As members we all agreed to the mandate and essence of what the committee does. We are here to examine programs and policies that matter to the health of the nation.

I don't know about folks around the table. When you have a motion that calls for the production of papers with thousands of pages, there are details that pour into data numbers. We have committees exactly for that.

It puzzles me why the Conservative members continue to use this committee to hunt for information, when they could hunt elsewhere. We could actually get back to the agenda of the health committee to finish the agreed upon schedule regarding the Liberal study on pharmaceutical sovereignty. That's the first point I really want to make.

Second, to my colleagues here, as you said, Chair, we are staying for extra time and extra hours. How does it respect a member's time when someone brings forward a motion that interrupts the time of a witness?

The Chair: Ms. Chi, we are speaking to the motion, please.

Maggie Chi: I'll come back to the motion.

I'm sure colleagues across the aisle have an interest in the matter, which is the interoperability piece on the data. PrescribeIT is part of the larger effort around this, so let's talk about that. Let's talk about the larger digital health context, which this committee could consider. If we want to understand PrescribeIT as a program, I don't think we can just understand it on its own. There's a larger picture. There's a larger road map that as a nation we need to consider.

Earlier this week, we called upon Canada Health Infoway to answer questions around the program. There is a larger, shared, pan-Canadian interoperability road map, which makes it clear that the real issue is much broader than just one program or one dataset.

Physicians around this table who have experienced frustrations around data—interoperability of systems and sharing patient data—will agree that the real issue here is that we need to build a system. We need to build a system in which the digital tools actually connect to each other, in which information can move safely and meaningfully across settings and in which patients and providers are being served by systems that work together rather than against each other.

That's the broader theme and frame I want us to keep in mind as we consider this topic. That's why I'm going to keep returning to the road map as I speak about this particular program. PrescribeIT matters in that discussion, not because the road map is a report about PrescribeIT. It's not. The road map is a report about the larger structure of interoperability in Canada.

The report also makes reference to PrescribeIT in ways that are revealing. The appendix of the report notes that Canada has “made important progress in integrating community pharmacy and primary care prescribers”, and specifically cites this program. Elsewhere, it indicates that the deployment of the program was expected to expand to support hospital discharge prescriptions. In its stakeholder discussions, it notes that Infoway has discussed the potential value of digital tools, including with various organizations. Together in the larger system, we all want an integrated system, as we heard from today's witness from the pharmacy association.

With that, Madam Chair, I move that the meeting be now adjourned.

● (1840)

The Chair: It's not debatable. There is a motion to adjourn.

Everyone seems to agree. I hear nobody saying no.

(Motion agreed to)

The Chair: The meeting is adjourned.