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Chair

Mr. Neil Ellis

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● (1550)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): Pursuant to Standing Order 108(2), we are studying medical cannabis and veterans' well-being.

For witnesses today, we have appearing Kyle Atkinson by video conference from Halifax, Nova Scotia; James MacKillop from McMaster University, who is the Peter Boris chair in addictions research at St. Joseph's Healthcare Hamilton; and Andrew Freedman, senior director of Freedman and Koski Inc., by video conference from San Francisco, California,

We'll start with witness—

Mr. Phil McColeman (Brantford—Brant, CPC): On a point of order, Chair, I have a motion to move.

Witnesses, I know you're here as experts in your field, and I appreciate your being here. However, there is some very important business that this committee needs to address before we get to you. I thank you for your patience and understanding in that matter.

Chair, this motion is urgent and will require unanimous consent in order to proceed to a vote. I will read the motion, but first I have to put it in context.

The context of this motion is that we had a full-time Minister of Veterans Affairs who was called to appear before this committee. It is the tradition of the committee that when expenditures for government are scrutinized, each committee is charged with the task of reviewing the spending. The committee has the ability to ask.... In most of the protocols that have been used in the past, it would be the Minister of Veterans Affairs who would appear before the committee. That has been the tradition of this committee up to this point in time. However, given the circumstances of the chaos that exists at Veterans Affairs with the fact that we lost our full-time minister—she resigned from the position after having been appointed to the position—and given the fact that we have a very tight time frame for the scrutiny of the expenditures for Veterans Affairs in what is called supplementary estimates (B), which we were prepared to look at and it's our responsibility as a committee to look at, I'm putting this motion forward.

Based on getting unanimous consent around the table, the motion reads: “That the committee invite the acting minister of Veterans Affairs to appear on the Supplementary Estimates (B) on February 25 or 27, 2019.”

Those dates are in the motion and are specific because supplementary estimates (B) will go back to the House as deemed reported by this committee without scrutiny at the end of next week if we do not call the minister to come and answer the questions we have about the expenditures at Veterans Affairs Canada.

It's of utmost importance to this committee to do its work, and to be able to do its work amongst the chaos that is happening within the cabinet and within the government. We are still responsible for reporting—if we choose to report as a committee—on the estimates, and making our thoughts known to the House of Commons through the process.

I know the rules for putting motions forward are set out in the standing orders as having to be delivered with some advance notice, but this is so urgent and so important to this committee that I would first of all put the motion forward, seeking unanimous consent of members.

The Chair: Gord.

Mr. Gord Johns (Courtenay—Alberni, NDP): Yes, Mr. Chair.

The Chair: Sorry, Gord, Ms. Wagantall was in the queue.

Ms. Wagantall.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you, Chair.

I want to voice my support for this motion to go forward. The fact is that this committee has the responsibility to deal with the estimates, and we have a very tight timeline due to what's been happening within the government with the circumstances around the newly appointed Minister of Veterans Affairs , who found herself in a scenario where she needed to resign. We are now facing circumstances in which we have an interim Minister of Veterans Affairs.

I think it's really important that we do our due diligence and give proper scrutiny to the supplementary estimates (B) and determine that it take place on either February 25 or 27. We are on a tight timeline to the end of next week, when they will be deemed reported whether or not we have the interim veterans affairs minister come. Due to the circumstances the government is in right now, I think it's very appropriate that this be done properly, as the committees—as we all know—function with independence from what's happening within the government. We have the responsibility to do that.

I would just say that even though the motion wasn't delivered with advance notice, I think there is clearly a reasonable explanation for that, and it is really important. I believe we have unanimous consent to move forward with this and have the interim Minister of Veterans Affairs come before the committee on February 25 or 27.

● (1555)

The Chair: Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Mr. Chair, I'd like to speak in support of this motion.

It's important, in particular on this motion, that we do have dates, because as was indicated by my colleague, if we don't have a chance to scrutinize these estimates by that date, they will go back to the House and be deemed as if we had scrutinized them, when we have not had that opportunity.

The Prime Minister today reiterated that committees are independent. Therefore, we make our decisions, and we need to make certain that when we make those decisions, we're making them with full information, full authorization and full understanding of what they entail. At this point in time, we don't have that.

I do recall that when Minister O'Regan was here, he indicated he would be back to this committee to talk about supplementary estimates (B). We haven't had that opportunity. We had a new minister who was brought into play and has since resigned, and now we have a new minister again.

Because of how important it is to our veterans, I think it behooves us all to make certain that when we're dealing with this issue, we've had the opportunity to have those discussions.

The Chair: Mr. Johns.

Mr. Gord Johns: I reiterate what Mr. Kitchen just said. It was expected that the minister would be back before the budget and the break, so that's our understanding. We were told just a few weeks ago that the minister would be back before this committee to report on the estimates. I think that expectation is still in place. I think veterans expect that we are going to have the minister here to have that full scrutiny that needs to be applied here.

The new minister has said that veterans are a priority and that he will be representing them, so I expect he will be here. I support the motion wholeheartedly with that expectation.

The Chair: Mr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): I move that the debate be now adjourned.

Mr. Phil McColeman: Mr. Chair, on a point of clarification, I'm not moving the motion. I'm moving for unanimous consent to move the motion.

The Chair: We've moved on, so that's the wrong motion.

Mr. Doug Eyolfson: Excuse me?

The Chair: You'd have to call the vote, then.

Mr. Phil McColeman: I'm seeking unanimous consent to put this motion—

The Chair: It doesn't get unanimous consent.

Mr. Phil McColeman: I'll admit I put the cart before the horse. I should have asked for unanimous consent to put the motion, but I wanted you to understand the content of it.

The Chair: Yes. Okay. I apologize. I will put it to the committee.

Do we have a unanimous commit for this motion?

Mr. Darrell Samson (Sackville—Preston—Chezzetcook, Lib.): May I speak to this for a second, or not? No? I don't have—

The Chair: No.

Mr. Darrell Samson: Okay.

Ms. Karen Ludwig (New Brunswick Southwest, Lib.): No speaking.

Mr. Darrell Samson: No speaking if no consent? I can't speak?

A voice: There was no consent.

Mr. Phil McColeman: You weren't going to vote for it anyway.

Mr. Darrell Samson: Oh, you can't be sure of that.

Mr. Phil McColeman: Yes; you just said to your colleague that you weren't going to vote for it.

Mr. Darrell Samson: I did not.

Mr. Phil McColeman: Yes, you did. I heard you.

The Chair: Mr. Chen.

Mr. Shaun Chen (Scarborough North, Lib.): On a point of order, Mr. Chair, can we get some order in the room, please?

The Chair: Yes.

We'll start the meeting and start our witness testimony now.

Mr. Phil McColeman: Excuse me; did we call the vote?

The Chair: There wasn't unanimous consent for the motion.

● (1600)

Mr. Phil McColeman: Just one second, please. On a point of order, Mr. Chair, I would like a recorded vote on the unanimous consent.

The Chair: We don't have to.

Mr. Phil McColeman: You don't have to. Okay.

On another matter, then, I would like to introduce another motion: That this committee call on the Prime Minister to appoint a full-time Minister of Veterans Affairs.

The Chair: Do we have unanimous consent for this?

Some hon. members: No.

Mr. Gord Johns: Are we going to have a discussion?

The Chair: The motion has to come before the committee. He didn't bring it before the committee until today, so there's not unanimous consent to discuss it.

Mr. Darrell Samson: So we can't discuss it?

The Chair: He has to give notice of it today.

Mr. Darrell Samson: We have witnesses waiting. He doesn't have my consent.

The Chair: Mr. McColeman.

Mr. Phil McColeman: On another issue, then, I would like to put forward another motion: That the committee invite the interim Minister of Veterans Affairs to appear before this committee so that he can understand the topic areas that we are discussing and how important they are to veterans.

The Chair: Do we have unanimous consent for that one?

Mr. Darrell Samson: No. He's a veteran and he understands very well. He's done lots of reading on it.

No, you don't have my consent.

The Chair: We don't have unanimous consent.

Do you want to take those as notices of motions for the next meeting?

Mr. Phil McColeman: I absolutely do.

I'd like to be able to speak to the fact that we are missing the opportunity here to scrutinize the money spent—some $323 million, as written in supplementary estimates (B)—for Veterans Affairs Canada. That's $323 million that this committee will not be scrutinizing.

The Chair: Today we're on medical cannabis. Let's start—

Yes, Cathay.

Mrs. Cathay Wagantall: On a point of order, just very briefly, when we discussed the schedule to up until the end of June, there was time set aside and an agreement that we would have the Minister of Veterans Affairs come and speak to—

Mr. Darrell Samson: March 20 is what was in our calendar.

Mrs. Cathay Wagantall: —the supplementary estimates. The deadline for that to happen is next week. To me it's counterintuitive that you would not simply agree to have the interim minister come on February 25 or February 27, before the time for this committee to do its work, to challenge the estimates, is to take place.

The Chair: I'm sorry, but you're debating again. We're on medical cannabis today, and I'd like to get the meeting started.

Yes, Mr. Kitchen.

Mr. Robert Kitchen: On a point of clarification, correct me here, or please explain to me how.... We have to talk about the estimates by the end of next week. We have a minister who's set to come supposedly in March. He's going to come and talk about the estimates, which will already have been done. How is that—

Mr. Doug Eyolfson: On a point of order, we have a meeting agenda. We have witnesses who are going to give testimony, and that's on the agenda. What is being talked about right now is committee business. This should be under committee business.

We should be starting the meeting, as per the agenda, unless we have unanimous consent from the committee, and I don't believe we have that.

The Chair: We'll start the meeting.

Mr. Robert Kitchen: Can I not get a clarification?

The Chair: You can make a point of order.

Mr. Robert Kitchen: My point of order is that I need clarification. We have dates that don't coincide with the forms that we have.

The Chair: The point of order was unanimous consent. We didn't receive unanimous consent, so we're not debating it.

We'll start with our first witness.

Mr. MacKillop, you have 10 minutes.

Dr. James MacKillop (Peter Boris Chair in Addictions Research, St. Joseph's Healthcare Hamilton, McMaster University, As an Individual): Good afternoon, honourable members of Parliament. I appreciate the opportunity to address this committee on this important topic.

At McMaster University and St. Joseph's Healthcare Hamilton, I hold the Peter Boris chair in addictions research, and I direct the Peter Boris Centre for Addictions Research and the Michael G. DeGroote Centre for Medicinal Cannabis Research.

I've dedicated my career to understanding addiction and, more recently, to advancing the science of medical cannabis.

With regard to the DeGroote Centre, I want to note that the central operations of the centre are supported by philanthropy, not by industry. Our mission is to develop an evidence-based understanding of medical cannabis both in terms of positive therapeutic effects and potential negative side effects.

Our highest priority is the objective study of cannabis, just like any other drug in medicine.

We exist not because we believe that cannabis is or is not an effective medicine, but because we're sure there's a need for more research on the topic.

I've personally published research documenting both the risks and harms from cannabis use and also its potential therapeutic applications. I'm neither pro-cannabis nor anti-cannabis. I am pro-evidence, and I'm pro evidence-based medicine and pro evidence-based policy.

As a preface to my comments, I am mindful of the sacrifices that are made by veterans. As part of my clinical training, I was at the U. S. Providence veterans administration hospital working directly with veterans. I'm aware of how common the conditions they often use cannabis for are and that those conditions are often a result of their service.

Moreover, over 8,000 Canadian veterans are currently authorized for medical cannabis, and I know that the decisions around policies will have significant effects on their lives.

My comments today are from the perspective of trying to use the best available evidence to advance the health and well-being of Canadian veterans.

I'm aware of the six priority topics, and I will comment on three areas where I have the greatest expertise. I'm happy to discuss other topics also.

The first priority topic is the scientific basis for the policy for reimbursement of up to three grams of cannabis in general and up to 10 grams with additional approval, and that's daily.

Is this amount the right amount? Is it too high? Is it too low? Unfortunately, precise dosing is not available from the current research. This is one of the ways that medical cannabis is different from traditional medicine.

The reality is that this is not a drug with a DIN, a drug identification number, like other drugs have. It's a plant, not a pill. It's a plant that has dozens of different compounds that interact with the body's internal endogenous cannabinoid system. The interaction of these compounds is believed to be part of the reason for its positive effects.

In addition, there are many different routes of administration, not just as a capsule, like most medications, but via inhalation and other routes. This could affect the effects, also.

To put this in context, for non-medical users three grams daily would be considered a very high level of use, and 10 grams daily would be considered an extremely high level of use. In research, we standardize a gram as being equivalent to about four cannabis cigarettes, or joints. These numbers equate to 12 and 40 joints per day, which would be a large amount of cannabis.

The reality is that pharmacology doesn't make any distinction between medical use and non-medical use. The more cannabis a person consumes, the higher the risk of adverse consequences.

A person who's consuming, for example, 10 grams of cannabis each day would be more likely to experience physiological dependence and other adverse side effects, such as cognitive difficulties, motor impairment, or risk for cannabis-use disorder, the technical term for addiction to cannabis. It's also the case that withdrawal symptoms would be more likely in high-dose patients.

In this context, I am not proposing or recommending any immediate changes or restrictions. The reality is that abruptly reducing access or making other policy changes that would dramatically increase the cost of cannabis to active medical patients could have adverse consequences.

I do believe, however, it's important that veterans who are using medical cannabis do so closely in contact with their treatment providers to monitor their progress and minimize potential harms.

With regard to the second topic, evidence for medical cannabis for chronic pain and PTSD, unfortunately, the utilization of cannabis in these contexts has outpaced the research on this topic.

● (1605)

For chronic pain, a recent review of numerous studies suggested that there is a small therapeutic effect on pain, but there were high rates of side effects, and the side effects were more common than the positive response.

In another recent review, when restricted to neuropathic pain, there was again evidence of a positive effect, this time larger than for general pain, but side effect rates were very high and patients who were taking medical cannabis for pain were more likely to drop out of trials.

On balance, both of these reviews concluded that although there is positive evidence for pain, the evidence for side effects may suggest that the benefits are outweighed by the harms. It's also worth noting that in these reviews, no trials to date have been conducted on Canadian veterans, so all of this is by analogy, rather than based on evidence we have in this population.

With regard to PTSD and other anxiety disorders, there are intriguing preclinical findings using animal models. There are anecdotal and case study reports that are promising, but there are no gold standard randomized controlled trials that show evidence of efficacy, either in civilian or veteran populations. At this point, there is insufficient evidence that cannabis is effective in treating PTSD or other anxiety disorders.

These are my personal conclusions, but they are very similar to the conclusions reached in a recent report by the U.S. Department of Veterans Affairs with regard to the benefits and harms of cannabis for pain and PTSD for United States veterans.

There are other circumstances in which cannabis has been shown to be helpful: reducing chemotherapy-induced nausea and vomiting, reducing spasticity in multiple sclerosis and reducing seizure frequency in children with rare pediatric seizure disorders. These are all areas where the evidence is more robust. That is not the case for pain and PTSD.

On the topic of how legalization will affect medical cannabis for veterans, there's a risk that individuals who have current authorizations may augment the amount available with additional non-medical cannabis that is legal. It's also possible that veterans who are considering getting an authorization will simply explore it and self-medicate without engaging with a health care provider. This could result in harms by way of individuals inadvertently accessing products that would be considered high risk. High THC products that have low rates of CBD can have a cannabidiol, a constituent that's believed to be responsible for the therapeutic actions to an extent.

The other reality is that, because there are known risks, any medical use, in my opinion, should take place in collaboration with a health care provider.

Finally, given that the market for recreational cannabis will necessarily be much larger than the medical cannabis market, it's possible that the products used primarily for medical purposes will become increasingly unavailable. Those are products like oral capsules, oral oils or high CBD products. In my opinion, it's important that Health Canada's dual system for medical and recreational cannabis be fully implemented and supported.

In this context, I would argue that there's a high need for large scale, coordinated research on medical cannabis for veterans in Canada. There are literally thousands of veterans who are effectively accessing what could most charitably be described as an experimental medicine, rather than an evidence-based medicine. Because there is evidence from U.S. veteran populations of the association of cannabis with suicidality and self-harm, the risk for true harm is present.

In terms of the research that we need, we need observational research to understand the effects that are happening among individuals who are currently using cannabis. We also need randomized control trials to actually test, using gold standards, cannabis for pain and PTSD. We also need more knowledge translation and guideline development efforts to make veterans aware of the realities of risks, and to give clinicians clear recommendations about best practices.

As a final point, it's important to remember that Canada still has a major opioid epidemic that has not abated. Increases in access to opioids, and a combination of overestimated efficacy and underestimated risk has contributed to the current epidemic. Those are lessons to be learned in the context of medical cannabis and for cannabis post-legalization in general. In my opinion, the bottom line is that excessive optimism can lead to real harm here.

Thank you for the opportunity to serve as a witness for this committee.

● (1610)

The Chair: Thank you.

Mr. Atkinson, the floor is yours for 10 minutes.

Mr. Kyle Atkinson (As an Individual): Thank you.

Good afternoon. Thank you for the opportunity to speak with you today. It's my pleasure to highlight my experience in helping veterans in a medical and professional setting as it relates to cannabis.

First, it is important for you to know that I am not a veteran of the Canadian Armed Forces or a member of a first responder organization. I am not a health care professional. I am an entrepreneur with a pharmaceutical and start-up technology background who realized that there was a serious issue with the way Canadians were accessing medical cannabis, and I wanted to do something about it.

I saw an opportunity to change the narrative around medical cannabis and also fill in some of the gaps that exist for soldiers exiting the military. I started an organization called Trauma Healing Centers over four years ago, which is not to be confused with an organization called Marijuana for Trauma.

In the 3.5 years under my leadership, we have helped 7,500 patients. Approximately 900 of them were veterans of the Canadian Armed Forces. Approximately 90% of the 7,500 patients who were referred to Trauma Healing Centers had already tried cannabis, and it happened to work for their condition or conditions. They didn't know how it worked or why it worked, but it provided the symptom relief that they desperately needed and the therapy significantly increased their quality of life.

Trauma Health Centers' approach is via multidisciplinary care. I have physicians, nurses, psychologists, social workers, dietitians, massage therapists and peer-support advisers all under one roof to help our patients. Patients have come to us via other physicians, either a GP or specialist referral.

For those who are not aware, medical cannabis is a last-resort treatment option. When all indicated medications and therapies have been exhausted, medical cannabis can be tried. As physicians would say, this is where the art of medicine comes into play.

Medical cannabis is not a silver bullet. It must be managed in a medical and professional way to ensure that positive outcomes are achieved. When positive outcomes are not achieved, physicians must discontinue the patient's cannabis authorization like they would any other medication. The vast majority of our patients were able to reduce or discontinue their existing pharmaceutical regimen when cannabis was helping to improve their symptoms.

I will be the first to say that there is no strong evidence for medical cannabis use in any medical condition, and that large-scale randomized clinical trials need to be conducted to ensure maximum benefit can be achieved with minimal risk. However, the lack of evidence is not proof of the lack of benefit. The key is managing the treatment in a medical and professional way in order to maximize the potential benefits and minimize the potential risks.

Unfortunately, there are many physicians in Canada who are authorizing medical cannabis in a risky manner. They are often not adhering to a start-low, go-slow approach. Some are authorizing medical cannabis with little or no knowledge of how cannabis works and are leaving patients to self-treat, which is really no different from patients buying off the street. Helping patients become—quote—"legal" is not the objective; helping them achieve symptom relief and improve quality of life should be the objective.

I am fortunate to have had many amazing physicians work for me over 3.5 years at Trauma Healing Centers. Most were GPs with experience in pain management and addictions. Some had occupational health experience and worked with their provincial workers compensation boards. Two were specialists—psychiatry and pain management—and two were veterans of the Canadian Armed Forces.

We were able to gain trust and to partner with many organizations that are tremendous advocates for the well-being of veterans. Wounded Warriors Canada, VETS Canada, MFRC, and the Royal Canadian Legion are just a few that have come to understand and believe in our approach.

I was also able to gain the trust of the director of policy for Veterans Affairs who was responsible for the medical cannabis file. My medical director and I supported the capped reimbursement to three grams per day, the need for special authorization beyond three grams per day and the inclusion of oil reimbursement.

I have spoken to hundreds of veterans and their families who have explained how cannabis has greatly improved their medical condition or conditions, and enhanced their quality of life. I have met with many of the highest-ranking officials in the military who care about the well-being of their members and former members.

I met with Surgeon General Downes at the 2017 CIMVHR conference and explained our approach and the results we were seeing. My team and I met with General Vance, with the intention of making him aware of what we are doing to ensure that his veterans suffering from chronic conditions, like PTSD and pain, are getting help via a multidisciplinary care approach.

We also made three simple recommendations that we felt could have a profound impact on the outcomes for veterans who struggle with medical conditions leaving the military.

● (1615)

We recommended that Canadian Armed Forces members who were exiting the military with pensionable conditions should access multidisciplinary care off base prior to being discharged so that they may continue with their care regimen uninterrupted and not have to wait for benefits to kick in via Veterans Affairs Canada to access care.

We recommended that all military members discharged with pensionable conditions be assigned a peer support adviser several months prior to their discharge date to ensure they had the support of someone on their level who had been through the process and could help guide them.

We recommended that the Operation Family Doc pilot program in Ottawa be expanded to other parts of the country to ensure that medically discharging members have a continuity of primary case services.

In closing, I strongly feel that much more can be done to improve the outcomes of veterans utilizing a multidisciplinary care approach and coordinated care. I also strongly believe that medical cannabis can be utilized as part of this approach.

Thank you for your attention.

● (1620)

The Chair: Thank you.

Mr. Freedman.

Mr. Andrew Freedman (Director, Freedman and Koski Inc.): Thank you, Mr. Chair, for having me appear before the committee.

For those who don't know, I was the director of marijuana coordination under Governor Hickenlooper in Colorado for the rollout of what we referred to as medical and recreational marijuana. I have since started a firm that works primarily directly for government and also ancillary businesses; however, we do not take money from the marijuana industry or cannabis industry as that would be in tension with...a conflict with our other work.

I'm obviously not a public health expert nor a veteran, and what I hope to speak to you about today—and maybe it's most appropriate that I'm coming last—is really the unfortunate policy tension that has arisen as a result of federal and really worldwide prohibition on cannabis research.

What you're dealing with is one of the more sympathetic communities, along with children with intractable epilepsy, who have really suffered from the lack of efficacy research at the top levels of government for what cannabis can do for PTSD.

That lack of research over a period of time, with anecdotal evidence that this was being helpful, has turned this policy debate from what would normally be for any other substance a guilty-until-proven-innocent model into an innocent-until-proven-guilty model of dealing with the substance in such a way that we are going to assume benefits under anecdotes and smaller research faster than we would for a different substance.

I'm not suggesting that is the wrong approach to take here. I'm simply stating that is what has happened because of this worldwide prohibition on the sort of research that would be needed here.

That community is clearly tired of waiting for traditional institutions to catch up, and over time, there has been more and more of a push for right to access and use, hopefully with financial reimbursement and with physician oversight.

However, research is direly needed in this space, in my opinion, most clearly for drug-to-drug interactions, especially for people who might be in a PTSD situation and already are on a certain drug. Research is also needed on side effects, such as liver toxicity, and on specific formulations for drug efficacy: What is working? Why is it working? How can we research that?

The tension that is arising here is that, while some of this may be done with public research money, in particular in Canada more than in the United States, you can make great strides forward with public research and rigorous work through people like Dr. MacKillop. There will be a need to continue to have a path towards profitability for companies, for pharmaceutical companies, to continue to incentivize research in this area and continue to really put in what is going to be more billions of dollars—rather than even hundreds of millions of dollars—to prove that it is safe but also to find the most efficacious formulas.

The mission that I believe is in front of this committee today is to figure out a way to provide access to these communities that have been waiting for long periods of time to have access to it while continuing to provide incentives for research moving forward and really thinking about the long-term research prospects for providing effective safe medicines to these communities.

I think this will be a particularly difficult goal considering adult use legalization is coming online as well. As mentioned before, that will lead to self-medication in the marketplace. Nevertheless, I do think that you will have to consider the path forward of how you provide access, and how you provide continuing incentives to research in this area.

With that, I'd be happy to answer any questions.

● (1625)

The Chair: Thank you.

We will begin our first round of questions with Mr. McColeman.

Mr. Phil McColeman: Thank you, Chair.

Mr. Freedman, you said that you were part of the rollout in Colorado. Is that correct?

Mr. Andrew Freedman: Yes.

Mr. Phil McColeman: It's my understanding that medical cannabis and recreational cannabis are two different categories. Did the taxation of medical cannabis differ from the taxation of recreational cannabis in Colorado?

Mr. Andrew Freedman: Thank you, sir.

I was part of the Colorado government. In fact, I was the governor's point person during the rollout from 2014 to 2017 of both medical and adult use cannabis. We taxed medical cannabis at a rate of 2.9% sales tax. Adult use had both a 10% excise tax and an additional 10% sales tax, along with the regular 2.9% retail tax. All those taxes on the adult use side have gone up. The medical tax has remained at 2.9%.

Mr. Phil McColeman: That's a greatly reduced rate. Is that how other medical products are taxed—at 2.9%—or are they taxed at all in Colorado?

Mr. Andrew Freedman: No, they are not taxed at the 2.9% sales tax rate. That is specifically because this is not going through pharmacy and is considered a sale in the State of Colorado. Also, yes, the 2.9% is to other goods in Colorado.

Mr. Phil McColeman: Okay. The reason for my questioning is to point out to this committee and to Canadians in general that the regime put forth by the current government is taxing medical cannabis going to veterans and other communities like the ones you've talked about, such as children with Tourette's syndrome or uncontrollable seizures who are using it as medicine because it is a prescription that they've received.

The Chair: The bells are ringing now. Will we continue the meeting and Mr. McColeman's six minutes or do you want to get out of here? Is there unanimous consent to stay?

Some hon. members: Agreed.

Mr. Phil McColeman: Thank you, Chair.

The current rollout here in Canada is that recreational and medical cannabis are considered the same in terms of the tax regime. You have HST, GST and then excise on top of that tax, and then a third tax that is being collected. Ours is being collected. I'm not sure of the exact rate, but I think it's around 15% or 16% on medical cannabis. There is an initiative in this country to move it to the Colorado model or that of the other states. I know, having done the research, that the other states do not have the tax. This boils down to some of the most vulnerable people not having accessibility because of the tax laws of this country and because of this particular government that rolled it out.

In my comments to you—and I would invite the other witnesses to weigh in on this matter—I will say that there are two distinctions here: medicine and recreational use. Being experts in the field of cannabis, do you make those distinctions in your minds?

I think I know the answer from the doctor from McMaster through his comments, but more particularly to our two witnesses coming in by video conference, do you make those distinctions? Also, do you believe that medical cannabis going to veterans and other vulnerable communities who are getting it by prescription should be subject to excise tax and other taxes that push up the price of this product, while at the same time every other prescription drug in Canada is not taxed?

● (1630)

Mr. Kyle Atkinson: I believe there are two separate streams, the recreational stream and the medical stream. I think the medical stream needs help to continue to move further down that road. Research is one effort that needs to take place. Obviously, the ability of pharmacies to dispense cannabis needs to happen, and insurance companies providing more robust coverage of cannabis needs to happen as well.

Ultimately the tax that is on cannabis, the government has basically lumped it in and made it sound like it's a recreational product. That cannot continue. It is unfair for Canadians.

Mr. Phil McColeman: Mr. Freedman.

Mr. Andrew Freedman: I would say that of course I do believe there should be access for especially the more sympathetic communities here that I think have been waiting a long time for research. They should have both financial accessibility as well as physician oversight.

The one thing I would caution against in terms of price differential is we didn't see in the Colorado model that a lot of people stayed within the medical system due to the tax differential. I believe they were not there for medicinal purposes but essentially for the tax break. Because of that, I think we had a price incentive, essentially a buyer's discount. The part of that I regret is that those who were likely to become more addicted to the substance often went and got medical cards in order to buy it at a lower price.

Mr. Phil McColeman: Mr. MacKillop, do you have any comments?

Dr. James MacKillop: I do. I'd like to make a number of distinctions.

One that's important from the start is the distinction between an authorization versus a prescription. It's important to note that medical cannabis is not prescribed like a prescription drug. It doesn't have a DIN, a drug identification number. It's authorized by a physician, meaning that effectively, the patient is given permission to use it, but it's not actually prescribed.

I also want to make the distinction that the products that exist in the medical marketplace in some cases are very distinct. They're pills. They're oils. They have non-psychoactive ingredients. But in other cases, they are also high-THC flower products that look indistinguishable from the recreational marketplace. Making a bright line between the two is possible in some cases but not in others.

I think that the use of tax policy makes a lot of sense in terms of making some of these distinctions, but I think that the point raised around unintended consequences and incentivizing people to pursue medical authorization has to be taken seriously too. It may be there could be greater precision that certain, very clearly medical products that are only medical, for example, unambiguously, would be appropriate and others might not be. This is difficult with tax policy but a nuance would be needed because there could be unintended consequences.

The Chair: Thank you.

We have to go to the House to vote so we'll have to adjourn the meeting.

I'd like to thank the witnesses for their patience today. The clerk will get back to you about re-booking you for questions.

The meeting is adjourned.