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Chair

Mr. Bill Casey

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● (1535)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call the meeting to order.

This is our fifth meeting of the Standing Committee on Health, and we have some very distinguished witnesses today. Just briefly, we have the Honourable Dr. Jane Philpott, Minister of Health, and Simon Kennedy, who is a career civil servant who has held important positions with the Privy Council and the Department of International Trade. He has also worked in public relations at Mount Saint Vincent University.

We have Siddika Mithani, who's on her first day on the job here today, so we're going to be especially hard on her. She is president of the Public Health Agency of Canada.

Congratulations on your new position.

We also have Dr. Gregory Taylor, chief public health officer for Canada; Alain Beaudet, president of the Canadian Institutes of Health Research; and Bruce Archibald, president of the Canadian Food Inspection Agency. I hope I didn't miss anybody.

There are more of you than there are of us. Anyway, I certainly welcome you.

Pursuant to Standing Order 108(2), we are studying the mandate of the Minister of Health. Pursuant to Standing Order 81(4), we are also dealing with the main estimates for 2016-17. I'm not going to detail those, but for now I'm going to call vote 1 under the Canadian Food Inspection Agency.

Minister Philpott, welcome to you and your officials. You have the floor.

Hon. Jane Philpott (Minister of Health): Thank you very much, Mr. Chair, for this wonderful opportunity to be with you. Good afternoon to all of the members of the committee. It's a real pleasure for me to be here at the Standing Committee on Health as the new federal Minister of Health.

First of all, Mr. Chair, I want to congratulate you on your appointment as chair of this committee.

The Chair: Thank you.

Hon. Jane Philpott: The Standing Committee on Health, as you know, is proud of its achievements in times gone by and currently. It has a lot of experience when it comes to working on difficult and important issues for Canadians. I have no doubt that the work you will do around this table and others like it will be good for Canada over the next few years as we address health issues that could actually redefine public policies in the field of health for generations to come.

In many ways, as you know, working as a doctor for the last 30 years has helped to prepare me for this role and I'm deeply honoured to be in this position and to have this opportunity. I have practised medicine here in Ontario for many years, and I've also had the privilege of working in a number of countries in sub-Saharan Africa including living and practising medicine in West Africa for almost a decade. Those were some of the most satisfying years of my life.

The harsh realities of health and living conditions in some of the world's poorest countries have taught me a great deal about social determinants of health, what it is that keeps people healthy. It has shaped my vision for how we can improve health outcomes, both here and internationally.

[*Translation*]

Helping people benefit from and enjoy healthy and fulfilling lives is a matter of more than just providing the right drugs. It is also a matter of ensuring sound governance and having a system tailored to all the necessary objectives.

[*English*]

Before I continue, I want to also thank my colleagues who have gathered around me today. They've already been introduced, but I would like to say again, thank you to Simon Kennedy, my deputy minister of health, and to Siddika, who has joined us. We're absolutely delighted to have a new president of the Public Health Agency of Canada. I also want to thank Dr. Greg Taylor, Dr. Alain Beaudet, and Bruce Archibald. I believe we also have Barbara Jordan here. Is that correct? She's with us at the back, and she's the vice-president of policy and programs for the Canadian Food Inspection Agency.

Today, in the next few minutes, it's my aim to provide you with an update on the activities of the health portfolio and to talk about some of the key issues that this committee is going to address in its work over the coming months. Afterwards I'd be very pleased to answer any questions that you may have.

Canada's publicly funded health care system is a source of pride, and it's a defining value, as you know, for Canadians who rely on it for timely access to universal and high-quality services based on need and not based on the ability to pay. However, while Canada's health care system has served Canadians well, we would agree I believe that it must be strengthened in order to better meet the needs of patients as Canada changes in its demographics and disease patterns, as new technologies emerge and continue to shape the delivery of care, and as we try increasingly to move the delivery of care into homes and communities.

Canadians will be pleased to know that our budget has provided immediate investments that will support pan-Canadian progress on a number of priorities in the form of innovations within the health care system. In addition, budget 2016, as you may be aware, has announced initiatives that will help Canadians maintain and improve their health, including expanding access to nutritious food in the north, expanding food safety and enhancing those mechanisms, providing funding for specific men's and women's health initiatives, improving vaccine uptake and coverage, and investing in concussion protocols.

[*Translation*]

As members know, our government is committed to helping Canadians maintain and improve their health.

Our health care system is a source of national pride, but the gaps are widening. Transforming the way that health care in this country is delivered is one of my top priorities.

● (1540)

[*English*]

In January, as I suspect you know, I sat down with my provincial and territorial colleagues, the health ministers across the country, to begin working out a new vision for health care. We discussed and agreed upon a number of shared health priorities that will resonate with Canadians. These priorities put us on a solid footing to move forward with the development of a new health accord, one that will help provinces and territories accelerate their work in transforming care for Canadians, and I'll have a bit more to say about that accord in a few moments.

I wanted to comment a little regarding the main estimates and the supplementary estimates (C). I want to outline for you where they fit within the portfolio. Health Canada's main estimates, as you have seen, outline $3.75 billion in spending authorities for 2016-17. This represents a net increase of $97.8 million over the spending in 2015-16.

There are funding increases of $249 million for 2016-17 that relate primarily to first nations and Inuit health programming, and funding for the Canadian Foundation for Healthcare Improvement. You will note there is a decrease in the program of $151 million. That is mainly due to the sunsetting of some program funding, and I'd be happy to respond to your questions about that as we go along.

The Canadian Institutes of Health Research main estimates outline just over $1 billion in spending authorities for 2016-17, and this represents a net increase of $17 million over 2015-16. The net funding increase consists primarily of contributions to projects funded under the Canada first research excellence fund and the Canadian centres of excellence for commercialization and research program.

The Public Health Agency's main estimates outline $589.7 million, which represents an increase of $22.5 million over 2015-16 main estimates, which were $567 million. The major factors contributing to this net increase include new funding for medical countermeasures for smallpox and anthrax preparedness, as well as the reprofiling of the Ebola preparedness funding and response initiative in 2016-17. The agency's funding increase of $13.7 million in the 2015-16 supplementary estimates (C) consists primarily of new funding for the aboriginal head start in urban and northern communities program. It also includes funding for responding to the Syrian refugee crisis and for establishing the Canadian Centre for Aging and Brain Health Innovation.

The main estimates spending authorities for the Canadian Food Inspection Agency for 2016-17 are $739.7 million and that's a net increase of $41.5 million over 2015-16.

[*Translation*]

The main elements of this funding include the federal infrastructure initiative, which will help renew and upgrade CFIA assets and infrastructure. The funding includes continued work under the electronic service delivery platform, which will make tools and technologies available to industry, trade and international partners, as well as inspectors and CFIA staff. In addition, the funding will be used to improve food safety oversight in Canada.

[*English*]

This proposed spending is going to ensure that the government can contribute to and focus on important health priorities that are designed to result in better health outcomes for all Canadians.

Now, as this is my first appearance before this committee, I want to take a few moments to outline other priorities within the health portfolio.

In terms of health care transformation, you and I know that high-quality universally accessible and publicly financed health care is an essential foundation for a strong and prosperous Canada, but it had been more than a decade since health ministers from across this country sat down together to map out a plan to improve health care for Canadians. Restoring the federal government's role as a vital partner in supporting a more adaptable, innovative, and affordable health system is critical.

● (1545)

[*Translation*]

I believe that, if we work together, we can bring about real change in the health care system, so that Canadians can continue to enjoy high-quality and sustainable health care.

To that end, I met with provincial and territorial health ministers in Vancouver this past January to kick off discussions around a new long-term health accord.

[*English*]

We discussed a plan to work collaboratively and to support health care transformation and health system transformation that would enable a more accessible, patient-centred, and responsive care for Canadians. As an important first step at the meeting, we agreed to the key priority areas where transformation actions will bring about real change. We're going to be looking for ways to make sure that drugs are more affordable and accessible. We will explore approaches to making sure we move more health services from institutions into the community, including both home care and palliative care. We will look at how we can improve access to high-quality mental health care across the country. We're also going to look at how promising and proven innovations in the organization and delivery of health care services can be adopted and spread across the country.

The work to support this is going to be a focus of considerable activity in my department—in fact, it already has been—as we work with provinces and territories to develop the best approaches to address these issues. Although, as you know, health care delivery is largely in provincial and territorial jurisdictions, there are a number of things the federal government can do to support provinces and territories in their efforts to transform the health care system, and we're going to carefully study how federal activities and levers can help to accelerate progress in these areas of shared priorities.

By that I mean, for example, how our role in regulating drugs and our support for pan-Canadian health organizations can accelerate progress. We're going to explore how the federal commitment to invest $3 billion in the next few years in home care can be implemented to the best effect. I'm excited about the opportunities this work holds, and I look forward to working with my provincial and territorial colleagues on our health priorities.

[*Translation*]

At the beginning of the summer, I will meet with them again to see how progress is coming along. My hope is that we can ultimately find common ground so that we can work towards a plan that will transform and strengthen our nationally funded health care system.

[*English*]

We already know, on the matter of research, what needs to be done to improve our health care system. Health research has been essential in improving the quality of care and ensuring that Canadians get good value for the money that's spent.

[*Translation*]

The Government of Canada has made significant investments in health research to broaden its knowledge of health matters. That expertise shapes best practices and leads to improvements in the health care system.

[*English*]

This builds on an existing collaboration with our provincial and territorial partners on efforts such as Canada's strategy for patient-oriented research, otherwise known as SPOR. You may know that SPOR is a national coalition that's committed to health care innovation across Canada. Its goal is to foster evidence-informed health care by bringing innovative diagnostic and therapeutic approaches to the point of care.

On the matter of indigenous health, those of us who are parents know that we want our children, for example, to have the best opportunities in life. Those kinds of great opportunities involve having access to a good education, access to nutritious food, access to clean water, a roof over our heads, and access to quality health care. These are the basics that every Canadian child should expect.

There is no doubt that health conditions in many first nations and Inuit communities across Canada are deplorable and must be fixed. It has taken generations, though, for these problems to develop, and they're not going to be solved overnight. I find it deeply troubling as a physician, parent, and Canadian that these conditions should exist in a nation as affluent as ours.

[*Translation*]

History has shown that a top-down approach does nothing to address gaps. To do that, we need to build partnerships with first nations and Inuit leaders, a process that will require respect and an attentive ear.

In its throne speech, our government reaffirmed its commitment to building a nation-to-nation relationship with aboriginals. Moved by that spirit of partnership, I am committed to working with first nations, the provinces and territories, as well as front-line health care providers.

● (1550)

[*English*]

Already, as you may know, our department is investing more than $2.5 billion each year in first nations and Inuit health. However, truly embracing wellness will require uniting the physical, mental, emotional, and spiritual aspects of health to help change health outcomes. Also, implementing the calls to action of the Truth and Reconciliation Commission is going to be an important part of that healing process. I believe that by working together we can close those gaps in health status. As Minister of Health, I am personally committed to beginning this change now and to ensuring that these actions are sustained over the long term.

Next is the matter of healthy living and healthy eating.

[*Translation*]

Physical inactivity, poor diet, and injury remain major concerns. As a result of these problems, an increasing number of Canadians visit the doctor or a hospital every year.

Promoting an active and healthy lifestyle and preventing injury and illness remain at the heart of the federal government's efforts to help Canadians—

[*English*]

Mr. Don Davies (Vancouver Kingsway, NDP): I have a point of order, Mr. Chairman.

Mr. Chairman, I'm sorry, with great respect for the minister, the standing orders of this committee give every witness 10 minutes to make their opening statement. That applies to everybody, whether you're a minister or not. Out of respect for the minister, we've allowed her 15 minutes so far, but I see by the pages coming that we could be looking at significantly more, and that will cut into the time that we have to ask questions, which is the purpose of this meeting. I respectfully request that the minister wrap up her comments.

The Chair: Yes, if that's possible. We're very interested in them but we're also very interested in asking questions. If you could finish up, we'd appreciate it.

Hon. Jane Philpott: Thank you very much. I will do so and be happy to provide further comments.

The two other areas I was going to touch on were the matter of responsible drug policy—and feel free to ask me questions about that—and physician-assisted dying and legal reforms.

I did want to make just a few personal comments at the end. Would you permit me to make those? Apart from my prepared notes, I wanted to tell you what I am committed to doing in terms of my relationship with this committee and what I would request of you in return.

I would like to make a commitment to three things. One is that when it comes to my relationship with the health committee, I commit to be honest with you. There will be times, even today, that I won't have the answers to your questions. I will look for those answers. I will let you know the direction that we're taking, but I commit to being open and transparent.

Two is accountability. The Prime Minister made it very clear to me that I as a minister am accountable to you. That's the way the lines of accountability flow, so I will uphold the direction of the Prime Minister and make sure that I remain accountable to you.

Three, I commit to being fair in responding to the needs of Canadians and responding to the needs of the health committee and responding to you as colleagues in the House of Commons. I intend to always uphold fairness.

My three requests of you would be these. Number one is pragmatism. I ask you in your efforts as a committee to be practical, to look for what we can actually get done. I will be depending on you to get some very important work done in the years ahead.

Number two is to be collaborative. I am delighted that this is a representation of all members of the House of Commons, and I encourage you to collaborate with one another to be effective in your work and to think about the legacy of this committee.

This is a tremendous opportunity. The work that I know you're already considering is of profound importance. What will matter is not necessarily whether you're going to have your name written down in a book as having been a member of this committee over this period of time, but the legacy this committee is going to leave behind. How will Canada and Canadians be different, how will they be healthier, as a result of the work you have done here? I encourage you to think about that, and I'll be happy to respond to any questions.

The Chair: Thank you very much.

I would just like to add a little personal note too. I read with great interest the article in *The Globe and Mail* about you and some of your endeavours. I certainly gained new respect and admiration for you, and I'm sure that you'll do a good job.

On your request of this committee on pragmatism, we are a pragmatic group I can assure you. We are collaborative. We don't always agree on everything but we have mutual respect all around, and I don't know if we have a legacy or not. That remains to be seen. Thank you very much for your comments and your work.

We're going to open up the questions with Mr. Kang, and we're going to start with seven minutes.

● (1555)

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Thank you, Mr. Chair. Thank you, Minister.

In your opening statements, you were talking about palliative care. It is very important to Canadians who require it. What actions are being taken to assist in the access to palliative care and how do you plan on improving the current palliative care options that patients have? How do you plan on working with the provinces to encourage access and options for patients requiring it?

Hon. Jane Philpott: Thank you very much for that very important question.

I believe the matter of palliative care is something Canadians are very interested in. I certainly look forward to hearing the thoughts of the committee and your recommendations in that regard.

This is something that came up in the meeting with provincial and territorial health ministers when we met in January. There was a tremendous amount of interest in palliative care, and I think it's safe to say that part of that interest has been spurred on by the fact that, as you well know, we are in the process of, in the very near future, tabling legislation associated with medical assistance in dying. I think that's highlighted for us as Canadians the fact that we have, as a country, not done as well as we could have. In fact, Canadians don't have access, in many cases, to the high quality of palliative care that they need.

I intend—and I think my colleagues in the provinces and territories are prepared to do so, as well—to direct a significant portion of our attention in the health accord discussions to palliative care. I think it's a very excellent vehicle for being able to make this happen. You know that we've committed to an additional $3 billion in home care, and a good portion of that money may, in fact, go to palliative care. I would look forward to your comments on that.

Going forward I think, as you know, the delivery of health care is in the hands of provinces and territories, but one of the things we are committed to doing as a federal government is responding to the innovative ideas across the country. I know that across the country there are a number of places where palliative care is being done well. We will make investments to make sure those good ideas are spread across the country.

Mr. Darshan Singh Kang: Has any study been done? You touched on home care. Have there been any studies done? I'm sure it's going to cut wait times in hospitals. Has any study been done on how effective home care and palliative care will be in cutting down those wait times?

Hon. Jane Philpott: That's a fantastic question.

I would actually encourage every member of the committee, if they haven't already done so, to read an outstanding book by Dr. Atul Gawande called *Being Mortal*. That's one of the most accessible ways to think about the matter of palliative care. He talks, in that book, about the evidence.

There's lots of other academic evidence, and perhaps Dr. Beaudet could refer to that. But there is a lot of evidence that, in fact, introducing palliative care costs less, makes patients happier, makes patients more comfortable, and guess what? It often extends life. When people decide to stop trying to live longer, when they accept the fact that they want to be kept comfortable, when they sometimes take measures to stop direct treatment of their cancer, for instance, they actually live longer, which is very interesting data.

I don't know whether you want to comment further on that, Alain.

Dr. Alain Beaudet (President, Canadian Institutes of Health Research): Only that at CIHR we are investing in palliative care research and looking at a number of issues associated with palliative care. We have, in particular, with a number of partners, recently invested $16.5 million in an initiative called “palliative and end-of-life care initiative", to look exactly at these issues.

The outcomes of these investments are really making a difference in the health care system. For example, research by Dr. Kirk and Dr. Lau on the palliative performance scale has now informed new eligibility criteria for the British Columbia palliative care benefits program.

Mr. Darshan Singh Kang: Thank you, sir.

My next question, very quickly, is about first nations. Can you elaborate on the nutrition north program that is taking place within our northern communities. How are you planning to expand that program?

Hon. Jane Philpott: This is an area that, as you know, was part of our platform commitment. It's something that I will be working on in collaboration with Minister Bennett from Indigenous and Northern Affairs.

The idea here is to address the costs of getting adequate nutrition to northern communities. We have made some investments in that, and we'll continue to invest in that area.

Are you comfortable commenting on that at all, Siddika, in terms of nutrition north?

● (1600)

Dr. Siddika Mithani (President, Public Health Agency of Canada): No, Minister, not at the moment, but we can certainly get back to you about further details on what this entails.

Greg, do you—

Hon. Jane Philpott: Do you want to add something, Greg?

Dr. Gregory Taylor (Chief Public Health Officer, Public Health Agency of Canada): Just that it's extremely important from a public health perspective, obviously, because of the distance, and the agency would be able to play a supportive role.

Mr. Darshan Singh Kang: Are you going to give us more information on how you are expanding it?

Mr. Simon Kennedy (Deputy Minister, Department of Health): Maybe just to clarify, Mr. Chair, the main delivery of the program is actually INAC, and Health Canada has a small portion. We provide the policy advice, the content about what should be covered, what constitutes nutritious food, that sort of thing.

In the budget we received a small portion of the money, because we're a participant. But the main program is actually run by Indigenous and Northern Affairs.

Mr. Darshan Singh Kang: Have you consulted with our northern communities on this?

Hon. Jane Philpott: We had some early discussions on a number of topics with indigenous leaders in the country. The topic of nutrition has come up to a certain extent. As you know there are a huge number of health problems in indigenous communities across the country. When it comes to things like the nutrition program, as the deputy minister has said, some of that falls under Minister Bennett's jurisdiction, but obviously the topic of getting access to great food is extremely important to maintaining good health.

Mr. Darshan Singh Kang: My next question is about mental health. Could the nutrition program be related to mental health as well? Do you believe the services for mental health in the remote areas are adequate? What improvements, if any, can be made to mental health services in remote communities?

Hon. Jane Philpott: That's a very important question and obviously very timely in terms of some of the things that you've probably been reading in the media recently. You asked whether or not I felt that access to mental health services was adequate in remote communities. I would argue that access to good, high-quality mental health services is not adequate in very many regions in the country, if anywhere. If fact, mental health is one of our real gaps in health care. There is a tremendous need to improve that if for no other reason than.... Obviously we want it for our own happiness and well-being, but when people look at the world from an economic perspective I think it's argued that something like 10 billion dollars' worth of lost productivity in the workplace each year is due to mental illness. So for all kinds of reasons we need to do better.

In indigenous communities in particular this is most widely seen, and I think it's very interesting you commented about the fact that even something like how well people can eat has an impact on their mental health. There are all kinds of other things that you'll hear in some of the remote communities, like kids not having access to recreational facilities. Many of these towns, depending on the time of year if there's no arena, no swimming pool, or there's nothing else to do, it has a huge impact on mental health. The mental health of remote communities is probably one of our most pressing health needs in the country. Whether we wanted to or not, it is pressed upon us as an urgent matter that we have to address.

We will be doing that obviously in a whole-of-government way, but mental health as I alluded to earlier is going to also be a big part of our health accord. We have some really interesting ideas about how we can improve access to mental health care. We're going to be putting together an advisory panel on mental health. This is such an important issue and you guys around this room are all smart people and have great ideas. If you have great ideas about mental health in particular, or if that's something the committee's going to be looking at, please let me know, please reach out to me with your good ideas. There are few things that are as important to us as a country as getting this right.

The Chair: Mr. Carrie, you have the floor.

Mr. Colin Carrie (Oshawa, CPC): Thank you, Mr. Chair.

I want to thank the minister for being here. I want to clarify too, Minister, are you here for the full two hours today?

Hon. Jane Philpott: I do need to scoot out at some point. Unfortunately I'm not able to stay for the full two hours, partly because of the crisis in northern Ontario. I need to go to a media interview, but my team is going to stay around and I'm happy to come back.

Mr. Colin Carrie: If you can, stay for as long as you can because we would like to get through one round of questioning.

Hon. Jane Philpott: I will stay as long as I can until someone pulls me out of here.

Mr. Colin Carrie: We'll get right to it then.

● (1605)

Hon. Jane Philpott: Congratulations, by the way. Is it true that you are the new health critic for your team?

Mr. Colin Carrie: I am. Thank you very much for that.

When we were in government, minister, our number one priority was the health and safety of Canadians. I did look through your mandate letter, and it didn't state this. I just want to clarify; is that still your number one priority?

Hon. Jane Philpott: The health and safety of Canadians...?

Mr. Colin Carrie: Yes.

Hon. Jane Philpott: Absolutely.

Mr. Colin Carrie: We did notice that in January you authorized Canada's second safe injection site. I was wondering if you could comment. Is there any safe or healthy way to inject street heroine into your arm, something that could be laced with anything, that could be kerosene, as far as you know?

Hon. Jane Philpott: I'm very glad that you brought that up. As you know, I'm very much a supporter of supervised consumption sites. I am not only a medical doctor, but I have a degree in public health. I'm a person who really believes that people who find themselves in the position of having an addiction to illicit substances like heroin need to be treated from the perspective of a public health problem because it is a health problem. It's an addiction.

I was very pleased that we were able to allow an exemption for this site. The reason I think it's important is.... As you asked, is there a safe way to inject heroin or not? Let me tell you, there are certainly unsafe ways about it. There is a serious problem of addiction across this country, and particularly opioid addiction. Supervised consumption sites have been shown repeatedly—and this has been well documented—to save lives. I'll perhaps ask my public health colleagues to reiterate this.

There is nothing that is so devastating on this issue than when I talk to parents whose kids have found themselves addicted and who have accidentally overdosed on something like heroin. If we can find ways to save those lives, then I'm going to make sure that's possible. If we can find ways to prevent infection because it is absolutely unhealthy to inject yourself with a dirty needle that might have hepatitis C or HIV on the needle, that's definitely one thing that a supervised site can help with. This is a great way for people who have addiction to access health care services.

When I was at Insite, I was moved to tears when I saw the way that people who are on the street could come in and access care, where people didn't judge them, where people didn't stigmatize them, where people said, “If we can help you, we're here to help you. If you want to talk to one of our counsellors, you can. If you want to talk about getting into safer housing, we'll help you with that.”

Mr. Colin Carrie: I agree with that, Minister, but the question was, is there a safe and healthy way of injecting street heroin? As a doctor, you come from Markham—Stouffville, and I'm sure you've worked in the emergency department. If somebody came to you with an unknown substance in a vial and asked if you would supervise their injecting this into their body, would you do it?

Hon. Jane Philpott: It's perhaps a little provocative the way that —

Mr. Colin Carrie: No, that's okay. I'm curious to hear what you have to say.

Hon. Jane Philpott: I am here to make sure that Canadians have better access to healthier and safer lives. I think we need to be very cognizant of the fact that people do inject heroin. Yes, there are safer ways to do it and there are less safe ways to do it. Do I wish people didn't inject heroin? Of course I wish that people didn't have to, but they do. And if they're going to do it, I would like to make sure that it's done safely, that it will not kill them, that they will not be infected by what they're being given, and ideally, that they might be able to eventually learn how to taper off that and to manage their addiction.

This is an area where it's not perhaps entirely intuitive to every Canadian to understand that this is the best way to go, but I am fundamentally supportive of this. I believe it's really important for us, as a country, to make sure we address the very serious opioid and addiction crisis across this country.

Mr. Colin Carrie: I think most people would agree on that ,and you've been very clear about addressing the opioid crisis, which we found curious because I think it was just last week there was a regulatory process about tamper-resistant opioids. I think you're aware, Minister, Canadians take more of these drugs than anybody around the world. There was, let's just say, a way of moving forward for tamper-resistant opioids and you've backtracked on that. I would think that we should make all these opioids tamper resistant, whatever it is, for example, fentanyl.

When people are using Oxycontin, I think you're aware, if they can't get it, they go for heroin. We're looking at the health and safety of Canadians. The way you are moving forward, do you really think that's going to help improve the health and safety of Canadians?

● (1610)

Hon. Jane Philpott: I'm going to assume you want me particularly to address the issue of tamper-resistant medication. Again, sometimes these things aren't entirely intuitive. Your first gut reaction might be that if we can provide a tamper-resistant drug, then that should be what we should enforce. Having said that, sometimes you have to dig a little deeper into the evidence. One thing I'm pleased about is that we're able to provide a comprehensive approach to drug policy. That comprehensive approach includes a number of things like educating prescribers, the public, the health workforce. It also includes making sure that we minimize the harms to people.

But on the matter of tamper resistant, something very interesting happened. In 2012 the first products of tamper-resistant Oxycontin were introduced into the market. As a result of that most provincial drug policies, not all, but most provincial plans included only the tamper-resistant version. What ended up happening around the same time, and this has been well documented, was a rise in the illicit use of other substances, particularly fentanyl, which is now our number one problem in the country.

Mr. Colin Carrie: That was my point, though. If we do not want Canadians to take these drugs—we're the number one in the world—doesn't it make more sense to make all these drugs tamper resistant because it...?

Hon. Jane Philpott: I wish it were possible to have tamper resistance for which it was impossible to find other routes, but the reality—

Mr. Colin Carrie: But the diversion, because of these prescriptions being left, right, and centre to criminal elements, don't you think it would be wiser not to have that option?

Hon. Jane Philpott: It would be wise if it worked, but the result is that the introduction of tamper-resistant products only serves to increase the use of other products on the market. You can't take a single approach to a drug. As you may know, fentanyl is a product that is intended to be given transdermally and the way it's actually used in many cases—and other medical colleagues around the room can attest to this—is that it's often tampered with and injected in other ways or accessed in other ways.

Again, this is something on which I'm very pleased with the advice I've been given by my department. I'm absolutely convinced that we're on the right track.

I don't know whether anybody.... Do you want to respond to that? My deputy minister is a huge expert in these things-—

Mr. Simon Kennedy: I don't know about that.

Hon. Jane Philpott: —so I will pass it over to him.

Mr. Colin Carrie: Mr. Kennedy, no offence, but you'll be here in the next hour. The minister has to leave and I have another question about the Respect for Communities Act.

The Chair: Were you saying something, Mr. ...?

A voice: I thought you said that time is up.

The Chair: Time is up, yes.

Mr. Davies.

Mr. Don Davies: Thank you.

Minister, welcome to the committee, and thank you to the officials for being with us here today. I want to start with some of the big, broad issues facing Canadian health care and I'm going to start with the health accord.

As you know, the Conservatives unilaterally imposed a 10-year health accord in 2014, with a formula that contained a 6% escalator for the first three years until 2017 and then it dropped to 3% for the remaining seven years thereafter. Your mandate letter, of course, commits you to negotiating a new agreement. I've asked the Parliamentary Budget Office to review your budget and fiscal framework and they have confirmed to me that they can't find any money budgeted, either in your budget or fiscal framework, for any increase to the escalator after 2017.

During the election your leader quite famously told Canadians that you can't have a Tommy Douglas health care system on a Stephen Harper budget.

Is your government going to increase the escalator after 2017, or are you going to adopt the Conservative's health transfer escalator funding?

Hon. Jane Philpott: Thank you for the question.

As you know, the matter of the Canada health transfer is something that I don't get to decide by myself. I will have input into that discussion, of course, as will other health ministers, but it's a decision that will fundamentally be made by finance ministers and first ministers across the country in terms of the size of the transfer. I've certainly had this discussion with my counterparts who are, of course, interested in addressing issues like the escalator, like demographic top-ups, etc.

What we have said is that there will be a long-term funding agreement. We have not yet made a commitment as to what that will be.

Second, we are committed to making sure there is transformation in the system, and I recognize that while money is not the only way to transform the system, money can ideally—and in best-case scenarios—help to buy change, and help to incent people to change. Those kinds of discussions will be a big part of those conversations with my counterparts.

On the third area of whether it shows up in the budget or not, I can tell you that we have committed to a $3-billion investment in home care. That money is going to be there. Whether it shows up in the fiscal framework at the Parliamentary Budget Office right now or not, it's a commitment we are holding to.

● (1615)

Mr. Don Davies: Can I move to that?

Thank you, you've foreshadowed where I'm going next because during the federal election the Liberal Party promised Canadians that a Liberal government would invest $3 billion over four years for home care. Now we're in year one of your four-year mandate and your budget doesn't have a penny allocated to home care in this year.

My first question in a two-part question is, where is the first year of home care funding?

Your leader also famously talked about back-loading promises and he appeared to object to that. I can't find a single reference, in not only the first year but in any of the years of your fiscal framework, to where that $3 billion is. Can you point to the budget or fiscal framework and show me where the $3 billion is budgeted for that commitment?

Hon. Jane Philpott: When I talk to Canadians about the federal government transferring money to the provinces, one of the things they're very interested in is making sure that we know what that money is going to do. There is a tremendous amount of interest in the concept that if there will be new investments, how will we know where that money is going to be spent and how is it going to inform the system.

I think the option was potentially there that we could have written the $3 billion into the budget and said that we would figure out later how the money is going to be spent. I don't think that would have been responsible of us. I'm very pleased that we have not yet written it into the budget. There will be another budget next year and between now and when our budget is produced next year, that's when I need to have those important conversations with the health ministers in the provinces and territories. You can be sure I'll be holding the finance minister to helping me out with that.

Mr. Don Davies: Okay. Good.

I want to move to pharmacare. Nearly a quarter of Canadian households report difficulties paying for prescription medication based on cost. Over one in 10 Canadians say they do not fill their prescriptions because they don't have the money.

Canada is the only country in the world with a universal health care system, the only one of many countries, that does not provide universal prescription coverage, and you said in your remarks, with which I agree, that in Canada folks need to get the medicine and care they need regardless of their ability to pay. That's not the case in Canada with prescription medicine now.

Your government has committed to entering the pan-Canadian pharmaceutical initiative, which entails bulk buying and a national formulary, and I applaud you for that. You'll have our support on that. But these initiatives do not result in every Canadian getting access to the medicine that they need. Are you open to implementing a national universal pharmacare system to make sure every Canadian gets the medicine they need during this term of office?

Hon. Jane Philpott: I want to thank you for your advocacy on this matter, because it's something that I am very interested in. I've talked to others about it and I think it's terrific that you are continuing to press on this matter. If I'm not mistaken I believe that the committee is planning to look at this issue. I think that's terrific.

I really, genuinely look forward to your report and your ideas as to what pharmacare could look like in Canada. Having said that, you know that it's not part of my current mandate. What the Prime Minister has asked me to do at the moment is to work on bringing down the cost of pharmaceuticals and making sure that they are accessible and affordable for Canadians.

I think that as a responsible step this is an important first step. If we were to lock in the prices that are there now, if we were to instantly institute a universal pharmacare program, we'd be locking in extremely high-priced medications.

There are actually a number of very interesting levers, and this is something you might want to ask about after I've left as well today, because I think you might be interested in some of the things that can be done. You talked about the pan-Canadian pharmaceutical alliance, which we're delighted to have joined as a federal payer, but there's actually a lot of work that can be done, for instance, with the Patented Medicine Prices Review Board around the regulations that are associated with that, which can help to drive down costs. There's work that needs to be done on the development of a national formulary, which we currently do not have and it will take some time to develop.

All of those are steps toward...and if you as a committee can help to make the case, then that's something I think I'd be interested in talking about.

Mr. Don Davies: We'll do our best. I want to get a couple of quick questions in on Bill C-2. I know I'm running out of time. I applaud your evidence-based decision on supervised consumption sites. I come from Vancouver and there's no question that they save lives, they help stop the spread of disease, they help encourage people seeking help and assistance, and, in fact, help them in getting off drugs.

But I am puzzled by the fact that despite your positive comments you have indicated quite clearly that you are not interested in repealing Bill C-2, which every stakeholder in the country who favours supervised consumption sites says presents unnecessary barriers to opening such sites. Twenty-seven different criteria in that bill make it very difficult to open those, which I think was the entire objective of the previous government in introducing it.

Can you tell us why your government wouldn't repeal that law if you truly believe that opening these sites saves lives and we need to actually make it easier for communities to get them, not harder?

● (1620)

Hon. Jane Philpott: That's a great question. This is something we are following very closely. I agree with you that it looks on first glance.... On that law there was a lot of interest in repealing it and I continue to hear from people who are interested in repealing the law.

The reality is that in order to provide an exemption for some of these supervised consumption sites, there are a number of steps that, whether that law had been put in place or not, Health Canada would have required a site to go through. They include things like making sure you've consulted with the chief of police, making sure you've consulted with other stakeholders, making sure you have safety mechanisms for surveillance in the building, for instance, for how the products get in and out of the building, for how the needles are disposed of, all kinds of regulations that have to be put in place.

The reality is that the extra additional steps the law adds are not considerably greater than the steps that would have been undertaken anyway.

Having said that, we're delighted that now not only the Dr. Peter AIDS Centre but also Insite have been able to get their exemptions under the existing law. There are other communities that are currently working on getting an exemption under the existing law.

We will watch this very closely. We believe that it's not an unreasonable bar. We had indicated very clearly that Health Canada will support communities that want to work their way through this process. I will keep an open mind, but at this point we don't believe that it should be a top priority for us to amend that legislation because we believe that it looks like the municipalities are going to be able to work within it.

The Chair: Your time is up.

Dr. Eyolfson, you have seven minutes.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Mr. Chair.

Thank you all again so much for coming. I've practised emergency medicine for 20 years and much of my subspecialty training involved toxicology and addictions. I also join Mr. Davies in congratulating you on your evidence-based approach to addiction and harm reduction.

This brings us to another very important addiction-related issue in Canada. According to your mandate letter, there are requirements for plain packaging of tobacco with regulations similar to Australia and the U.K. What progress has been made with that so far?

Hon. Jane Philpott: That's a great question and again it speaks to the huge role of public health, and I'm really pleased to be able to support public health evidence-based approach to matters like tobacco control. You know Canada used to be seen as a world leader in tobacco control. Unfortunately in recent years many other countries have surpassed us and we are no longer necessarily seen as a world leader. It's time for us to get back onto the world stage in leading that.

You alluded to the fact that the mandate letter does include a number of measures including introduction of plain packaging. I think I'm allowed to tell you that we will be following the Australian model of plain packaging a little more. I'm very excited to say that all sorts of things happen in the background, but a lot of work is being done to get us to the point where we're going to, very soon, be able to take steps to introduce those measures and adjustments and regulations around plain packaging. Health Canada has been working a great deal on it, and we will be presenting the next steps in the very near future.

Mr. Doug Eyolfson: Okay, thank you.

Further to that, are you able to elaborate on any of these specific regulations that are inspired by Australia that we'll be adopting?

Hon. Jane Philpott: I almost need my packages here to show you. A lot of it has to do with things like the colour of the packages, the text on the packages, the health messages. There are clever ways that companies are able to get around our current regulations, for instance, tucking advertising inside the packaging. The Australian approach is responding to all those different ways that advertising was able to bypass the mechanisms in the current approach. The reality is that there is a huge variance across the country so that a number of provinces have been quite proactive in introducing changes that would support better tobacco control. We hope to be able to provide a more uniform approach, and as I say, we probably will be a world leader in that matter.

Again, I would encourage you to get Simon to give you some more details on that. I don't know if you want to do that now or whether you'd like to wait until later.

● (1625)

Mr. Doug Eyolfson: It doesn't matter. I think we'll take advantage of the time you have with us right now.

Hon. Jane Philpott: These guys are getting bored, you see.

Mr. Doug Eyolfson: All right.

Can you think of any specifics regarding Canada in our marketplace and culture that would differentiate it from places like Australia and the U.K., and that might cause differences in how we might regulate this?

Hon. Jane Philpott: I'm not sure whether I can. Obviously we're a unique culture and there are challenges that Australia has faced as they've introduced their regulation that we will learn from. Australia, I believe, has had some legal challenges related to their introduction, and we'll learn from the lessons that Australia has undertaken in that regard to make sure that we manage those problems and try to avoid legal challenges as much as possible. But overall, they are seen as a world leader, and I think that we'll very much look to their example.

Mr. Doug Eyolfson: All right.

Has the government or your department approached tobacco companies with this issue?

Hon. Jane Philpott: I have not had conversations with tobacco companies about this, but I know the department has.

Mr. Doug Eyolfson: All right.

There is also a lobbying group that is associated with convenience store owners who feel they have lost income due to the plain-wall provisions. Likewise, have those groups contacted the government yet regarding this issue?

Mr. Simon Kennedy: I'm not aware. It is possible. Certainly at my level we haven't met with that organization.

When we get to the regulatory process and get draft regulations, presumably a lot of these groups that have an interest would be wanting to make submissions and representations, but at this point I don't think we've had those kinds of detailed representations from some of the groups that you've mentioned.

Mr. Doug Eyolfson: Okay, thank you.

I still have some time. I think I've taken care of all the questions on that issue.

On an unrelated note, part of the mandate is to encourage the adoption of digital technology and electronic charting. There's quite a bit of disparity, not just from province to province but even within provinces and within different health regions.

Is a strategy being developed right now to level the playing field and make a consistent approach to electronic medical records?

Hon. Jane Philpott: This is something that I'm really interested in. As a health care provider myself I know, if I may say politely, the chaos that exists across the country in electronic health records. I think we've made progress in terms of health care providers, hospitals, and others using more and more electronic records, although we had lagged for some time. Canada's starting to improve our track records in terms of the availability, but the huge challenge is integration of systems.

We've seen for instance that Quebec has recently taken some steps to ensure that there will be much more uniformity across different platforms, and I think we need to do much more of that in Canada.

One of the areas that we did invest in through the recent budget is the Canada Health Infoway, so we were able to add some funding there.

I would like to make this a part of our health accord discussions because you know as a provider as well as I do that it's really unacceptable that a family doctor in one part of a city should not be able to communicate with a family doctor in another part of the city in accessing laboratory results and all sorts of other things, and a patient should not have to repeat their whole story, repeat blood tests, because there's a huge amount of waste in the system. You will have my full support in making sure we do better on digital technology.

The Chair: Thank you.

Ms. Harder, welcome to the committee.

She is our newest permanent member of the committee, and we look forward to her contributions.

Ms. Rachael Harder (Lethbridge, CPC): Thank you very much.

Thank you for being here. I've looked at your record and the background that you're coming with and you have a lot of experience.

I'm just curious. When it comes to physician-assisted dying, should you return to the field, I'm wondering if you would be comfortable with assisting someone in dying.

● (1630)

Hon. Jane Philpott: First of all I'm going to say this is probably the last set of questions I can take. I'm not trying to avoid this question. I'll answer you in a second. I just want to let you know that you're probably the last person I can take questions from and then I'm going to have to go, but I will be available in the future.

I believe that patients need to have access to a range of options at the end of life and I would support the fact that they need to have access to that range of options.

Ms. Rachael Harder: Is PAD something that you would be comfortable with administering?

Hon. Jane Philpott: On matters of the choices that I would make as a physician—and I'm here as the Minister of Health and not as a physician—I would make sure that my patients had access to the range of options at the end of life. That's a necessity for us and in fact it is required of us.

The other thing that I would point out to you is that the legislation that is going to be introduced in the very near future addresses the fact that the Supreme Court of Canada has made it very clear that we need to make sure that Canadians have access to assistance in dying at the end of life and it is our responsibility as parliamentarians to make sure that we put the laws in place. There is no question about whether or not medical assistance in dying needs to be available to all Canadians. That has already been made clear by the court.

Ms. Rachael Harder: I find it interesting that in your personal life as a doctor you would make sure that your patients had access to whatever form of care they chose at the end of life, yet as a minister you haven't put an emphasis on palliative care. I don't see it anywhere in the budget, so I find that precarious.

Moving on, I'm just wondering as well if you placed emphasis on the Charter of Rights and Freedoms and whether or not you believe it should be upheld no matter what.

Hon. Jane Philpott: I fully believe in the Charter of Rights and Freedoms.

Ms. Rachael Harder: When we move forward with regard to putting legislation in place for PAD would you say that the conscience rights of doctors and institutions will be protected in the legislation that we expect to come forward soon?

Hon. Jane Philpott: I have heard from all kinds of colleagues, physicians as well as others, who are very concerned about the matter of conscience rights of health providers. Whether it's the special joint committee, the external panel, the provincial and territorial report, none of those reports had any argument with the fact that we should uphold the conscience rights of health care providers. I think that will give you a clue as to what the legislation will show.

Ms. Rachael Harder: Thank you.

The report that did come out required referral from doctors, which could arguably be against their conscience protection or their conscience rights. I'm going to leave it at that for now, and I'm going to share my time with my colleague over here.

Mr. Len Webber (Calgary Confederation, CPC): Thank you.

I'm glad you can at least stick around for a little of the time, Minister. I find it a little disturbing that you have to leave a standing committee to address the media. Anyway, I will ask my questions and hopefully I can get some answers here.

Minister, while reviewing your hospitality expenses, I note that your office charged the taxpayers of Canada $3.94 for a trip to the cafeteria on Friday, December 4. You would have signed off on these expenses, of course, and I'm sure that the processing of this minor expense cost more than the $3.94 you claimed. The MP per diem that week when we were in there was $95 a day. Did you make a hospitality claim, as well, while also collecting this claim? Can you please let us know what the purchase was of such a minor amount that needed to be charged to taxpayers here in Canada? Do you believe this is a wise use of taxpayer money?

Hon. Jane Philpott: Thank you for the question.

I will have to look into the specifics of that. I can't recall off the top of my head what I spent money on, on December 4, but I will be happy to get that information for you.

Mr. Len Webber: Good. Thank you. I appreciate it.

I also have a question on pharmacare, Minister. As you know, this committee is studying the issue of pharmacare here in Canada, and I think it is fair to say that everyone around this table would love to see medicines more accessible and affordable. But the reality is that someone has to pick up this tab, and ultimately it's the taxpayer. I also noted, Minister, that your mandate letter says that you need to work with the provinces and territories to improve access to necessary prescription medicines. With regard to the issue of pharmacare, we can't ignore the elephant in the room: the enormous cost that is associated with expanding drug coverage here in Canada.

Without funding set aside in your main estimates, Minister, for a massive new drug coverage plan, it appears to me that the intention here is to download these costs to our provinces and territories. Would there be any increased drug coverages expensed to our provinces, and would any of these increased drug coverages be an additional expense for the federal government? If so, how much do you think we can afford, as taxpayers, from the federal level?

I'll let you answer this question.

● (1635)

Hon. Jane Philpott: Thank you.

Clearly, the federal government would have to have a long and thoughtful conversation with the provinces and territories on the direction of drug costs. Certainly I'm not in the business of off-loading expenses to provinces and territories that are not appropriate. Having said that, as I said, we've already undertaken some important measures. I can tell you the provinces were delighted when we decided to join the pan-Canadian pharmaceutical alliance, which will effectively decrease costs for all jurisdictions across the country that participate in that alliance.

Obviously we're not in the position of implementing pharmacare at this time. Mr. Davies already pointed out his support for pharmacare. I think the other thing I would emphasize to you is that one of the reasons I'm interested in making sure drugs are affordable and accessible to Canadians is that there is considerable evidence, particularly with certain medications, that we would save money in the long run if we were to make sure that Canadians had access to drugs. I'm happy to give you, and I know Dr. Eyolfson would similarly be happy to give you examples of patients who could not access insulin or blood pressure medications and who ended up having end-stage heart and kidney failure, which in the end cost the health care system thousands of dollars. If we had been able to make sure that those people had access to the medications they needed when they needed them, it would have saved huge money down the road.

There is no question that, while it sounds as if it might be expensive and that's one of the reasons why we're not in the position where we're about to implement pharmacare, there are public drug plans across this country for people who can't afford their medication. That's a good thing. But we still need to make sure all Canadians can access the medicine they need, and that's what we're working toward.

Mr. Len Webber: Does this include experimental drugs as well?

Hon. Jane Philpott: You raise an interesting point, because with advances in technology, drugs are getting more expensive. That's a matter we can't be in denial about and we need to make sure there are mechanisms in place to keep those costs under control.

The Chair: Thank you.

Are you departing now?

Hon. Jane Philpott: I believe I am apparently departing. It's been a pleasure to be with you. I do hugely appreciate the work you're doing, and we really look forward to hearing the results of all of your projects.

The Chair: We look forward to having you back.

Hon. Jane Philpott: I'd be happy to come back.

The Chair: Thank you.

We'll just take a little break, and then, Ms. Sidhu, you're up for questions.

● (1635)

(Pause)

● (1640)

The Chair: Welcome to our committee again.

Are you intending to make a presentation on the main estimates or would you like to launch into questions? What's your preference?

Mr. Simon Kennedy: I think, Mr. Chair, we're just ready for questions, no statements.

The Chair: Just ready for questions, all right.

Ms. Sidhu, you have five minutes. We're in five-minute rounds now.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair, and thank you, panel, for being here with us.

This government has committed to eliminating the stigmatizing donor-screening policies preventing healthy men from donating blood just because they have been sexually active with other men. Can you please update the committee on this commitment?

Mr. Simon Kennedy: Mr. Chair, with regard to the blood system, I'm sure the various members of the committee know that Health Canada is the regulator and reviews applications from the blood operators when there's a desire to make a change. This was the system set up following the Krever commission. It's up to Héma-Québec and Canadian Blood Services to come forward with a proposal.

They have come forward actually within the last week with a proposal to reduce the deferral period involving the issue of MSM from five years to one year. We are now in the process of actually reviewing the submission. There's a lot of detailed statistical data, a review of the international experience of other jurisdictions, and so on. Obviously, we want to give it a careful review. The objective will be to ensure that any changes to the blood system maintain the same level of safety. We anticipate that review will be finished over the summer and that we will be in a position to provide a regulatory authorization by no later than September.

That's the current status. If that's successful, it would reduce the deferral period significantly to one year.

Ms. Sonia Sidhu: My next question is on food labelling. According to the mandate of the Minister of Health, improvements need to take place so that food labels contain more information on the sugar and artificial colour added to processed food. What are the objectives that the Department of Health hopes to achieve with such regulations? What progress has been made in this regard?

Mr. Simon Kennedy: Members may know that Health Canada had put out a regulatory proposal—I don't remember exactly the date, but it was eight months ago, a year ago or so—and were out consulting on that proposal. That proposal laid out a series of proposed changes to food labelling, including providing more detail on sugar. For example requiring that sugars be grouped on the list of ingredients because some products might have various kinds of sugar, but they're not necessarily all labelled as sugar. They're all over the place in the ingredient listing, so the proposal was to group them all so you would see much more clearly the amount of sugar in the product. That proposal would have required more information on dyes and so on.

We consulted on that. Obviously we now have the comments from all the stakeholders. The government has made a series of new promises, commitments, for example, on added sugars and so on. The ministry is looking at the original labelling proposal that we consulted on and at the comments we've received, at the new commitments the government has made, and our aim would be, once the government has made some decisions, to go out with details on those proposals.

In terms of what we would be aiming to achieve—my colleagues I'm sure could talk about this as well—there's certainly lots of evidence that Canadians are consuming too much in the way of sugars. We obviously have concerns about issues such as obesity. Many Canadians are concerned about dyes and colourings, and whether those can produce reactions in sensitive individuals. The proposal is to provide more information to consumers about these features of their food so they're able to make more informed and better decisions.

● (1645)

Ms. Sonia Sidhu: Thank you.

What steps are going to be taken to promote a national strategy around concussions?

Dr. Gregory Taylor: Perhaps I can talk a bit about concussions. Some of the work on concussions is toward research, so I'll let Alain talk about that in a second. We have some resources that came with the current budget, and we'll be focusing on standards so people can understand treatment and how to recognize a concussion, basically best practices that we're going to disseminate to various groups, Sport Canada, etc. I think part of the way forward on that is ensuring that people are kept off long enough so they have a chance to recover. We're working toward that.

From a research perspective, Alain, did you have anything?

Dr. Alain Beaudet: The research evidence will inform the development of a national strategy on concussions. CIHR is investing heavily in research that aims at improving the prevention, diagnosis, and treatment of Canadians who suffer from traumatic brain injuries, including concussions. Since 2011, we've invested close to $20 million in research on traumatic brain injuries. We certainly are now supporting a number of high-level research teams investigating the underlying causes and approaches to treatment, which I believe will be very useful in developing proper policies, programs, and products related to this issue.

Ms. Sonia Sidhu: Thank you.

The Chair: Your time is up.

Mr. Webber, welcome back.

Mr. Len Webber: Thank you, Mr. Chair.

I'd like to read some quotes from the minister's mandate letter from the Prime Minister. It says, “We have promised Canadians a government that will bring real change”, “We committed to a responsible, transparent fiscal plan for challenging economic times. I expect Canadians to hold us accountable”, and “We have also committed to set a higher bar for openness and transparency in government. It is time to shine more light on government”.

Those are some quotes from the Prime Minister. It seems that he has set a pretty clear expectation to the minister, and to all ministers, but this just does not square with what we have seen so far. The parliamentary budget officer says, “The Government has made changes to the presentation of its fiscal plan that have made it more difficult for parliamentarians to scrutinize public finances.”

I'm wondering if you and the minister will provide detailed spending plans for her department over a five-year horizon, as was done by the previous Conservative government, instead of the short two years that has been done. Does the minister not think that it would be more in line with what the Prime Minister has asked you guys to do?

Mr. Simon Kennedy: Mr. Chair, I think that probably at least a portion of the question is better directed to the minister. As officials, we work within the fiscal framework established by the government, and obviously as senior officials we will provide whatever information is required.

I think the broader question about whether or not the government may change its budgeting process or present the information differently is probably better directed to the finance minister or maybe to the minister herself.

Mr. Len Webber: Thank you. I appreciate that.

With that comment, then, will the minister then provide the committee her department's information within seven days? Can we get a fixed time for the answer to that question and to all the other questions?

Mr. Chair, there have been numerous questions where she has to get back to the committee. I hope we can get that within a certain time period—let's say seven days.

Mr. Simon Kennedy: Certainly, where the minister has committed to provide information in her previous remarks, we can work to get that to the committee as quickly as possible.

Mr. Len Webber: That's great. Thank you.

I also would like to bring up the issue of a private member's bill that is coming up this week in Parliament and is calling for an organ donor registry. You may be aware that this issue is very important to me, to many people here in this room, and to many people in my Conservative caucus as well.

Of course, I'm sure that organ donation is widely supported by all of us, but sadly, when it comes to improving organ donation systems in Canada, there is often a lot of talk and little action. Insofar as national organ donor registries go, we lag behind all other developed nations and many of the world's poorest nations as well. It is really quite sad.

About a year ago, we opened and implemented an organ donor registry in Alberta. The Library of Parliament just got back to me with some stats. The donor registry is now up by over 227,000 people as of today, with 336 people in Alberta currently on the waiting list for an organ transplant. These transplants are up because of this registry. They're up by 20%, which is fantastic, so obviously this registry is working.

My question is for you or the minister. Will the minister and the department support an organ donor registry in this country?

● (1650)

Mr. Simon Kennedy: Mr. Chair, maybe to clarify Health Canada's role, or at least the institution I have administrative responsibilities for, it is responsible for regulating the safety of organs and tissues for transplantation. We have provided funding over the last number of years to Canadian Blood Services to work on this issue.

I would readily acknowledge that this is a very important issue and we need to do more, but the principal work on organ and tissue donation has been through CBS and our work with the provinces and territories. Our principal role as Health Canada has actually been to regulate these activities.

In terms of the government's position on the bill and its approach, I don't want to pre-empt what the government's decision might be on a matter before Parliament. Again, I think this is probably one matter that the minister or the government might want to respond to.

Mr. Len Webber: All right. Thank you.

I'd like to share some time with my colleague, who would like to ask a question as well.

The Chair: You have 13 seconds.

Mr. Len Webber: Then let's just pass it on.

Again, it would be nice to know where the minister stands on this. It's my hope that she would support the creation of a donor registry. Even though you say that it's more of a jurisdictional issue, in order to have a national umbrella when it comes to organ registries and to build shared information amongst the different silos around this country, I think this is a bill that needs to be passed.

Thank you.

The Chair: Thanks very much.

Mr. Oliver, you have five minutes.

Mr. John Oliver (Oakville, Lib.): In the 2016-17 main estimates, PHAC is requesting $14 million “to acquire medical countermeasures for smallpox and anthrax preparedness”.

I was curious about that. What are the vaccination rates for smallpox? How are they changing over time? What is the status of smallpox vaccination?

Dr. Gregory Taylor: I can speak to that.

Smallpox is not vaccinated for at all. Smallpox, as you may know, has been eliminated from the globe.

There are certainly some stores of smallpox in some labs; I believe the U.S. has it. There's a potential for smallpox to be used as a bioweapon. What we're using and keeping in our stockpile is vaccines against smallpox. Hopefully, smallpox will not emerge in the world at all and we'll never have to vaccinate against smallpox again.

Mr. John Oliver: What's leading to the additional medical countermeasures that you've requested in the estimates?

Dr. Gregory Taylor: It's to keep our supply up.

Smallpox is interesting. There's a first-generation smallpox vaccine, which is good for everybody; about 3% of the population is not able to take that. We also have a smallpox immunoglobulin for folks who get exposed, and then a third-generation vaccine. We were just talking about it. They don't last forever, so they have to be turned over, and the old supply has to be replaced.

Mr. John Oliver: So it's the renewal of that inventory, then?

Dr. Gregory Taylor: Yes, it is.

Mr. John Oliver: Is it the same with anthrax? Is anthrax currently viewed to be a public threat? How prepared are we for anthrax?

Dr. Gregory Taylor: Anthrax is a little different. It's a bacteria. Yes, it still could be a bioterrorism threat, so we keep a couple of antibiotics for anthrax in the stockpile, and we're looking to purchase some vaccination for anthrax as well.

If you have an exposure to anthrax, we would selectively treat those people closest to the exposure with antibiotics, potentially, and vaccinate around them. It's a very slow-growing bacteria so you have some time to do that. We're looking at storing both of those as well.

● (1655)

Mr. John Oliver: I think the minister mentioned Ebola as well. Is that something new? Obviously there was a world crisis two years ago, but it seems to have resolved. I think we had a few active cases in Canada. What's the status of Ebola?

Dr. Gregory Taylor: Luckily, we've never had a case in Canada. In West Africa, in Guinea, there's an outbreak currently. It's very small. I think there are about nine or 10 cases. There are three cases in Liberia. This is a little worrisome in that it's not totally eliminated, but I think a lot of experts predicted that we'd have this sort of new reality in terms of Ebola.

As for what we did with regard to Ebola, these are reprofiled dollars. We got some money for this a couple of years ago, and we're looking at two things. One is supporting vaccination with our vaccine, which is doing very well. That's what's being used in both Liberia and Guinea right now to control this. I think Canadians should be very proud of the Canadian Ebola vaccine.

We're also looking at a new technology called "monoclonal antibodies". These are synthetic antibodies. The antibodies that your body would produce are synthesized and given to people who are sick with Ebola, once they're infected. This is the so-called cocktail of the ZMapp. We had two lines of investment in that, including looking at plant-based monoclonal antibodies—ZMapp—which we do have some of at the agency in the lab in an experimental status. We're also looking at trying to build capacity in Canada to produce it on an animal model. You need an animal model to produce larger quantities of this.

That's being rolled over from previous years until the current fiscal year. The rationale for this is that it took a lot longer to negotiate and to try to find the capacity in Canada, because it just didn't exist. We're using that resource to try to build that capacity, and again, to try to keep some of those in our stores in Winnipeg at the lab.

Mr. John Oliver: Thanks.

For the Canadian Institutes of Health Research, in the main estimates there's the "inaugural competition for the Canada First Research Excellence Fund". How does that new program differ from other federal research programs?

Dr. Alain Beaudet: As you know, this is a major initiative aimed at allowing the institutions—the universities, actually, or the academic health research centres—to propose the creation of a centre of excellence in one priority area that would make the centre a really unique centre of excellence in the world in that specific area.

It's a highly competitive process. As you can see, they're very large grants. Two of the successful grants in the previous competition were in the health sector. One was in regenerative medicine in Toronto and beyond, and the other one focused on the north and on optics, at Laval University in Quebec City. There's a health component and the money flows through CIHR.

Mr. John Oliver: With regard to the additional CIHR funding, I've heard from many of the different universities and others that they've had difficulty in maintaining their Ph.D. programs and that the cuts to research, or for your health research, have been felt across Canada. Are you looking at how we're going to restore, rebuild, or keep the health research programs active across Canada and rebuild the programs for Ph.D. students and make sure we have the right leadership in this area?

Dr. Alain Beaudet: Yes, absolutely, and I must say that the injection of $30 million in additional recurrent funding to the Canadian Institutes of Health Research has been extremely welcome. As recommended, as per the budget language, this money will be entirely invested in projects that are initiated by investigators. We're extremely happy that we'll be able to inject the money we're receiving this year into an ongoing competition. That will allow us to fund a larger number of researchers than we originally expected. It's really needed and it's good news.

Mr. Don Davies: I want to go back to the question that my colleague asked you on tamper-proof opioids. One of the clear concerns about this has to do with the so-called balloon effect; that is, if you make tamper-free resistance in one molecule of Oxycontin, that will drive users to other forms like fentanyl.

Isn't the answer to that exactly what the U.S. drug administration has done, which is to make tamper-proof regulations across the entire class of opioids? In terms of not being able to do it, the U.S. has done it and it has resulted in a reduction in opioid deaths, which, as you know, are reaching epidemic proportions across Canada. Why not just make it across the entire class of opioids?

Mr. Simon Kennedy: One of the things we are definitely doing is coming out with guidance for pharmaceutical firms that wish to bring forward tamper-proof formulations and be able to make a claim for tamper resistance. We actually are consulting. I don't have the date immediately top of mind, but certainly we're already out in the field with proposals around what criteria would have to be satisfied in order to be able to sustain a claim that something is tamper resistant. There are criteria you need to go through in order to be able to demonstrate from an evidence basis that something actually will be tamper proof and that people won't be able to defeat those features. Health Canada has been doing a lot of work to enable the pharma sector to come forward with those kinds of proposals.

We are doing a lot in the area of prescription drug abuse and particularly with regard to opioids. I would say a lot of the actions we've taken are very similar to those in the United States. We've certainly been talking to the Americans about the work we've been doing.

I'm happy to elaborate if there's an interest in it, but I know you don't have a lot of time.

● (1700)

Mr. Don Davies: Maybe after.

Is it fair to say there's a possibility of adopting regulations to go to opioid-class tamper resistance in the future? You're not closing the door to that.

Mr. Simon Kennedy: At the end of the day, I think that would be a policy decision that governments would have to make, and we would also have to consult with the provincial and territorial governments.

When we looked at the particular regulation that was out for discussion last year, one of the concerns was exactly this issue of the balloon effect. The other thing was that most provincial formularies had taken generic oxycodone off of their formularies. It's the tamper-proof version that they make available, but there are a number of Canadians who, for financial or other reasons, may not be able to afford that kind of medicine. You have to realize that the tamper-proof formulation is two to four times more expensive. If you move an entire class of pain medication into that kind of technology, you would effectively be dramatically raising the cost of—

Mr. Don Davies: I want to move to another issue. I'm sorry to interrupt, but I have limited time.

Regarding indigenous health, we know there's a crisis facing our indigenous communities across the country. A number of bands have declared public health emergencies. There's been an alarming number of suicides and attempts made by first nations people, most compellingly by many youth, yet the main estimates that I've looked at confirm that this government will cut first nations and Inuit primary health care spending in 2016-17 by some $30 million over what was spent in 2014 and almost $90 million over 2013 numbers. I don't see any specific money targeted for mental health.

Is it appropriate that funding for primary health services for first nations and Inuit Canadians should be cut in these circumstances? I have the reference to that part of the budget here, if you need it.

Mr. Simon Kennedy: I think one of the things that I'm sure is frustrating for parliamentarians—it's certainly frustrating for officials—is perhaps the way information is presented in the estimates. It's been a long-standing issue and I know many people are familiar with it.

Actually, our funding for indigenous health is going up—

Mr. Don Davies: May I interrupt you?

I know, but I'm reading the line, “First Nations and Inuit Primary Health Care”. This is from the main estimates, page II-130. It says the government is spending $843 million this year, and I'll leave the change off. It was $809 million last year, but $870 million in 2014-15. I realize, globally, you may be increasing health care, but on first nations and Inuit primary health, there's easily a $30-million reduction over two years ago.

Mr. Simon Kennedy: The three major funding decreases in the estimates, when you kind of break it out, are primarily the sunsetting programs. Therefore, funding to support the Indian Residential Schools Settlement Agreement, that was mental wellness funding. There is money for first nations water and waste water. We do work with first nations to test their water systems and provide them advice on how to make sure there's good water quality. There's also some funding for clean air, which is not directly related, but all of those are actually being renewed or have been renewed in the budget.

It's hard to see in the estimates, but the bulk of the reductions are for sunsetting programs that have subsequently been renewed. I can assure you that, generally speaking, in terms of funding for first nations health—recognizing that the minister said there's more to be done—there's not actually an absolute reduction. There are actually increases.

The Chair: Thank you.

Now, according to our original rules we're supposed to go back to a seven-minute session, but I'm going to propose that we go to five minutes for questioning so that we get in more questions. Is that okay with everybody? All agreed? Okay.

Mr. Don Davies: In the same order, though, as the first round, but just cutting the time down...?

The Chair: Yes, it's the same order.

Mr. Nick Whalen (St. John's East, Lib.): Then I guess I don't need to bring a point of order about having been skipped over.

Voices: Oh, oh!

The Chair: No, no. You're up.

Mr. Nick Whalen: On that same line, in addition to the programs you talked about that are going to be renewed, presumably we're going to see the information in supplementary estimates (A), when they come out, that those programs have been renewed. As a result of the budget being tabled a month after the main estimates, are we likely to see any other big-ticket items in supplementary estimates (A) on which the policy and the costing have already been developed and that we should be aware of now so that we can have this discussion?

● (1705)

Mr. Simon Kennedy: In regard to the single biggest area, members will be familiar with the significant investments in the budget on indigenous priorities more generally, but with regard to the health portfolio, the biggest investment would be in infrastructure for on-reserve health facilities. For example, we operate many nursing stations in remote communities in Ontario and Manitoba. A lot of those facilities are not in the best condition, so the budget set aside $270 million over the next five years to renovate and expand these sorts of health facilities.

There was also some funding to renovate and fix up facilities for the aboriginal head start on-reserve program. This is a program to give an advantage to young indigenous children and to provide a kind of cultural element, but basically it's to support early learning for indigenous children. We received some money to actually renovate those facilities as well. Within the ministry right now, we're putting it as a pretty big priority and trying to get it out the door quickly.

We have quite a few projects that we need to get moving on—three or four dozen—and that was provided for in the budget.

Mr. Nick Whalen: Thank you.

Along a similar line, then, in terms of some of the other items in the budget for mental health and home care, and what sorts of timelines there may be, what has been done on each of those topics to develop policy and program delivery specifically with respect to mental health initiatives and home and palliative care? When can we see budgetary proposals or estimates in that respect?

Mr. Simon Kennedy: I think the minister probably covered that well. What I might be able to add, just by way of a bit of elaboration, is that the minister met her provincial and territorial colleagues in January in Vancouver. They had a two-day meeting. They reached agreement on the priority areas they want to work on over the coming year. That work is going on now at the level of officials. For example, in my case as deputy minister, we've been having regular engagements with the provincial and territorial deputy ministers to flesh out work plans and priorities that we can bring back to the ministers.

The minister is committed to meet mid-year to take stock of progress, so our expectation would be that at some time mid-year, and certainly before the conclusion of the summer, there will be another meeting of ministers to take stock of the work that will have been done. The work we're doing now is focusing on the priorities that were agreed on in Vancouver, and they include mental health, home care, and pharmaceuticals, the various items that the minister talked about and that were laid out in the government's electoral platform. That work is happening now.

Mr. Nick Whalen: Okay.

On a slightly different topic, that of e-cigarettes, here is something that comes out of Health Canada's 2016-17 report on plans and priorities: the department has continued “to develop a policy and research approach to vaping products”.

However, the House of Commons Standing Committee on Health recommended in its 2015 report on the issue that “the Government of Canada work with all affected stakeholders to establish a new legislative framework”, possibly under the Tobacco Act or new legislation, “for regulating electronic cigarettes and related devices”.

Can you describe where you are in the policy and research approach that Health Canada is currently taking towards these e-cigarette products?

Mr. Simon Kennedy: What I should note is that these devices, where they have nicotine, currently are actually not legal, so Health Canada has been pursuing enforcement measures. We have been working with the Canada Border Services Agency to make sure that when product comes in that contains nicotine and that is not consistent with the rules, it gets stopped at the border.

On our efforts domestically when we are taking a regulatory action, we're obviously well aware that a lot of provinces have put in place frameworks, and we have been focused largely on product that has been mislabelled. The label might say that it's “nicotine-free” or that it doesn't contain nicotine, but in fact it does. We've been targeting our enforcement efforts.

We have been doing policy work and looking at the report of the standing committee from the last session and the recommendations it laid out. There's been a lot of work internally in the department on what options we can bring forward to the government for response. I'll leave it to the government to speak to next steps, but we certainly have examined that report carefully.

In terms of research, that would be more for CIHR.

● (1710)

Dr. Alain Beaudet: We do actually support a number of research projects to look at the harms and possible benefits of e-cigarettes. We're supporting work to study the chemical components, actually, that are released by vaping products. We're also supporting a large-scale clinical trial that started in September 2015, still ongoing, on really looking at the safety and effectiveness of the use of the e-cigarette for smoking cessation.

Mr. Nick Whalen: Thank you, Mr. Chair.

The Chair: Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Mr. Chair.

My question is for you, Dr. Taylor. Do you know what the Respect for Communities Act is?

Dr. Gregory Taylor: Yes.

Mr. Colin Carrie: Great.

Just for the committee, back in September 2011 the Supreme Court of Canada rendered a decision in regard to Insite. The court specified factors that the minister must consider when assessing an application for a supervised injection site. These include any evidence related to the impact of a site on crime rates, the local conditions indicating a need for such a site, the regulatory structure in place to support the facility, the resources available to support its maintenance, and expressions of community support or opposition. The Respect for Communities Act authorized the minister to publicly post a notice of application for an exemption for a supervised consumption site and to invite comments from the public on the application.

I think it was in January that the minister okayed the second supervised injection site.

I like “supervised” better than “safe” injection site, because as I think the minister confirmed, there is no way to safely inject street heroin.

Did you follow that 90-day period as outlined in the Respect for Communities Act?

Dr. Gregory Taylor: That's a regulatory issue that I would pass to Health Canada.

Mr. Simon Kennedy: I would just note that it's a discretionary authority, and it was not exercised in that case. So it wasn't—

Mr. Colin Carrie: Do you know why the minister would not want to have input from the community when opening a safe injection site in the community?

Mr. Simon Kennedy: Mr. Chair, I'd probably leave that particular question to the minister, although perhaps I could try to speak to the general area.

When you're referring to the second site, you're talking about Insite's latest authorization, or...?

Mr. Colin Carrie: Wasn't it the Dr. Peter Centre?

Mr. Simon Kennedy: Generally speaking, at least, I can say that with regard to the last two facilities, Insite and the Dr. Peter Centre, there was extensive input provided, including letters and those sorts of things. I mean, it was—

Mr. Colin Carrie: I think the minister was appointed in November, and I believe she okayed it in January, so there wasn't 90 days. I'd love to have the department provide the input that was received for the decision-making process. The minister has been very clear, and I think the Liberal government has been clear....

Do you know somebody named Hilary Geller?

Mr. Simon Kennedy: Yes, Hilary Geller is one of my assistant deputy ministers.

Mr. Colin Carrie: She was at the United Nations, and there was quite a lot of applause for it, I guess, but she said, "With one long-standing supervised injection site already operating in Canada, we have recently approved a second, and anticipate"—she did use that word—"that there will be others in future." I think the minister has been clear that she is open to having these.

My concern is that 90 days is not a lot of time to consult with the public when you're opening up these sites. I don't know if the minister is aware, but many of these addicts are not people of means, and I believe four to eight crimes are committed for these addicts to get their hit for the day. By putting a site in a community, especially a community that has not had the opportunity to give input on whether they feel that, as I read earlier, it would increase crime levels.

In terms of getting input from the department, I think there is a concern, as in my community, that the government may be trying to anticipate putting these safe injection sites or supervised injection sites across Canada. She's taking advice from you guys; that's what she said. Will you go over the Respect for Communities Act with her, and kind of state the importance of listening to community members and the police in the community? If they are committing acts to get these hits, it would make sense to me that they would be committing crimes in the communities where the facilities are.

Would you commit to that?

Mr. Simon Kennedy: As the minister noted when she gave her remarks on this issue, what is maybe not broadly known to the public is that even prior to the Respect for Communities Act, there was a series of requirements that needed to be met before Health Canada could actually authorize one of these facilities. There is the Controlled Drugs and Substances Act—

● (1715)

Mr. Colin Carrie: But you didn't follow that. Right?

Mr. Simon Kennedy: The specific authority to establish one of these sites is to issue a section 56 exemption. Health Canada has always had a very involved process before issuing a section 56 exemption for this kind of activity. It's not like they're just handed out.

As the minister noted, what the Respect for Communities Act arguably did was codify in some detail the kinds of steps Health Canada would normally have followed in making a determination of a section 56 exemption. For example, when Insite received its first approval many years ago, there was a very detailed review. I can assure the committee that when these recent decisions were taken, they were taken after quite a bit of review of the evidence in the applications from the providers. Insite, for example, provided a very extensive, very detailed application—

Mr. Colin Carrie: Don't you think that would be biased, though? Wouldn't that be biased, if it was coming from the facility?

There was the ability to post for 90 days to let the community know this decision was going to happen. The minister has been clear. She welcomes, or anticipates, opening more of these across the country. If the government wants to put one of these sites in my community, and the potential illegal behaviour that would occur with that, considering that addicts are not people of means and they need to commit crimes to achieve.... This is not pharmaceutical-grade heroin we're talking about; this is street heroin. This could be kerosene that somebody is injecting into their veins in front of a health care professional.

The minister said quite clearly that her priority is the health and safety of Canadians. She talked about the health accord, etc., but it seems her first actions are things along the lines of legalizing more street heroin injection. I'm really concerned about this, Mr. Kennedy. I hope the department reviews.... Communities would really like to have some input into this.

Mr. Simon Kennedy: In the case of the recent applications, as I noted and as members would know, there is a requirement to solicit letters from various stakeholders in the community. In the case of these facilities, it was quite evident there was a large body of support for these facilities.

From an evidentiary point of view, because obviously Health Canada as a regulator tries to look at the analytical evidence, there are more than 80 such facilities that have been established around the world. In Europe, for example, there's a very large body—

Mr. Colin Carrie: Do they use street heroin, though, Mr. Kennedy?

Mr. Simon Kennedy: —of literature that these kinds of facilities actually help to reduce crime rates, help to reduce overdose deaths, and those sorts of things.

Mr. Colin Carrie: Do they use street heroin, though, Mr. Kennedy? Or is it pharmaceutical...?

Mr. Simon Kennedy: Mr. Chair, if it's helpful, we could share a bibliography with the committee on the various studies that have been produced.

In this case, I guess all I can do, as the regulatory authority, is to assure the committee that we made sure the stipulations in law were fully respected and that all the criteria were covered before the decision was made to issue the exemption under the CDSA.

The Chair: Your time is up.

Mr. Davies, you have fifteen minutes.

Mr. Don Davies: Fifteen? I hit the jackpot.

Voices: Oh, oh!

The Chair: No, it's five minutes.

Mr. Don Davies: Thank you, Mr. Chairman. I'll try to get some short snappers in.

I've introduced a bill in two Parliaments now to have prominent labelling of sugar on the front of prepackaged foods. We know there's an epidemic of obesity. Is there any appetite in the department to move ahead with such a wise and necessary initiative?

Mr. Simon Kennedy: What I would say is that we are concerned about sugar. I know parliamentarians are as well. The government has obviously made commitments. There is ample evidence that sugar consumption.... A little bit of chocolate now and then, I suppose, is a good thing, but over-consumption of sugar is not healthful and is something that needs some attention paid to it.

As a ministry, we have spent a lot of time looking at the experience of other jurisdictions, looking at all the various options that might be available to the government. Different jurisdictions have taken different approaches. There are various ways to measure sugar—

Mr. Don Davies: Mr. Kennedy, I'm sorry, but I'm going to be rude here.

Mr. Simon Kennedy: I can't get into the details of what we may have advised the minister or what the government may choose, but what I can say is that we certainly have looked at a variety of options, including front-to-back labelling. I can say that.

Mr. Don Davies: Thank you. I don't mean to be rude, but I have limited time.

On palliative care, Canada has been aging for a long time. There's been a need for investment in palliative care. With the soon-to-be-introduced physician-assisted dying legislation, palliative care is going to take on an increased role.

I can't find any specific allocation in this budget where the federal government is saying we're going to be adding funds to establish palliative care or increase palliative care services in the country. Is there such funding in the budget?

● (1720)

Mr. Simon Kennedy: I would reiterate what the minister said, which is that the government has indicated that they first want to come up with a plan with the provinces and territories about what is going to be done, before the funding is allocated. Right now, we are actually talking to the PTs. There is a real interest on the part of our jurisdictional colleagues to look at palliative care as potentially a major priority for the funding for home care. We are having that conversation with the provinces, but as the minister said, the game plan is to talk about what we are going to do before we put the money on the table.

Mr. Don Davies: Okay.

I am going to be smart aleck about it, but that means the money is not there yet. I used to work for the teamsters and a lovely old teamster used to tell me, “You know, talk is cheap, but money buys whisky.” There is no money that is allocated to palliative care in this budget yet, for the next fiscal year.

Mr. Simon Kennedy: Mr. Chair, I think that in our conversation with provinces, generally, if we wanted to use an analogy it would be more that if you are going to the bank and you are looking for an investment, the bank expects a business plan. In our conversation with the provinces and territories, we are talking not just about this area, but about Infoway, electronic health records, and a variety of other areas. The discussion is, look, we first have to have the business plan before we decide how much money is put on the table. The government has been very clear on its commitment to the $3 billion and to a long-term funding commitment, but we want to focus on what we are going to do before we start putting the money on the table.

Mr. Don Davies: That's the difference. With respect, there is a commitment made in words, but it is not budgeted for. I mean, money doesn't materialize out of thin air. You can't have three years of deficits, chart the paths, and indicate spending, and not have a penny of the $3 billion indicated anywhere. I have seen firm deficit figures for the next four years, which indicate that the spending commitments have been made and costed.

If that $3 billion is not budgeted for, where does it come from?

Mr. Simon Kennedy: There are future decisions to be made, Mr. Chair, in future budgets.

Mr. Don Davies: Okay, so it is a future budget.

I have one other question I want to ask, quickly, about user fees.

There is no question that there is privatization in user fees in this country. In my own province, the election of the Saskatchewan Party, which has just opened private MRI clinics, indicates there will be further privatization. How much does the department spend, each year, on policing the Canada Health Act to ensure that provinces are conforming to it and that the federal government is actually returning, on a dollar-for-dollar basis, violations of the Canada Health Act?

Mr. Simon Kennedy: Maybe the most productive way to do this would be to get back to the committee. I believe it was in the last two or three weeks—sorry, Mr. Chair, I don't remember when it was—that we tabled the most recent report, which has that kind of data in it in terms of what we have done about enforcement with respect to the Canada Health Act.

Mr. Don Davies: The shocking thing was that there were zero dollars for most provinces recovered back to the federal government, indicating that there are no privatization or user fees being charged to provinces. That is why I'm asking. I am trying to get a sense of how big of a commitment there is in the federal government to police that. Certainly the provinces aren't. If they don't know that the federal government is going to punish them by taking the dollar, which is the essence of the federal-provincial agreement, they are not going to be cracking down.

That is why I want to know how much money is being spent. I don't think that was in the report.

Mr. Simon Kennedy: To be honest, I'll have to get back to you on that.

I think—just indulge me for 10 seconds—there is one piece of good news that maybe gets overlooked sometimes in these conversations. There is a lot of work Health Canada does collaboratively with jurisdictions to try to deal with some of these issues before they get to the point where the Government of Canada might be threatening to dock the funding that goes to provinces. In most cases, provinces have legislation governing their health care systems that is even more aggressive than the Canada Health Act in terms of the kinds of conditions in it.

We have a lot of cases where we work collaboratively with provinces to take issues off the table. I know there is a lot of focus on user fees and these sorts of things, but there is also a good story about the work we do collaboratively with provinces, where you have these instances and the provinces take action and remedy them. I think sometimes that goes unnoticed.

The Chair: Thank you.

Mr. Oliver, go ahead.

Mr. John Oliver: Thanks.

The minister has left, but I wanted to ask her about mental health in the health accord discussions, and where the focus was. I know you just talked about it briefly a few questions back.

The Mental Health Commission estimates that one out of five people suffers some kind of mental health episode. There is about $50 billion a year spent on that, yet it seems to be an area that we struggle with across Canada in terms of access and comprehensive care.

Does Health Canada have a view of the access to mental health services? Have you done studies looking at access and service across Canada under the lens of the Canada Health Act? Where are you at with that?

● (1725)

Mr. Simon Kennedy: We certainly have done some work in this area. I know the Public Health Agency has, as well as CIHR. I think any one of my colleagues can probably speak to this.

This is an area where, frankly, more work needs to be done. The government committed to establish an expert advisory council to give us some guidance, and we're working with the minister to get that set up. It is a big priority in our work with the provinces and territories, but off the top of my head, I'm sorry, I can't give you a detailed list of the kinds of studies and so on that have been done.

I'd be happy to get back to the committee if that's helpful, but others may want to comment.

Dr. Gregory Taylor: We've been creating a suicide prevention framework and that should be released relatively shortly as part of the broader picture from the agency's perspective. We have a fair bit of work as well that's going on in mental health directly.

Mr. John Oliver: In terms of that health accord, that would be good to see or understand. I know that when the last accord was negotiated in 2004, there was a fair bit of focus on wait times and access in mental health, but in particular I'm thinking about child and adolescent mental health, such as eating disorders. My own experience in my own riding is that there are tremendous delays in accessing mental health services and huge frustrations for families, particularly for young Canadians.

Do you have any perspective on that or do you have a thought on how you will approach that in the accord?

Mr. Simon Kennedy: At this point we're still talking to the PTs.

I think this is an area where we know, for example, that for a lot of Canadians, the first expert they see when they're dealing with mental health issues is their physician, so there are issues around what kinds of tools and training physicians might have. There's the issue of what kinds of specialists are part of the system and maybe could get coverage under provincial health insurance, and there are acute issues around suicide.

There's a whole variety of areas that one could focus on. That's the conversation we're having with PTs now: we have to start somewhere so what are the areas we want to drill down on first? I'm not in a position now to say that we're going to pick these three. We're still having that conversation.

Mr. John Oliver: The Mental Health Commission had six strategic directions they had identified. I don't know whether that's being brought to bear in the health accord discussions, but one of them was the concept of care across lifespan.

Again, I'm thinking of younger Canadians and building school systems and community support looking at that lifespan situation. Is Health Canada focusing on those six directions in some of those areas?

Mr. Simon Kennedy: The Mental Health Commission is very important foundation for us, a very important piece of work as we work with our colleagues in the provinces on what to do. Even at Health Canada we've adopted the national standard of Canada for psychological health and safety. We're actually rolling that out across the whole department. There's a lot of good work that the commission has done in their report. We're on board and we work with them very closely.

I can't tell you now what kinds of pieces will fit into an eventual accord with the provinces, but they're definitely a key player that we're working with.

Mr. John Oliver: We've talked a bit about palliative care as home care, but as I knocked on doors and talked to people in my area, there was significant fatigue for caregivers who did not feel they were getting adequate home care support.

Does home care in terms of those home deliveries fall under the Canada Health Act in terms of the definition of comprehensive and what's included in it? Where are you with discussions around enhanced home care at that table?

Mr. Simon Kennedy: What we have seen with the PTs generally is that all jurisdictions are undertaking work to try to modernize and reform their health care systems so that they are sustainable and that they continue to provide good services to citizens.

As you and other members would know, we have a system that, when it was established, was built largely around physician services and hospitals, so it's a system that's really built around specialized institutional and relatively high-cost care. It delivers great service if you have an acute need or you need that kind of service. However, the result is that, for folks who are aging or have a chronic condition, providing that care in the community or home would actually be considerably cheaper. It's literally like $1,000 a day as against $100. It's a small amount.

● (1730)

Generally speaking, all jurisdictions are looking at how we shift that out of the high-priced institutional care into home and community settings. The conversation we're having with them as part of the health accord is how the Government of Canada can really support that shift and take advantage of what provinces and territories are already trying to do to make the system more sustainable, which is to have more home care, more community care, and high-priced institutional care where it's needed but isn't for everybody. You don't need to be in the hospital bed, necessarily, depending on the kind of condition you have.

That's the way we're trying to fit the commitment of the government into the discussion with the provinces.

The Chair: It's 5:30, and it's time to bring this to a close, but I have a question on research that I'd like to have some thoughts on.

A few years ago, I was helping the Canadian Cancer Society develop a plan to attract research funds. I'm from Atlantic Canada. We did a research study by province. The federal research money that goes to cancer research is very inconsistent. Atlantic Canada, if I remember correctly, gets an average of $2.40 per person. Two provinces get over $9 per person. Another province gets something like $7 per person, and for the rest of them it's awful low. But in Atlantic Canada, we have some of the highest rates of colon cancer, some of the highest rates of melanoma, and some of the highest rates of cancer fatalities amongst women.

What can the provinces who do not get an equal share of federal research money do to access an equal amount of research money per person?

Dr. Alain Beaudet: As you know, most of the research money, in fact all of the research money that we're disbursing, is disbursed on a competition basis. Obviously the provinces that have large infrastructure and can attract more researchers will get a larger share. It is a competition. It's best people, best ideas.

You're absolutely right, though, that for research, particularly when it comes to research that will be directly applied to improving care and access to care, there must be a way to ensure that there's more uniformity across the country. It's why we are partnering with our provincial counterparts and the ministers of health of the provinces and territories on the major initiative that the minister was referring to earlier, the strategy for patient-oriented research. That is focused on the type of research that will bear directly on the integration of research results into better care, better practices, and also will directly involve the patient in the elaboration of the research priorities and research strategies.

The provinces have really responded extremely positively to that. All provinces, actually, are investing monies in this endeavour, which we have committed to match. We're matching the funds that the provinces are willing to invest in this venture. It has allowed us to some extent to redistribute, if you will, among the jurisdictions that have fewer researchers and help them build capacity to develop research that's immediately applicable to care.

The Chair: You actually hit the nail on the head there. The provinces that get the money build the capacity, so then they can access more money. But then the provinces that don't have the capacity are turned down because they don't have the capacity. They didn't get the money to build the capacity. At any rate, we'll talk about this again.

I want to thank all the presenters very much for coming and providing answers. We look forward to your coming back.

Yes...?

Mr. Len Webber: I would like to propose a motion, Mr. Chair, with regard to the minister providing answers to the questions that she had said she would get back to us on, as well as the department. I'd like to propose a motion that we get written responses to the questions that were promised to us.

● (1735)

The Chair: Fair enough.

All in favour of the motion that we get written responses to the questions asked?

Mr. Len Webber: And in a timeline as well, Mr. Chair, of perhaps two weeks.

The Chair: Well, I wouldn't want to put that on, but let's—

Mr. Len Webber: I'd like to put a timeline on. Otherwise it could take a year.

The Chair: Is there any debate or comment on that?

Mr. Nick Whalen: I'd like to propose an amendment to the motion to remove the timeline.

The Chair: I think we can count on an answer in a timely fashion.

Let's ask her for the written answers. If we don't get them, then we can move another motion. Is that okay?

All in favour of the motion to get written answers?

Some hon. members: Agreed.

The Chair: Are there any against ?

Mr. Len Webber: I'm against. I would like to see a timeline on there, but obviously I'm outnumbered and I respect that.

The Chair: I'm sorry, Mr. Webber, did you just vote against your own motion?

Voices: Oh, oh!

Mr. Don Davies: That's on YouTube.

Mr. Len Webber: I voted against the amendment. That's what I voted against.

The Chair: That's all right. I expect we'll get answers.

Thank you very much.

The meeting is adjourned.

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