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Chair

Mr. Bill Casey

Standing Committee on Health

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• (1530)

[English]

The Vice-Chair (Mr. Len Webber (Calgary Confederation, CPC)): I'd like to call the meeting to order, please.

I would like to thank all of our presenters who are here today. We have a busy day of presentations, so I won't waste any time.

I would like, though, to go around the table and have you introduce yourselves and let the panel know what constituency you're from. That would be a nice thing to do.

Ms. Kamal Khera (Brampton West, Lib.): I'm Kamal Khera. I am a member of Parliament from Brampton West.

I see a lot of familiar faces and it's good seeing you all. I'm also the parliamentary secretary to the Minister of Health.

Mr. Nick Whalen (St. John's East, Lib.): I'm Nick Whalen. I'm the member of Parliament for St. John's East, and I'm subbing on the committee today for Bill Casey.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Good afternoon. My name is Doug Eyolfson. I am the member of Parliament for Charleswood—St. James—Assiniboia—Headingley in Winnipeg.

Ms. Sonia Sidhu (Brampton South, Lib.): I am Sonia Sidhu from Brampton South.

Mr. John Oliver (Oakville, Lib.): My name is John Oliver. Thanks very much for being here. I'm the member of Parliament for Oakville.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): I am Darshan Kang, member of Parliament for Calgary Skyview. Thanks for being here.

Mr. Colin Carrie (Oshawa, CPC): I am Colin Carrie, MP for Oshawa.

Mr. Don Davies (Vancouver Kingsway, NDP): I'm Don Davies. I'm the MP for Vancouver Kingsway and the health critic for the New Democratic Party.

The Vice-Chair (Mr. Len Webber): I'm Len Webber. I'm chairing the meeting today for Mr. Bill Casey, who is with his wife as she is going through some surgery right now. We wish them well.

Let's start with our presentations here today. We're going to start with Lisa Ashley. You have ten minutes, and then we'll ask questions after all the presentations are done.

Thanks.

Ms. Lisa Ashley (Senior Nurse Advisor, Policy, Advocacy and Strategy, Canadian Nurses Association): Thank you very much. I'd like to thank the committee for this opportunity.

I represent the Canadian Nurses Association and 139,000 registered nurses. I am a registered nurse and a senior nurse adviser at the Canadian Nurses Association.

Our prepared brief and my comments today align with the positions of other national nursing organizations, collectively representing more than 400,000 nurses in Canada.

As you know, Canada is the only developed country with a universal health insurance system that does not include universal coverage for prescription drugs.

At this stage of your consultations, you're well versed on the issues that catalyzed the call for a national prescription drug program. You've heard informed estimates of needs and costs. The Canadian Nurses Association relies on that same data, experts, and peer-reviewed literature to inform our recommendations.

Today we are pleased to contribute the professional perspective of nursing. From our vantage point in acute and long-term care and in community settings, the inequities in access to prescription medication are clear.

Every day we work with patients, their families, and their caregivers. Every day they make choices between filling a prescription and purchasing other necessities, such as food. We see vulnerable Canadians with chronic conditions caught in cycles in which they cannot access the medications they need to stay healthy and as a result end up in emergency rooms and clinics, needing urgent and complex care. The problems you have heard about are real.

What we know is that Canadians pay more than citizens in other comparable countries for prescription medications. As time advances, Canadians are paying more for prescription drugs and getting less. Significant savings could be redirected to other health care gaps, such as health promotion, home care, or palliative care, and the vast majority of Canadians would support a national prescription drug program. Canadians want this.

What we need now is political leadership.

The Canadian Nurses Association's mission includes promoting a publicly funded health care system. As part of this, we believe every Canadian should have timely access to safe, affordable, and effective prescription drugs, and that no citizen should be deprived due to inability to pay.

Today, I highlight five recommendations from our prepared brief that outline a role for the federal government, in partnership with the provinces and territories, and as both a funder and the fifth-largest provider of health services in Canada, to implement an equitable pan-Canadian strategy for prescription medications.

First, the Canadian Nurses Association recommends comprehensive, universal, public, affordable prescription medication coverage that ensures access based on need and not the ability to pay.

Fewer than 50% of Canadians are covered by public drug plans that pay for day-to-day prescription medications, while nearly 100% of citizens are covered in virtually all similar countries. As you have heard, as many as one in five Canadians reported not taking medications as prescribed because of concerns about cost. This increases their risk of poor health outcomes and complications, which is more costly overall to the health care system.

Second, Canada requires information and mechanisms to support appropriate prescribing practices. This includes government support for the implementation of Choosing Wisely Canada and for a portion of Canada Health Infoway funds to be targeted for e-prescribing.

In addition, the federal government could modernize the Food and Drugs Act and food and drug regulations to enable nurse practitioners to distribute drug samples in a way similar to that of physicians, pharmacists, dentists, and veterinary surgeons.

To expand on this, a medication that is inappropriate for a patient is not only wasteful and expensive, but it can also bring side effects that require other medications. Seniors in Canada who are given multiple prescriptions are often at the highest risk of medication misuse. Given our aging population, prescribing practices must be aligned with Canada's seniors strategies in order to limit such use of multiple medications and promote adherence to best practice guidelines.

• (1535)

Updated federal legislation that allows nurse practitioners to provide patients with samples is one simple, no-cost measure the government could enact that would help address access and safety. I would be pleased to discuss this in more depth.

Third, the Canadian Nurses Association recommends purchasing strategies such as bulk purchasing to reduce drug costs. Canada has achieved some progress in this area with all jurisdictions, including Quebec and the federal government participating in the pan-Canadian Pharmaceutical Alliance, the pCPA.

Provinces and territories are also working together to reduce the price point of commonly used generic drugs to 18% of the brand name price, but there are still efficiencies to be realized.

Fourth, CNA recommends the establishment of a single pan-Canadian formulary to eliminate inequities in the availability and cost of drugs between provinces and territories and to reduce the administrative costs of maintaining 13 separate lists of drugs. Our current system results in significant variation in the number and types of drugs covered and lag time between the regulatory approval of new drugs and their formulary listing.

In addition, there are many differences among private health insurance company formularies. A pan-Canadian formulary would eliminate regional inequities in prescribing patterns and drug prices and would provide clear guidance to drug companies during their listing process of what profit they can expect.

Fifth, the Canadian Nurses Association recommends that governments implement mandatory generic substitution, allowing for patient choice at their own expense and for prescriber reservation notes against substitution for medical reasons.

Several countries, including Norway and Sweden, employ mandatory generic substitution. Doctors and nurse practitioners are obliged to prescribe the least-expensive equivalent product unless a serious medical reason exists for more expensive alternatives. Pharmacies are also obliged to inform patients if a less-expensive generic alternative is available. If patients do not want the generic version, they must pay the difference out of pocket. When generic drugs should be avoided for medical reasons, doctors and nurse practitioners may provide reservation notes against such substitutions.

Our written submission also contains recommendations for attaining a stable supply of clinically safe and cost-effective drugs and for the federal government to address medications for rare diseases, which the committee has also heard about from other witnesses.

In closing, the Canadian Nurses Associations offers these recommendations today to assist the standing committee in comprehensively informing the development of a comprehensive, universal, public, affordable, pan-Canadian pharmaceutical strategy. By adopting these recommendations, the standing committee can contribute to better health, better care, and better value for all Canadians.

Thank you.

• (1540)

The Vice-Chair (Mr. Len Webber): Thank you, Ms. Ashley. I appreciate that.

We're going to move right on to our next presentation, from the Canadian Pharmacists Association.

Mr. Eisenschmid and Dr. Emberley, please start your presentation.

Mr. Perry Eisenschmid (Chief Executive Officer, Canadian Pharmacists Association): Thank you very much, Mr. Chair, and to the committee, thanks for inviting us to join you today.

My name is Perry Eisenschmid. I'm CEO of the Canadian Pharmacists Association. I am joined by my colleague Phil Emberley, CPhA's director of professional affairs, who is also a practising pharmacist here in Ottawa.

We're here today on behalf of Canada's 40,000 pharmacists. Every day pharmacists see the impact on patients when they can't afford their medications. Not only do they counsel patients to help them get the most from their prescriptions, but pharmacists are the ones who must deliver the devastating news that a patient isn't covered.

Pharmacists are, quite simply, the health care professionals closest to this issue. It's pharmacists' proximity to some patients' daily struggle with inadequate prescription drug coverage and the negative impact on patients that drives our efforts to inform the conversation on national pharmacare.

Our primary concern is ensuring that patients have access to medically necessary medications that are right for them. Above all, we must prioritize health outcomes and patient needs. Investing in the right drugs and services early on is not only good for patients, it is also necessary for the sustainability of our health care system.

From CPhA's perspective, the status quo is not acceptable. Let me be clear: CPhA absolutely supports a plan for pan-Canadian pharmacare in which the federal government has a role in ensuring that all Canadians have access to medically necessary medications, regardless of income.

CPhA believes any future pan-Canadian pharmacare plan must address four key priorities: first, ensuring all Canadians have access to the medications they need; second, protecting Canadians from undue financial hardship; third, ensuring patient access to a stable supply of clinically effective and cost-effective drugs; and fourth, providing access to the full range of pharmacy services.

We have two main messages here today to convey to the committee. The first is that the committee should consider both incremental and long-term solutions. The second is the importance of the word "care" as an element of pharmacare.

This committee has heard testimony from witnesses with different ideas about how best to help those Canadians who don't have coverage or whose insurance doesn't go far enough for them to make ends meet. We all agree that Canada can provide better access to prescription drugs. The real question is on how we get there.

Broadly speaking, the discussion has been framed around an assumption that there are only two ways we can approach this issue: create a brand new national pharmacare system, or build on our existing system to make it more equitable and efficient. It's our position that this need not be the case. These choices aren't mutually exclusive.

What we do know is that Canadians don't want their friends, their family, or their neighbours to have to choose between paying the rent and paying for medications. We also agree that moving towards a new national pharmacare system that could replace all public and private plans would take time to develop and implement. In the meantime, many Canadians would still have to go without the medication they need.

That's why we're recommending both immediate steps to improve Canadians' access to medication as well as considerations for a longer-term approach. Our research provides the committee with various practical and affordable options to enhance the current

system that could immediately help those Canadians who are falling through the cracks.

In the long term it's important to recognize that all potential models have strengths and potential drawbacks. Regardless of the approach Canada pursues, we should be fully aware of the potential risks. This is especially important as they relate to access and achieving optimal health outcomes, and we should identify ways to mitigate those risks. At the end of the day, we have to ensure that pharmacists have access to medications to provide their patients with the optimal drug therapy to achieve the best health outcome.

That brings me to our second recommendation, which speaks to the care element of pharmacare. While managing costs is essential, it's only a piece of the puzzle. An effective pharmacare system must not only address gaps in patient coverage but also address gaps in access to services that support safe and effective drug therapy for patients. As medication experts, pharmacists know there are important considerations for the functioning of any future system, public or private, to ensure that Canadians are receiving the maximum health benefit from their prescription drugs.

No matter what your perspective is on this issue, the fact is that drugs represent only 15.7% of total health spending in Canada. The right prescription, taken appropriately, is a low-cost, high-value intervention that improves health outcomes, especially when compared with costly alternatives such as surgery and visits to the emergency room.

● (1545)

Prescription drugs are a powerful, sophisticated tool. They can save lives when used correctly, but improper use can lead to ill health or even death. Containing and controlling drug costs is a key piece of any pharmacare plan, but now is the time for bigger and bolder thinking. Wouldn't it be better to make an investment to ensure first that the right medication is available to all Canadians, and second, that our citizens have easy access to effective medication management and oversight?

A long-term plan for pharmacare has to focus on the health of Canadians over their entire life cycle, not only when they're at the counter paying for drugs. A holistic focus that recognizes the value of appropriate drug therapy can help us realize savings for the broader health system while delivering sustainable patient-centred care. That means ensuring that Canadians have access to the drugs that make them healthier, and that means that Canadians have access to the advice and oversight of the undisputed experts in medications. The 40,000 pharmacists who work in communities and hospitals across this country have spent many years at school and on the job focusing exclusively on understanding how and when medications work, and when they don't.

In recent years, pharmacists' scope of practice has grown by leaps and bounds, delivering value for patients and payers alike. Expanded pharmacy services extend beyond dispensing of prescription drugs and capitalize on pharmacists' accessibility and expertise in providing much-needed oversight to our system of pharmaceutical care.

Take, for example, the medication reviews that pharmacists provide. These services help ensure appropriate use and enhance adherence, two major drivers of optimal health outcomes and drug plan costs. In some cases we're talking about reducing the use of medications, and in other cases it means expanding someone's drug regimen.

Here's a practical example. Most seniors over 65 take at least five drugs. With those aged 85 plus, it's ten or more at once. Let me tell you, this is a challenge that the profession is tackling head-on. We know of one 77-year-old woman in Ottawa who was taking no less than 32 different drugs, but a pharmacist was able to help her get that number down safely to 17. With medication reviews, pharmacists can collaborate with patients and prescribers to identify optimal drug therapies to ensure Canadians are on the right medications.

Unfortunately, these services aren't available to all Canadians. It's a real challenge that pharmacist services are covered differently across the country, some more comprehensively than others. A pharmacare program that recognizes the role of pharmacist services, such as medication reviews, would address many of the concerns this committee has heard about the need to go beyond simply paying for drugs and instead address the care aspect of pharmacare.

It's not only medication reviews; there are benefits to expanding pharmacy services in other areas as well. A study in Ontario found that pharmacist care can deliver a meaningful reduction in blood pressure, one that lowers the risk of stroke by about 30%. As well, consider how pharmacists are assisting people in their efforts to stop smoking. Recent numbers from the pharmacy smoking cessation program in Ontario show that 29% of participants in the program were still cigarette-free after one year. Consider the flu shot, especially for those who are considered at high risk for influenza complications: a recent survey found that 28% of Canadians in this group would not have been immunized if not for the convenience of pharmacy-based vaccinations.

The final thought we would like to leave with the committee is that the goal of any pan-Canadian pharmacare model, both in the short term and the longer term, shouldn't only be about reducing costs. It should be about providing optimal care. Getting value for each health care dollar is a principle that should be adopted across the entire health care system, not just for drug costs. We need to acknowledge that spending on drugs is an investment in the health of Canadians. We also need to acknowledge that the rush to achieve short-term savings can sometimes lead to longer-term costs, both in terms of health care expenditure and quality of life.

We know the committee has a complex task before them. There are no simple answers or solutions. Nevertheless, we encourage the committee to consider both short-term and longer-term approaches. Equally important, we encourage the committee to ensure the care in pharmacare. Including pharmacist services is an essential element of any pan-Canadian plan.

Thank you very much. We would be pleased to answer any questions.

● (1550)

The Vice-Chair (Mr. Len Webber): Thank you, Mr. Eisenschmid.

We'll move on to Ms. Julie White with the Canadian Health Coalition. Julie, you may start now.

Ms. Julie White (Board Member, Canadian Health Coalition): Thank you for the opportunity to talk to you today.

I am primarily a researcher, and the author of four books and many, many articles focusing primarily on labour force issues. I worked for 10 years for the Communications, Energy and Paperworkers Union. This is the union that has now joined with the Canadian Auto Workers to form Unifor.

My work included research around the negotiation of benefits for workers, including drug plans. I've now been retired for four years and am a member of the Congress of Union Retirees of Canada, and I represent that retirees' organization on the Canadian Health Coalition.

The Canadian Health Coalition is an organization dedicated to the preservation and improvement of our national public health care. I wrote the CHC's recent policy document, called "A National Public Drug Plan for All", which you either have or will be receiving.

Today I'm going to direct my comments to that part of the population referred to as being covered by work-based private plans, and I want to question the use of that term in some ways.

I think we all know that work-based plans cover the majority of the population. The figure I use in my report is 66% of the population. That comes from a document prepared by the pan-Canadian Pharmaceutical Alliance. I've seen other percentages, but all agree that the majority of the population are in private plans.

I want to make three points. The first is about who pays for these plans. The second is that work-based plans are very expensive. The third is that the quality of care provided is poor.

First, who pays? There is a tendency to talk about work-based drug plans as if they are paid for by employers, because it is employers, of course, that remit premium costs to insurance companies. However, this is not at all the case, because employees also pay for their drug plans, both directly and indirectly.

To give examples, nurses in Alberta, as several people at the table will know, pay 25% of the cost of their health insurance plan directly—that is, it is taken out of their wages. Nurses in Newfoundland pay 50% of the cost of their premiums directly. Retirees from your very own federal public service are currently seeing their contributions to their health plan, including for drugs, increase from 25% to 50% of the cost over a four-year period. Others pay in less direct ways, through lower wages or reductions in other benefits. Where unions are negotiating benefits and wages, there are often trade-offs.

Let's be clear: employees are paying for their drug plans.

The second point is that work-based plans are very expensive. First, there is the inability to negotiate drug prices. There are thousands and thousands of plans, so there is none of the negotiating power that is necessary to bargain for lower prices with pharmaceutical companies. Also, employers are not in the business of determining which drugs are more effective for the price than others, so these plans tend to cover all drugs, regardless of their effectiveness or their price. This is expensive.

Money is also wasted in the administration of these many thousands of different plans. Each plan has its own set of limits, its requirements, and its coverage rules. Every individual prescription must be checked against the plan covering that person. Insurance companies must also analyze costs, set premiums, discuss premium increases every year or two years with employers, and search for new business. Most insurance companies are also in business to make a profit—not unreasonably—but this is not the case in public drug plans. All this costs additional money.

The Quebec drug plan, the RAMQ, compared the cost of administration of its public drug plan with the cost of private health plans. Administrative costs were 2.9% in the Quebec public drug plan, but five times that amount in private plans, at 14.6%. Other studies have suggested much larger differences than this. If we are talking about cost, public drug plans are less costly than private plans.

- (1555)

I want to talk about the quality of care that these expensive plans provide.

When we say that the majority of the population is covered by work-based plans, this is a questionable statement. We need to ask what kind of coverage they get, especially at such high costs. Among other things, the problems are that coverage is unfair and haphazard, that most plans don't provide anything like full coverage, that plans are getting worse as costs increase, and that benefit coverage is not secure. I'll talk briefly about each of those.

Which workers have work-based coverage? Public service workers are more likely to have coverage than the private sector. Full-time workers are more likely to have coverage than part-time workers. Unionized workers are more likely to have coverage than non-union workers. Men are more likely to have coverage than women. Older workers are more likely to have coverage than younger workers. Please note that none of this bears any relationship to medical needs. It just depends on where you work and the nature of your drug plan. This is a haphazard and unfair way to provide health care to the population.

Most plans do not provide anything like full coverage. An Ontario study by Mercer for the Ontario Chamber of Commerce found that 38% of private employers with drug plans cover 100% of the costs of the drugs. The other 62% are providing just a percentage of the drug costs, which might be 80%, 70%, or 60% of the cost. This means that at the pharmacy counter, the employee must pay anywhere from 10% to 40% of the cost of the drug. It's important to note that this bears no relationship whatsoever to a person's capacity to pay these amounts. In fact, I would argue that workers who have been able to negotiate better drug plans and better coverage are often the workers who have better jobs and better incomes anyway.

There is increasing pressure on these plans as costs rise. This means both employees paying more and reductions in the coverage provided. When I worked at the Communications, Energy and Paperworkers Union of Canada, we saw the introduction of flexible benefit plans, something which, in my opinion, simply should not be permitted. This is a plan whereby individual workers decide what level of drug coverage they will take and pay differential premiums according to the level that they decide upon. You may decide to take a lower level of coverage and pay less, or a higher level of coverage and pay more. I think you can see the dilemma that this creates. Essentially, you guess what you think your drug needs might be for the following two to three years, because that kind of plan normally ties you in for that period of time. Guessing the future health of your family should not be the basis for drug coverage.

I advised CEP unions to avoid flexible benefit plans, but they came in anyway, under pressure from the rising cost of premiums transferred through employers and pressed on employees.

I want to talk about how secure our work-based plans are for those that they cover. The words “work-based” really say it all. If you change jobs or are laid off, you will lose your drug plan. Over the 10 years that I worked for the CEP, 30,000 paperworkers were laid off from their jobs. Due to a drop in demand for newsprint and the rising value of the Canadian dollar, many mills closed entirely, and others cut back substantially. Each one of those 30,000 workers lost their drug plan, and it was not only the workers but also their families, their spouses, and their children.

Let's not forget that at every negotiation, every two to three years, your drug plan may be up for changes. For workers without unions, your drug plan may be changed at any time.

I have a couple of final comments.

In my experience, employers want out from dealing with drug plans for employees. They wonder, as I do, why employers who are running businesses making paper or automobiles, or employers who are managing municipal and provincial public services, are making decisions about the provision of prescription drugs.

•(1600)

Why do we have this absurd situation in which employers, and in some cases unions, are determining health issues around prescription drugs? Would this not be better in the hands of medical professionals and medical researchers?

In the presentation that you heard by Marie-Claude Prémont, she explained with great clarity the mistake made by Quebec in institutionalizing work-based plans and requiring workers to participate in them. The spiralling cost of this decision should surely make us reflect on the successes of universal public systems in other countries at controlling costs versus the unsustainability of the Quebec system.

To summarize, work-based plans are a failure. They are expensive, inequitable, inadequate, and insecure. They are a major part of the problem; they are not part of the solution.

Thank you.

The Vice-Chair (Mr. Len Webber): Thank you, Ms. White. I appreciate that presentation. You went a bit over, but seeing as you're retired, and the fact that you came here—

Ms. Julie White: I have all the time in the world. I'm sorry.

The Vice-Chair (Mr. Len Webber): Exactly. We appreciate your coming anyway.

For our final presentation, we have Connie Côté and Debra Lynkowski here from the Health Charities Coalition of Canada.

Please start, Connie.

Ms. Connie Côté (Executive Director, Health Charities Coalition of Canada): Thank you.

Mr. Chair, committee members, thank you for the opportunity to appear before you today. My name is Connie Côté, and I am the executive director of the Health Charities Coalition of Canada. As Mr. Webber said, joining me is Debra Lynkowski, who is a member of our governing council and president and CEO of the Canadian Lung Association, which is one of the 30 members of our coalition.

[*Translation*]

First and foremost, I would like to express our gratitude to Parliament for initiating discussions on the issue of pharmacare and for taking important steps in working collaboratively with the provinces and territories to find solutions.

[*English*]

The Health Charities Coalition of Canada is a member-based organization comprising 30 national health charities and patient groups. Our members represent the majority of Canadians affected by health issues. We reach millions of people every year. We work together to improve health by identifying gaps, monitoring trends, promoting and improving best practices, and investing in health research. We believe in patient partnerships, and we create meaningful opportunities for patients to participate in the planning, decision-making, and review processes, such as the CADTH review process. Most importantly, we are a trusted source of information. Canadians rely on our members to provide evidence-informed, consumer-friendly information about disease.

The perspectives we share with you today come from the patients and the families we work with every day. We're here to tell you that access to medicine is extremely important to Canadians.

Imagine the following. A doctor continues to have repeat visits from a patient who has chronic obstructive pulmonary disease. The patient is experiencing severe exacerbations that are bringing him back into the clinic repeatedly, and occasionally into the emergency room. The doctor is concerned that the prescribed treatment is not working, until one day his patient confesses that he's only been using his inhaler once a day rather than twice a day, as prescribed. Why? Because he can't afford to renew his prescription. He thought he would reduce the number of times he took it per day and make it last a little bit longer.

A young woman living with arthritis has just completed her degree. She has secured an entry-level position and is eager to enter the workforce. What should be an exciting time of her life has turned into a nightmare. Now that she has graduated from university, she is no longer eligible for insurance under her parents' plan. In order to manage her symptoms, she takes a TNF-alpha inhibitor known as a biologic. The cost is over \$1,800 per month. She is registered for the catastrophic drug coverage plan in her province, only to learn that the drug she needs is not listed on their formulary as a treatment option for her disease. She's distraught. Just imagine not being able to gain access to the medication you need. In her case, this results in her pain and symptoms becoming unmanageable, and ultimately she's not able to work. She feels defeated.

These are the stories we hear every single day. So what can we do?

The Health Charities Coalition of Canada believes all people living in Canada should have equitable and timely access to necessary prescription medications, based on the best possible health outcomes rather than the ability to pay.

We have three recommendations that we will elaborate on today: one, that the Government of Canada create an advisory panel to establish comprehensive, evidence-based, pan-Canadian standards for pharmacare; two, that the Government of Canada also take a leadership role and share the cost in implementing these standards; and three, that health charities and the Canadians they represent be active participants in any federal, provincial, and territorial consultations on pharmacare.

From the patient perspective, inequitable access to medication has a very real and profound effect. It means that people cannot afford or access the medications they need. By way of example, 57% of people living with diabetes report that they do not comply with their prescribed therapy because they cannot afford their medications, devices, and supplies, thus potentially compromising their ability to manage their disease.

While the majority of Canadians have some level of drug coverage, either through an employer-sponsored program, privately purchased insurance, or a provincial drug program, many Canadians still report challenges in accessing medication.

• (1605)

Ms. Debra Lynkowski (Governing Council Member, Health Charities Coalition of Canada): I was going to give you some compelling statistics to get your attention, but you've heard some of them today, and I suspect you have actually heard many statistics over the past few weeks. My guess is that you don't have to be convinced any longer that this isn't simply a small crack in the system. I know sometimes that's what we think, or we think these are isolated instances.

I will tell you, because we're all about the patient and all about the stories of the patient, that the two that really hit home for me were learning that sometimes you actually have to fail at a drug before you get the drug you really need, the one your doctor wanted you to have to begin with, which to me was completely mystifying. There's also the fact that sometimes it's actually in your best interest to stay in the hospital, because you actually might get better access there to the medications you need.

You know the stories, you know the statistics, and I'm not going to repeat them. I'm going to move into a solution and what we, as a coalition of 30 national health charities.... It's hard to get 30 national health charities to agree on anything, so believe me, the fact that we agree on this tells you that there is actually a profound problem.

Our solution starts with principles. We really think there are four principles that have to be at the foundation of this. They are patient partnerships, quality, equity, and sustainability.

Regarding patient partnerships, we believe any standards that need to be developed have to be done so in partnership with patients in a very meaningful and collaborative way, not in a way that feels in any way token, and we need to ensure that the right medicine gets to the right patient at the right time and, of course, in a cost-effective manner.

On quality, Canadians deserve high-quality therapies and services that are appropriate to their needs—you've heard that a lot today—and respectful of their choice and the best recommendations of science and their physician.

As for equity, all Canadians should have equitable access to a comprehensive range of evidence-based medications. This is key. It shouldn't matter who you are, what illness you're suffering from, where you live in Canada, or in what setting you're being treated in determining what kind of access you have.

Of course we need sustainability. We're not naive. We know the implementation of any standards must be adequately resourced, they must be cost effective, and it should be within a health care system that is continuously reviewed, evaluated, and improved.

With those four guiding principles, we offer these specific recommendations that my colleague referred to already, but I will elaborate on them briefly.

The Health Charities Coalition of Canada asks the Government of Canada to create a multi-stakeholder advisory panel. I put emphasis

on the multi-stakeholder aspect, because we believe that's key. This panel would establish comprehensive, evidence-based, pan-Canadian standards for pharmacare. The panel would collaborate to provide recommendations on standards that would then inform a federal-provincial-territorial agreement that would be sustainable and equitable and provide greater access, all with the goal of improving health care outcomes.

Again, implementation of standards would ensure all Canadians have access to prescription drug coverage based on the best evidence and would respect an individual's and their physician's choice based on need, not on cost.

We further recommend and believe that the Government of Canada has a leadership role to take. We understand jurisdictional issues, but the Government of Canada is also responsible for the health and welfare of Canadians, and we believe the Government of Canada should share the cost in implementing these standards.

On a practical level, the government could take a role by ensuring accountability for increased investment in pharmacare and specifying requirements that must be met in order for the provinces and territories to receive increased transfer payments.

Finally, we ask that health charities and the Canadians they represent be active participants in any federal-provincial-territorial consultations to support the development of these standards.

As my colleague mentioned, we represent millions of Canadians and millions of patients. They want a meaningful voice and they want to be at the table. We can provide valuable perspectives on the development of policies and reform. We're well positioned to identify and describe these real-life examples, but more than that, we're well positioned to offer constructive and innovative solutions.

• (1610)

In closing, we know this is complex, we know you have lots of competing interests, and we know that meaningful collaboration can be challenging, but we trust in the collective wisdom not only in this room but of what a multi-sectoral panel could provide, and we strongly believe that if you use the patient as your compass, you won't go off course.

Thank you, and we're happy to respond to your questions.

The Vice-Chair (Mr. Len Webber): Thank you very much.

You were right down to one second left. You must have practised.

Thank you all for your presentations. We're going to move right into our questions in round one.

I understand, Darshan Kang, you will start with your seven minutes of questioning now. Thank you.

Mr. Darshan Singh Kang: Thank you, Mr. Chair.

My first concern that comes to mind is conflict of interest, so it is very important to let the public know if any witnesses have any potential or perceived conflicts of interest.

My first question is this: are you, your organization, or a representative on your behalf currently registered with the Commissioner of Lobbying for the purpose of influencing federal government policies on the subject of a national pharmaceutical strategy?

Second, does your organization receive any money from pharmaceutical manufacturers, insurance companies, marketing firms, or other entities related to pharmacare who have a vested interest in influencing national pharmacare policy?

There are two questions.

The Vice-Chair (Mr. Len Webber): Mr. Kang, who have you directed the questions to?

Mr. Darshan Singh Kang: Everybody.

Ms. Julie White: I think that's a very good question. I think it's really important that we understand who we're talking to and whether there are conflicts of interest.

I have no conflict of interest to disclose, and I am not waiting for a telephone call, either.

Mr. Perry Eisenschmid: I think there were two questions there.

I am a registered lobbyist, but not for a particular issue.

I think generally in terms of payments, what is commonly misinterpreted about the Canadian Pharmacists Association is that we actually represent the 40,000 hard-working pharmacists around the country. We're not representing big retail chains or drug manufacturers, so we represent the pharmacist workers in communities and hospitals across the country.

The other thing that is often not well known about our organization is that over 90% of our funding is secured by the selling of our products and services, which are the gold standard drug and therapeutic reference tools that we sell to health professionals around the country. That's 90% of our funding.

We do receive occasional funding from various private sector interests for specific issues. For example, on pharmacare we receive funding to do national consultations of the general public and the pharmacy profession around the country.

•(1615)

Mr. Darshan Singh Kang: What about the Health Charities Coalition?

Ms. Connie Côté: I am not registered as a lobbyist. We certainly have not met the threshold that is set in order to register. Members of my coalition, however—a majority of them—are registered as their own health charity.

In terms of your second question with regard to a conflict of interest and funds, we are a member-based organization, so we receive funding from our own members. We do not receive any outside funding other than small grants, occasionally, to support specific projects, but nothing that's in conflict of interest with this particular dossier.

Ms. Debra Lynkowski: I am a registered lobbyist on behalf of the Canadian Lung Association, although I don't meet the threshold there.

I don't have any conflicts to declare. When and if we've ever received any funding from private sector partners, they're unrestricted educational grants and have no relation to this matter.

Mr. Darshan Singh Kang: So not even in the future, you don't think?

Ms. Debra Lynkowski: We wouldn't do that. We guard our independence and autonomy very jealously so that we can be independent and honest brokers.

Mr. Darshan Singh Kang: Thank you.

Lisa.

Ms. Lisa Ashley: Thank you.

I am registered as a lobbyist, as we speak on a number of health issues with the government.

I do not have any conflict of interest and neither does our organization. We are a member-based organization, which is where the majority of our funds come from. We may at times have some sponsorship at a conference where a pharmaceutical company may be there. I don't believe that is actually the case for this upcoming conference.

Mr. Darshan Singh Kang: Thank you.

My second question is to the Canadian Pharmacists Association.

Do your members generally receive compensation from pharmaceutical manufacturers for prescribing brand name medicines when an equally effective generic drug is available?

Second, how would this practice be affected by a national pharmacare strategy?

Dr. Philip Emberley (Director, Professional Affairs, Canadian Pharmacists Association): Thank you for the question.

No, pharmacists are not compensated by a pharma company for dispensing brand name medication. They're required to dispense the lowest-cost drug for a specific molecule. That's part of their code of ethics.

As to the second part of your question, this will not change with a national pharmacare plan.

Mr. Darshan Singh Kang: You said they are required. Who monitors that? For the pharmacists, there could be enticements for prescribing brand name drugs. There must be benefits to the pharmacist or the pharmacy for providing expensive drugs rather than generic drugs.

Dr. Philip Emberley: No, pharmacists are regulated at the provincial level, and they're required to dispense the lowest-cost molecule. If there's a generic available, they're required by their regulations to dispense it.

Mr. Darshan Singh Kang: Even if the patient insists?

Dr. Philip Emberley: If the patient insists, in most provinces the patient is required to pay the difference between the generic cost and the brand name cost. That is a patient preference that is sometimes relayed by the patient to the pharmacist.

The Vice-Chair (Mr. Len Webber): You have 40 seconds.

Mr. Darshan Singh Kang: Okay, I think I'll stick with this. If the patient has coverage, is it still possible to get the brand-name drug?

Dr. Philip Emberley: If the patient has coverage for the brand name—and often they would know if they do—then they can request it from the pharmacist, who would then dispense it. For example, if someone works for a pharma company, they often have a policy of using only brand name products, in which case they will tell the pharmacist this, and the pharmacist will dispense the brand name.

Mr. Darshan Singh Kang: The patient will not be encouraged to go with the generic drug because it's going to cost less for somebody.

Dr. Philip Emberley: The discussion would normally happen. As pharmacists, we believe there's equivalence, bioequivalence, as dictated by Health Canada, so they would be encouraged. However, in many cases they specifically request it.

Mr. Darshan Singh Kang: Thank you.

The Vice-Chair (Mr. Len Webber): Thank you, Mr. Kang.

We'll move on to Dr. Carrie, and after Dr. Carrie, Mr. Davies.

Mr. Colin Carrie: Thank you, Mr. Chair. You're doing a fine job today.

One of the things I'm concerned about is that we are talking about increasing access to pharmaceuticals. I think we should be aware that without controls, it could be a dangerous and costly thing. In Canada we have challenges with over-prescription and with prescription drug abuse. I'd like your opinion on these questions.

We've heard from different witnesses that up to 40% of seniors are on inappropriate medication. Mr. Eisenschmid, I think you mentioned the role pharmacists could play in catching this. Mr. Emberley, I think you worked for the British Columbia government, and you are an expert on the optimal use of medication.

Have you guys ever run the numbers on how much money could be saved by the public system if medication were more properly prescribed to patients?

• (1620)

Mr. Perry Eisenschmid: I've never seen an analysis of that. It's patient by patient, but I think there are significant potential savings.

That goes back to the theme of my presentation. Making sure that all Canadians have appropriate coverage and that their drugs are covered by public or private plans is a great thing. The end goal, however, is not to dispense more medications; rather, it's to manage medication by professionals to make sure the patient is getting the appropriate care. We think pharmacists, being in 10,000 locations that are often open 24/7, are the perfect first point of contact and are the experts required to make sure medication is being prescribed appropriately and not excessively.

Mr. Colin Carrie: I think that's important when you're looking at the scope of your practice, because 40% of the time we're getting it wrong with elderly people. How dangerous is that to the system?

I'm also concerned about the stats on opioid abuse. I think Canadians, per capita, are the number one users of opioids. You wonder why Canadians need more opioids than anybody else in the world.

What role could you perform as pharmacists, and how would that affect your relationship with medical doctors?

I had a neighbour in Oshawa who was a pharmacist, and he told me about catching medical contradictions in different medications. I can see how your role could be expanded. It could be very cost-effective. How would your relationship with the medical profession have to change?

Mr. Perry Eisenschmid: I think our resident pharmacist is probably in the best position to answer that question.

Dr. Philip Emberley: That's a great question, and I have to say this is not a problem that belongs to doctors. It's not a problem that belongs to nurses or to pharmacists. I think what it speaks to is that we need to have a team-based approach. It's an approach that leverages the knowledge and skills each professional brings.

I've been a pharmacist for 28 years, and I think in the last 10 years, as a profession, we have become much closer to prescribers and working with prescribers in order to optimize care. When we mention taking people off medication, it's not about that. It's about finding the optimal mix of medications that people need.

I will mention that I see seniors come in, and some of them are on so many medications they lose track of what's what and what this medication is for and what that medication is for. It becomes sometimes a toxic mix. I think there's a valuable role for pharmacists there in pulling things apart, making a recommendation where it's appropriate, and prescribing or saying, "Look, we think there's a problem here that could be addressed." This is how we can move forward to optimize the care of the patient.

Mr. Colin Carrie: When you mention care versus cost, I remember that a few years ago Deb Matthews was concerned with the federal government because she wanted to see more opioids, the tamper-resistant type, brought in instead of the generic and easily diverted type of opioids. I believe she quoted 85% of the population of one of our first nations communities were addicted to opioids.

The concern, I think, is that it's kind of an easy thing to do, write a prescription. In some situations, how could a pharmacist work into a system to make it more appropriate, as you mentioned, with the right medication available for Canadians? How could we look at your role and your scope of practice and the importance of pharmacare with this study?

You mentioned that in some provinces you're not fully covered for giving out advice. How could we look at that to improve the entire system and the team that's involved in the entire system?

• (1625)

Mr. Perry Eisenschmid: I can start, and then Phil can embellish.

One of the biggest impediments, and many people don't realize this, is that pharmacists' compensation for those kinds of expanded services is pooled, unfortunately, under the drug plan budgets of the provincial governments. With all of this focus on cost containment and more cost containment, the unintended consequence is that provincial coffers are less able to fund the important expanded services we're talking about here.

One of the things we would put on the table for consideration is if the federal government is getting more financially involved through a national pharmacare program or other means, we need to somehow start funding those services outside of the provincial drug plan budgets, which we know are continually constrained, to make sure the medications that are being prescribed are being managed effectively.

When there is over-prescription, pharmacists see this first-hand. They see the patients wandering in with the unintended consequences of inappropriate prescribing. They are there first-hand, and if they're empowered through regulation and compensated appropriately, they would be able to step in and make the appropriate intervention.

Mr. Colin Carrie: It seems that Canadian professionals are well versed in prescribing, but it's the unprescribing.... Is this a role that pharmacists could be partnering with medical doctors on? With the opioid crisis and the huge numbers rolling through Canadians' blood systems every single year, is there any reason why we're number one in the world for this type of product? I think 25% of users, when they start on these prescribed opioids, turn to addiction.

The Vice-Chair (Mr. Len Webber): Mr. Carrie, you're almost out of time. You are out of time, so if you can answer that briefly.

Mr. Perry Eisenschmid: I think some of these partnerships do exist today. They can and should be expanded. Your point is physicians typically prescribe a medication, and it's the pharmacists who see the patient on a regular basis as they refill those prescriptions. They are in the best position to make an appropriate intervention, I would argue.

Dr. Philip Emberley: Yes, it's true, we do see patients getting into trouble, and you can't strictly just stop a medication. In a lot of cases you need a systematic way of helping them to reduce.

I think a big part of what pharmacists also do, because they see their patients so often, is get a sense of when patients are getting into trouble. There are visible cues with, for example, patients refilling their medications early. You get a sense that people may be getting into trouble. I think an important role pharmacists play is to let members of the team become aware of those situations so they can intervene and provide addiction management services.

The Vice-Chair (Mr. Len Webber): Thank you.

Up next we have Mr. Davies, and then Mr. Ayoub.

Mr. Don Davies: Thank you, Mr. Chair, and thank you to all the witnesses for being here and sharing your expertise with us.

I have seven minutes to parse and get the unified theory of pharmacare in Canada, so I'm going to ask you if you can be crisp in your answers so I can get to as many questions as possible.

Ms. Ashley, I'm going to start with you. Can you provide the committee with an example of an outcome of cost-related non-adherence to prescriptions that some of your member nurses have to deal with? In other words, give me an example of what happens when a patient doesn't have access to pharmacare and how that costs our system more.

Ms. Lisa Ashley: I can't give you a monetary cost, but I can certainly give you the life costs that make a difference. If a senior with multiple chronic conditions is unable to afford their medication, they are going to end up in an emergency department with a stroke. They may end up having falls because they haven't had the right medication to control that, so they will end up in the emergency department and then they will end up in a long-term care facility and not be able to be at home.

Mr. Don Davies: Do your members see that kind of example?

Ms. Lisa Ashley: Yes.

Mr. Don Davies: In your submission you recommend mandatory generic substitution, which you also mentioned in your remarks. Some witnesses have come before this committee and warned us that measures like that—and in fact a universal pharmacare system itself—would restrict choice for patients and potentially undermine access to quality therapies.

What is your response to those criticisms?

Ms. Lisa Ashley: Certainly there is the opportunity for the team approach, and the way something is created will actually make a difference. While we may have a difference of opinion about how to get to the bottom line in what we're talking about, I think the bottom line consistently is to ensure that patients have access to medications they can afford.

Mr. Don Davies: Ms. White, in a previous meeting we heard a witness state that unions and union members are opposed, or may be opposed, to a national public drug plan, instead preferring the coverage they have under private work-based plans. As an organization that works closely with unions and unionized workers, would you agree with that statement?

• (1630)

Ms. Julie White: I saw that comment. It made me smile, because in the Canadian Health Coalition, we have a huge amount of support from the union movement, and that includes all the big unions. I could list them off, but to save space, I won't.

It's not just that the unions themselves are in favour. We have many union members who come to our annual lobby of MPs to talk to MPs about the importance of a prescription drug plan. I'm not saying there are no union members out there who might have 100% coverage who wonder what might happen under a public plan. There may be.

What I tend to say to them is "It's fine for you to have coverage, but does your whole family have coverage? Do your grown children have coverage? Do your grandkids have coverage?" I think it's entirely wrong to suggest that unions are not interested in a national public plan. That is what they are struggling for.

Mr. Don Davies: Thank you.

Ms. White, some witnesses have also recommended that the committee look at the Quebec model, which has a public floor for those who have no coverage and then it retains a private system paid for by employers for coverage above that.

Does your organization have any position on the Quebec model, or would you instead prefer a single-payer first-dollar universal system?

Ms. Julie White: I would prefer the latter. My remarks tended to say that these are the kinds of problems you're going to have if you try to integrate some kind of work-based model like the one in Quebec with the public system, which just picks up the outliers who aren't covered with a workplace plan. You're going to have all those increased costs that workplace plans entail, and you're going to have a lack of general coverage for the population and a lack of capacity to negotiate the prices of drugs with pharmaceutical companies, so you're going to be looking at a much more expensive system with results that are not as good.

Mr. Don Davies: Thank you.

Ms. Ashley, does the Canadian Nurses Association have a position on the Quebec model, or do you instead prefer a single-payer first-dollar universal system?

Ms. Lisa Ashley: I would have to check on that.

Mr. Don Davies: Thank you.

Mr. Eisenschmid, I'm not sure I got this correct, but I think I did. You suggested that a universal pharmacare system would take time to implement, which is logical, but if I heard you correctly, you suggested that the process of implementing it would leave some patients without coverage.

I'm just wondering about the source of that statement. Do you have data on that? Is that inevitable? Could we not build a universal pharmacare system and make sure that Canadians are covered while that process is taking place, or do you think it is inevitable?

Mr. Perry Eisenschmid: You could. In terms of the development of the ultimate program, what we're commenting on is more the reality of how long it takes to get such a comprehensive fundamental change in our coverage. It's going to take some time, and in the meantime, shouldn't we look for ways to make sure the gap isn't maintained? It's more of a temporary situation.

Mr. Don Davies: I see. Okay.

Ms. Côté, I believe your organization does not have a particular system that you're advocating. Is that correct?

Ms. Connie Côté: That's correct.

Mr. Don Davies: Has your organization expressed any concerns with Canada moving to a single-payer, first-dollar system to ensure universal coverage for Canadians?

Ms. Connie Côté: We've looked at many different options, and what's really important to us is that no matter what option is implemented, we think it's crucial that patients have a voice and that we really look at some of the ways that patients will be able to have access. It's the inequitable access that we're really concerned about, so we really caution you to look at what those outcomes will be for patients.

Mr. Don Davies: Right.

How am I doing for time?

The Vice-Chair (Mr. Len Webber): You have one minute remaining.

Mr. Don Davies: I have one minute.

I can't remember who asked or stated this—I think it was you, Ms. White, or maybe it was you, Ms. Côté—but it was that 50% of Canadians don't have workplace prescription plans. Did I hear that from someone?

Ms. Julie White: What I said was that the majority of Canadians, probably in the region of 60% to 65%, have workplace coverage. The rest do not.

Mr. Don Davies: Okay, so your testimony would be that about 30% or 35% do not have workplace coverage plans.

Ms. Côté, I want to ask you, if you could give this committee one single piece of advice as to how we could best move forward, what would it be?

Ms. Connie Côté: We're really calling for pharmacare standards. We really think it's important that we all understand what we're working toward and the standards we're trying to achieve. We really hope we will have a much broader discussion and that it is a very comprehensive multi-stakeholder approach.

We all see things through a very different lens, so it's not just one view that will get us to the place where we need to be.

Mr. Don Davies: Thank you.

The Vice-Chair (Mr. Len Webber): Thank you.

We'll move on to Mr. Ayoub and then to Ms. Harder.

• (1635)

[Translation]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Mr. Chair.

I also want to thank the witnesses for their insightful presentations and the extremely important information they are contributing to this study.

I have not yet had time to introduce myself. I am the member of Parliament for Thérèse-De Blainville, located north of Montreal, in Quebec.

I will first mostly address the Canadian Pharmacists Association representatives.

Mr. Eisenschmid, you mentioned several times that we shouldn't focus too much on the cost of medications. Whether we like it or not, the cost of research is reflected in the cost of medications. According to a cost estimate for a Canada-wide pharmacare system, the costs would be high.

I would like to hear your thoughts on the fact that retail pharmacies sometimes raise the prices of prescription drugs. I have here figures going back to 2012-2013. That profit margin accounted for 4.2% of the total costs paid by public insurance plans for prescription drugs, or about \$323 million. So public insurance plans put a cap on the profit margin refund for prescription medications.

Why are retail pharmacies raising the price of prescription drugs? Do private plans also set a cap on profit margin refunds?

How do you think we should address the issue of caps in terms of profit margins for prescription drugs if a Canada-wide pharmacare system was instituted?

[English]

Mr. Perry Eisenschmid: I'm not clear on the question. When you say pharmacists are increasing...drug prices are going up, or manufacturers are increasing prices....

[Translation]

Mr. Ramez Ayoub: I'm talking about retail pharmacies.

[English]

The retailers.

Mr. Perry Eisenschmid: Do you mean dispensing fees?

[Translation]

Mr. Ramez Ayoub: I would like to know more about pharmacies' profit margins.

[English]

It's not dispensing fees, but it's...

[Translation]

profit margins.

[English]

Mr. Perry Eisenschmid: The profits of the stores, do you mean?

[Translation]

Mr. Ramez Ayoub: I want to talk about markups in the price of prescription drugs.

[English]

Mr. Perry Eisenschmid: You're saying that you have information that the profits on prescription drugs in Quebec went up.

Mr. Ramez Ayoub: No, no, not in Quebec, in general. That's what the research has been trying to get information about and that's the information we have right now. Are you not aware of that?

Mr. Perry Eisenschmid: We represent the pharmacists, who are typically on hourly wages or are salaried employees. That question is probably more for the owners of the retail chains and what they're doing with their business operations.

Mr. Ramez Ayoub: All right. I'm a little bit surprised, but it's okay.

[Translation]

Since the first provincial pharmacare plans were implemented in the 1970s, generic drug companies have given pharmacies discounts. Generic drugs have also become an important part of pharmacies' revenues. However, over the past few years, the lower refund rates for generic drugs through public plans have reduced the discounts generic drug makers give to pharmacies.

Are generic drug companies still giving pharmacies those kinds of discounts? If so, what percentage of their revenues do those discounts generally account for? How much of those discounts are passed on to clients by pharmacies?

[English]

Mr. Perry Eisenschmid: Again, unless Phil has other information.... You're talking about the business of pharmacy? You're talking about the relationship between the drug manufacturers and the retail store owners?

[Translation]

Mr. Ramez Ayoub: I am talking about generic medications.

[English]

Mr. Perry Eisenschmid: Yes.

[Translation]

Mr. Ramez Ayoub: Do pharmacies that get a discount on drugs definitely pass on a portion of that discount to their clients? It's a simple question.

[English]

Dr. Philip Emberley: A number of provinces in Canada do still allow rebates to pharmacies. A number have put in controls. For example, Ontario does not allow rebates for generic companies.

With a number of the changes that have been made to generic drug pricing across Canada, these rebates have gone down considerably. We feel it's very important for a lot of the services we've described that pharmacists do to be adequately funded. I know these rebates have decreased in recent times.

• (1640)

Mr. Ramez Ayoub: My second question was on whether those kinds of rebates are given back to the customer. Do they get a percentage of rebates, or do all the rebates go to the pharmacists? Do you have that kind of information?

Mr. Perry Eisenschmid: I think the undercurrent of your question is with regard to compensation models both for the business of pharmacy and for pharmacists themselves. I think you're bringing up a very good point, which is that right now the compensation for pharmacies and pharmacists is not aligned with the services and the value they are providing. There's no question that right now pharmacies rely a lot on either rebates or allowances in certain provinces to fund their overall operations, because, they would argue, they are not getting appropriately compensated for direct interventions like medication adherence.

We would all agree that we ultimately need a change in the compensation structure for pharmacies and pharmacists to ensure that there's appropriate payment for the appropriate service and that pharmacies don't have to rely on earning a margin on the drugs they dispense to cover other services. We would agree with that.

[Translation]

Mr. Ramez Ayoub: Most of the time, pharmacists own or operate their own pharmacy. However, as you said, that's not always the case. Some pharmacists are paid an hourly wage. That's a different matter, if I understand correctly.

[English]

The Vice-Chair (Mr. Len Webber): Mr. Ayoub, your time is up.

Mr. Ramez Ayoub: Thank you, Mr. Chair.

The Vice-Chair (Mr. Len Webber): We're in round two now. Members have five minutes each.

We'll go to Ms. Harder and then Mr. Oliver.

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

My question is directed to you, Mr. Eisenschmid.

Here at committee we've heard from a number of groups of witnesses—academics and industry, individuals and representatives—and many of them have pointed a finger at pharmacists for higher drug prices. The Pharmacare 2020 academics even went so far as to question the credibility of your organization to conduct research and picked on some of the statistics you brought forward, indicating that your conclusions were motivated by profit margins rather than other alternatives.

I can imagine these allegations are familiar to you. I'm actually just looking for you to comment on those allegations today.

Mr. Perry Eisenschmid: We were very disappointed by those allegations and that they struck at the credibility of the Canadian Pharmacists Association. We thought they were unfounded. In fact, we've had follow-up conversations with them to try to understand the rationale behind it.

The particular research study that I think they are critical of didn't have a particular perspective. It was an economic analysis conducted by an economic researcher who was trying to basically put some facts on the table and to update Professor Morgan's model with updated information, because he was using the exchange rates from 2013. We knew the world had changed a lot since he had first put his model together, and we commissioned a study to look not just at his model but at alternative models, including the Quebec model and the P.E.I. model, for example.

We just wanted to get some facts on the table. It wasn't a position piece. We didn't make a recommendation. We just wanted to make sure there was appropriate information to guide decision-makers.

Ms. Rachael Harder: I have another question for you. I was interested to see that only 31% of Canadians wanted a truly national system, according to the brochure that you provided, and 85% of Canadians had concerns about the government's ability to manage a plan officially.

Could you comment on these findings and perhaps expand on them a little further?

Mr. Perry Eisenschmid: I can only speculate. This was purely opinion research on the Canadian population. The undercurrent... It was quite a comprehensive survey.

The majority of Canadians are covered by private plans, and many are satisfied with their current plan. They hear stories about moving to a public plan that would cover everybody and that there might be a reduction in the benefits they receive. Roughly three-quarters of Canadians were concerned that moving to a national first-dollar public plan would actually result in lower coverage for themselves.

● (1645)

Ms. Rachael Harder: I'll direct another question your way, if you don't mind.

Your organization has publicly stated:

...a single public payer national pharmacare program would likely incur significant public costs for limited net benefits to Canadians, based on our research to date.

Can you explain to me why this would be the impression that you've been left with and why your research results would differ from those of the Pharmacare 2020 report?

Mr. Perry Eisenschmid: The foundational fact to that point came out of that piece of research, which suggested that moving to a national public-payer first-dollar coverage plan would result essentially in a \$6.6 billion annual cost transfer to the public purse from the private sector.

Again, the public sector has the ability to raise taxes to offset that, but that's a significant shift from private sector to public sector funding, and it has its inherent risks.

Ms. Rachael Harder: Earlier Ms. White said that perhaps it's time for the government to involve itself in terms of picking up some of the costs.

I find this statement interesting, because where would you suggest the government find that money? Perhaps you could comment on that, Mr. Eisenschmid.

Mr. Perry Eisenschmid: Where the government would find the \$6.6 billion?

Ms. Rachael Harder: Yes. If they were to involve themselves, where would they find this \$6.6 billion?

Mr. Perry Eisenschmid: That's beyond my scope.

Ms. Rachael Harder: Do you think you could take an educated guess?

Mr. Perry Eisenschmid: Where they would get the money?

Ms. Rachael Harder: Yes.

Mr. Perry Eisenschmid: Well, clearly, from the taxpayer, whether it was corporate or—

Ms. Rachael Harder: Thank you.

The Vice-Chair (Mr. Len Webber): Time is up. Thank you.

We'll move on to five minutes with Mr. Oliver, and then we'll go to Dr. Carrie after that.

Mr. John Oliver: Thank you very much, and thank you all for your presentations.

My questions are going to be directed to Mr. Eisenschmid and Mr. Emberley for the most part.

In your pan-Canadian pharmacare document, you indicate that a national pharmacare program will result in inappropriate drug therapy. The rationale, as I read through this, is that a closed formulary will limit choice for patients and clinicians' autonomy, and that will negatively impact patient health outcomes.

Every single hospital across Canada uses a closed formulary. Are you basically saying then that hospitals are negatively affecting patient health outcomes by using a closed formulary?

Mr. Perry Eisenschmid: No, what we're saying in that is when we look around the world at countries that have implemented that kind of program, it becomes very much a cost containment strategy as opposed to a patient outcome strategy.

What we've seen, whether it's New Zealand or the U.K., are restrictions on the number of drugs being covered, for good reason. Part of the reason you move to this system is to try to get volume discounts on purchasing. Obviously you can't get volume discounts if you're not trying to consolidate the drug expenditure.

Mr. John Oliver: Are you stating for the record, then, that other countries that have a universal drug care program are negatively impacting patient health outcomes by using those formularies? That's the kind of argument that was being used in the 1980s and the early 1990s as hospitals moved to closed formularies.

I feel it's a bit anachronistic on the part of your association to be staying there.

Mr. Perry Eisenschmid: Can I say something?

Mr. John Oliver: My second question deals with the report "Pharmacare Costing in Canada". In there, the statement was made that a national pharmacare program would result in a negative impact on the ability of pharmacists to serve patients. When I asked the author of the report what that was about, he explained that in other jurisdictions where the public systems don't pay pharmacists as well as the private systems, pharmacists hold their services back.

I have to ask you this question as the leader of your association. If we move to a national pharmacare program, does that really mean you'd be directing pharmacists across Canada to withhold their services, rather than negotiating with the government and coming to a fair and honest price payment for their services?

Mr. Perry Eisenschmid: Of course not.

Again, I think we're mixing associations here. We represent the pharmacists who work typically on an hourly wage or on a salary basis in pharmacies. They're not negotiating with governments on their particular working conditions or compensation.

• (1650)

Mr. John Oliver: I'm sorry; you didn't sponsor the PDCI report?

Mr. Perry Eisenschmid: Of course. Yes, we did.

Mr. John Oliver: In there, he says that this would negatively—

Mr. Perry Eisenschmid: That was the researcher's perspective.

Mr. John Oliver: The third question I have is in regard to your document comparing pharmacare options. It's the same kind of question my colleague Ms. Harder asked.

In terms of the \$6.6 billion, you don't state it, but that's the cost comparison for the government. It's not the cost of the overall system. Other studies have shown that in fact the whole system would be cheaper if we were to move to a national pharmacare system.

When we converted from an employer-based health care sponsored system in the late 1960s and early 1970s, there was a

sharing of costs between private sector firms that had been paying insurance and the government. Do you see that as a possible solution to cover this gap? Could we probably lower the cost that private companies are currently paying for drug plans and at the same time, carrying some of that support from them, manage to cover a public system in Canada?

Mr. Perry Eisenschmid: Absolutely. We were, again, just putting the facts on the table.

Mechanically, that's a transfer of costs of \$6.6 billion. How the government manages to offset that, or partially offset it, is completely up to the managers.

Mr. John Oliver: There are solutions, then, to pharmacists being kept well paid and continuing to provide services for Canadians. There are solutions to how we're going to pay for these services.

Generally you would support, then, the statement that a closed formulary model does not result in poorer health care outcomes for Canadians.

Mr. Perry Eisenschmid: It doesn't have to.

Again, we're not for or against a fully public-paid program. We wanted to put some facts on the table. Any national pharmacare program can work effectively as long as it has the patient's interest in mind, ultimately, and not just cost savings.

Mr. John Oliver: I just want to say that your documents come across as being very negatively directed toward a national pharmacare system. Whether you've intended it or not, it looks as though you are against it, which is difficult for your association and your membership, in my view.

The Vice-Chair (Mr. Len Webber): Your time is up, Mr. Oliver.

We'll now move back to Rachael Harder, and from there we'll go to Mr. Whalen.

Ms. Rachael Harder: Thank you.

Ms. White, you made comments before with regard to the efficiency with which services could be provided if turned over to the government rather than being kept within the private sphere. I'm wondering if you can tell me, perhaps, of two other instances you've seen of services being moved from private to public and becoming increasingly efficient and less costly. It would be helpful to have a case study or an example in mind.

Ms. Julie White: The thing that immediately comes to my mind is simply the price Canada is paying under this system we have, which is extraordinarily high, versus the price in those countries that have a national public drug plan, which is, in general, lower in cost and provides better service to the population.

I'm not sure if that answers your question.

Ms. Rachael Harder: Not quite.

I'm wondering if there are other places where the Canadian government has done similar things in other departments, where we've taken things from the private sphere and put them into the public sphere, and we've done it more cost effectively and with more administrative efficiency.

Ms. Julie White: How about doctors and hospitals? We did both of those. There was a time in Canada when neither doctors nor hospitals were covered in the public sphere, and people paid out of their pockets for what was, I think, generally accepted as inferior care, compared with having a pooling of risk so that everybody was involved as a community in providing care to everybody. Not everybody gets sick and not everybody needs to go to hospital, but everybody helps cover those people who need those services.

What I would say is we are looking for that same approach with regard to the third strand, which is, of course, pharmaceuticals.

Ms. Rachael Harder: Mr. Eisenschmid, I'm coming back to you.

Your organization has said that one model has really been discussed for Canada, and only one model, rather than considering multiple ones. Certainly at the committee all that we've heard has been largely to do with Pharmacare 2020. I haven't heard much expansion beyond that at this committee.

I'm hoping that today you could perhaps mention some other models that might be worth considering as well.

•(1655)

Mr. Perry Eisenschmid: Sure.

I think you're reading something that was probably written six months or so ago, when up to that point no other models had really been under serious consideration nationally. The ones we put forward in our paper would be the Quebec model, which was discussed earlier today, and the P.E.I. model, which entails basic generic coverage for patient populations in P.E.I. It is probably the lowest-cost entry point. Those would be two others that we would put on the table.

Ms. Rachael Harder: Okay. Thank you very much.

Perhaps I'll go to Ms. Ashley.

You made a comment earlier with regard to prescription drugs and people not filling their prescriptions on time. We have had conversations about that at this table, and it seems to be assumed that it's due to cost. We have yet to see a study on that and have actual facts and figures come to this table.

Would there be a study that you could reference that actually shows this? Are there facts and figures that you could provide to this committee?

Ms. Lisa Ashley: I would certainly be happy to forward that to you.

Ms. Rachael Harder: Okay.

Ms. Lisa Ashley: I do have a couple of testimonials from nurse practitioners if you're interested.

Ms. Rachael Harder: No. Actually, I would be interested in knowing the numbers.

Do you know what percentage of people don't fill their drug prescription purely because of cost?

Ms. Lisa Ashley: No. I would be glad to look that up for you.

Ms. Rachael Harder: Okay.

Do you have any sort of indication of where that percentage point would lie?

Ms. Lisa Ashley: No.

The Vice-Chair (Mr. Len Webber): Ms. Ashley, if you could provide that information through the chair, we could distribute it to the committee.

Ms. Rachael Harder: I'm going back to you.

The Vice-Chair (Mr. Len Webber): You have 30 seconds.

Ms. Rachael Harder: Okay. Here we go.

What costs do you think would be associated with offering the full range of pharmacists' services that are offered right now through private care if we were to move that into public care? You said \$6.6 billion. Do you think that's fully comprehensive?

Mr. Perry Eisenschmid: It's not a matter of what I think. It was the consultant who is the expert in the field who thought that was the appropriate price, and we have no reason to question it.

Ms. Rachael Harder: Does that seem pretty accurate?

Mr. Perry Eisenschmid: Yes.

Ms. Rachael Harder: Okay. I just wanted to check.

Thank you.

Mr. Perry Eisenschmid: That wasn't for pharmacists' services. There's a separate conversation around pharmacists' services, which I alluded to. They have not been costed. That's the medication management and the medication adherence.

Ms. Rachael Harder: Right. We would have to account for that in a pharmacare program, would we not?

Mr. Perry Eisenschmid: You don't have to. We highly recommend that you do. There's not much point in having a national pharmacare program if you're not ensuring that people are using medications appropriately.

Ms. Rachael Harder: And—

The Vice-Chair (Mr. Len Webber): I'll have to cut you off there, Ms. Harder.

We will move on to Mr. Whalen and then Mr. Davies after that.

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

Thank you all for coming. We all appreciate so much what you and your members do to help promote health for Canadians, your work on this issue, and your very detailed submissions. We are all very appreciative of your efforts. There are lots of questions.

I'm going to share one minute of my time with Mr. Eyolfson at the end. If someone could remind me, that would be great.

I have a couple of questions for Ms. Ashley.

With respect to the plan that has been put forward by the Canadian Nurses Association, there are certain aspects that I see as very fruitful. On our side of the House we're very interested in closing these gaps in some way, shape, or form, to help Canadians receive the full scope of care they need. This is something that we're committed to. At least, I am personally committed to it.

We want to make sure that this is operationally achieved with the type of excellence that provides Canadians confidence that they're gaining something and not losing something in this endeavour. When I look at one of your recommendations or requirements, I'm wondering whether it's just nice to have or is actually a requirement. It's that the scope of prescribing be extended beyond physicians, surgeons, veterinary surgeons, and pharmacists to nurses. Nurses are already very overworked. Is this division of labour that we have currently appropriate? Is it appropriate to extend these other duties to nurses?

Ms. Lisa Ashley: Perhaps I could make a point of clarification. Legislation across the country allows nurse practitioners to prescribe medication, full formulary. They're almost close to full formulary in Ontario, and it's the only province.

That's not something that is new. In actual fact, it allows for areas where physicians are not located, because of access points, to provide access to Canadians.

Mr. Nick Whalen: Okay. That's great. Thank you for informing me on that.

With respect to electronic health records and making sure the scope of service can be provided, do you see gaps across the country where the lack of electronic health records in some provinces is making it difficult to know the full benefits and effects of prescribing practices?

• (1700)

Ms. Lisa Ashley: Certainly. I think our pharmacist colleagues here spoke about that as well. This is where the team approach comes into effect.

An electronic health record allows all providers to have access to what medication a patient is on. While a patient might be seeing many different health care providers, the pharmacist may end up being the point person who could make sure there are no contrary indications or polypharmacy occurring.

Mr. Nick Whalen: Okay.

Is your organization satisfied, Ms. Ashley, with the level of oversight provided by a pharmacist in ensuring that generics are being appropriately used? Would you consider that this aspect of your plan is being addressed by the code of ethics of the pharmacists?

Ms. Lisa Ashley: I wouldn't want to make that judgment call on my colleagues, but I certainly think that's again an opportunity to work together and ensure that a patient has the appropriate medications that they need and can afford.

Mr. Nick Whalen: Okay.

In terms of ways that we can pay for pharmacare, do you believe your membership would be open to the idea of a dollar-for-dollar reduction in compensation paid if that dollar-for-dollar value is provided in health care benefits through a universal pharmacare plan? If you could answer that quickly, I could get an answer from Ms. White.

Ms. Lisa Ashley: We have not asked that of our members, but certainly, if we're looking at ensuring that people have access to what

they need and it integrates with the other systems that are being looked at, yes.

Mr. Nick Whalen: Okay.

Ms. Julie White: I'm sorry, but I wasn't clear about the dollar-for-dollar part of that.

Mr. Nick Whalen: In the membership of the unions that you've been involved with—and I know that you're retired from it now—would you see an openness and a willingness on behalf of the union movement for a dollar-for-dollar reduction in compensation paid to members if that amount was picked up on the universal pharmacare side in terms of benefits being paid through that amount? Governments who are paying nurses and public sector employees could say, “We no longer have to provide this compensation. You no longer have to pay 50% coverage. We're going to take all that in, but we're going to drop your incomes as a result to pay for the universal national pharmacare program.”

The Vice-Chair (Mr. Len Webber): Can I just interrupt you? You do have less than a minute now. I don't know if you want to—

Mr. Nick Whalen: We'll get that answer, and then—

The Vice-Chair (Mr. Len Webber): Okay, sir.

Ms. Julie White: Sorry, you're asking me to say how all these various unions would consider this idea. I can't honestly speak for them directly. The only thing I can say very clearly is that all the major unions in this country are in favour of moving to a full public national pharmacare program.

You are asking me whether they personally will be prepared to pay for it? Well, many of them would actually get money back if they were not contributing these amounts to drug plans, so there is some wiggle room there.

Mr. Nick Whalen: Thank you.

The Vice-Chair (Mr. Len Webber): Mr. Eyolfson, you've got seven seconds. I don't know if you can have—

Mr. Doug Eyolfson: Seven?

The Vice-Chair (Mr. Len Webber): Seven seconds, and now we're down to three.

I'm sorry, we'll have to move on from there.

We'll move on to Mr. Davies.

Mr. Don Davies: Mr. Eisenschmid, does your association believe that a universal single payer in a public pharmacare system would reduce dispensing fees for pharmacists?

Mr. Perry Eisenschmid: It may or may not. It's possible.

Mr. Don Davies: Okay. You don't take a firm position on that?

Mr. Perry Eisenschmid: No.

Mr. Don Davies: You've referred to the report your organization commissioned entitled “Pharmacare Costing in Canada” intermittently throughout your testimony, and you called it research. You referred to “experts” in the field and “putting the facts on the table”. That study was not peer reviewed, was it?

Mr. Perry Eisenschmid: No, it was not.

Mr. Don Davies: Mr. Emberley, you're a pharmacist yourself?

Dr. Philip Emberley: That's right.

Mr. Don Davies: You're a man of science. Would you agree with me that.... Should the committee consider consultancy reports to be as credible as peer-reviewed papers?

Mr. Perry Eisenschmid: Can I answer that?

Mr. Don Davies: I'm asking Mr. Emberley; he's a pharmacist.

Dr. Philip Emberley: I refer to peer-reviewed studies in therapeutic areas, and that's where peer review is very important. This was a research paper that was done on the subject of cost, so I don't really see how they would be similar.

Mr. Don Davies: But isn't it part of the scientific method that peer-reviewed research is considered to be a staple in coming to an accepted scientific—

Dr. Philip Emberley: When you're dealing with science, yes it is.

Mr. Don Davies: Okay.

We're hearing wildly different figures. Some groups say that national pharmacare will cost Canada \$6 billion a year, as your report says. Others say that going to a national pharmacare system will save us billions of dollars a year. I'll tell you that the latter is contained in peer-reviewed research. In fact, Dr. Steve Morgan's article entitled "Estimated Cost of Universal Public Coverage of Prescription Drugs in Canada" was just named the Canadian Institutes for Health Research's article of the year last week, and that was following a lengthy adjudication process by health policy researchers, professionals, and policy-makers.

I'm just wondering if we should discount that and instead place more emphasis on your report, which was not peer reviewed. Help me out. Where are the credible numbers?

• (1705)

Mr. Perry Eisenschmid: There are two things, and I think Phil touched on this. Peer review is very important for scientific journals, and when you're talking about medicine and therapeutics, peer review, when it comes to economic analysis, is more around research methodology, but they don't really typically question the assumptions built into that. When there's a fundamental difference between the costing study that we did and the Morgan study, it's all around the assumptions—for example, the exchange rate.

Do I think our study has credibility? I do, because unlike Professor Morgan, who has no real-world experience, our researcher actually worked in the federal government and worked with PMPRB. He's actually lived in the real world.

Mr. Don Davies: Ms. White, quickly.... One of the reasons it is thought that a national pharmacare would save money is that it would bring in bulk buying, have a national formulary, start dealing with cost-related non-adherence, provide exclusive access to some providers to negotiate lower prices, streamline the administration—cancelling thousands and thousands of private administration plans and substituting one streamlined public plan—and have better prescription practices. Are those some of the factors that might lead to lower costs?

Ms. Julie White: Those are some of the factors. I think part of it is also the capacity to bring pharmaceutical companies under control. They have huge profits. They are going to our doctors and talking to them about what drugs they should be carrying. They are providing conferences to doctors.

We need the kind of independent information to doctors that is provided in some of these fully public drug plans, as in Australia and the U.K., where information is independently given to doctors about what drugs they should be prescribing.

We have had some concerns here today. I will tell you one of my concerns. If we want to talk about statins, there are 38 million prescriptions a year for statins in Canada. That is more than one for every man, woman, and child in the country. It is out of control.

Statins are very controversial for people who have not had a heart event. We really have no way of controlling this. It is a situation of doctors prescribing statins after getting their information from pharmaceutical companies. There are a lot of savings to be made there, too.

The Vice-Chair (Mr. Len Webber): Very interesting. I am going to have to stop everyone here. Our session is over.

I would like to thank the panel sincerely for coming out and enlightening us all here.

I do have one quick question for Mr. Eisenschmid. You mentioned in your presentation that you represent 40,000 pharmacists in Canada. Are you seeing any significant increase in pharmacists and pharmacy retail outlets in the past six months or so?

The reason I ask that question is that I have been searching hard for a constituency campaign office in my riding of Calgary Confederation, and it has been very difficult, because when something does become available, a storefront property, I am always too late to get there because a pharmacist has taken the outlet. Three times this has happened to me.

I don't know.... Have you experienced this throughout the country, or is it just in my riding?

Mr. Perry Eisenschmid: No, the number hasn't changed much. We are between 9,500 and 9,800 storefronts. There is some shifting, some closing of smaller locations and consolidation into bigger enterprises, but there hasn't been a plethora of....

The Vice-Chair (Mr. Len Webber): Some of these spaces are 850 square feet, which I can't imagine would be sufficient for a pharmacy. Then I start to think that perhaps it is in anticipation of our government's moving forward with medicinal marijuana, and they are hoping to dispense it. I don't know.

Thank you all very much. We appreciate it.

I am going to adjourn the meeting. We will see you all again at the next meeting. Thank you all.

The meeting is adjourned.

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