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Chair

Mr. Bill Casey

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● (1105)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): We have two issues to talk about today: the national pharmacare program, and later on the blood issue. We're going to do a bit of committee business at the end.

I want to welcome our guests. We appreciate your taking the time to come and share with us your knowledge on this subject to help educate us on where we should go and what we should be doing.

On behalf of Alberta Blue Cross, we have Dianne Balon, vice-president of government, and Margaret Wurzer, senior manager, benefits and product development. Also, on behalf of the Department of National Defence, we have Commander Sylvain Grenier, senior staff officer, pharmacy services.

We'll start with seven-minute rounds of questions, and we'll start with Mr. Oliver.... I'm sorry. I'm skipping along a little quickly today. First, we'll have opening remarks.

On behalf of Alberta Blue Cross, who will be making the opening...? Dianne, go ahead.

Ms. Dianne Balon (Vice-President, Government, Alberta Blue Cross): Thank you very much, Mr. Chair and committee, for inviting us to join you here today. We sincerely appreciate the invitation and the honour of being able to provide our perspectives to the committee.

My name is Dianne Balon, and I am the vice-president of government at Alberta Blue Cross. Accompanying me today is my colleague Margaret Wurzer. Margaret is a pharmacist by training.

As Alberta Blue Cross is a leading benefits carrier, we provide a full range of supplementary health benefits. Prescription drug coverage is one of the main benefits provided through the plans that we administer. Alberta Blue Cross is a not-for-profit organization, and we have a unique legislative mandate to serve the health and wellness of Albertans.

Our company administers and provides benefits coverage for both the private and the public sectors. Our plans include publicly funded, government-sponsored benefit plans for the Government of Alberta, as well as for the Government of the Northwest Territories; employer-sponsored benefit plans—we currently have over 5,700 employer group plans, some of these from publicly funded organizations and others entirely privately owned—and we also provide health benefits that individuals can purchase, for those who are self-employed or who have retired early.

Collectively, across these plans, Alberta Blue Cross provides prescription drug coverage to more than 1.6 million Albertans.

We are also part of the Canadian Association of Blue Cross Plans, which is collectively the largest not-for-profit benefit carrier in Canada, providing coverage to more than seven million Canadians.

Given the diversity of the customers we serve, along with many of our counterpart Blue Cross plans, we have a unique perspective on the provision of prescription drug benefits that is applicable to the discussion surrounding pharmacare. Our experience with these different plan sponsors highlights their varying objectives and philosophies, which form the basis for their decisions about the prescription drug coverage they offer.

As you know, publicly funded government-sponsored programs provide benefits essential for the societal good, typically with a focus on select populations, such as seniors, the vulnerable in social services programs, or those with specific disease conditions like cancer and organ transplant. Coverage decisions are guided by government policy, and as these programs are funded using taxpayer dollars, there is the ongoing challenge of sustainable funding. We typically see a traditionally smaller basket of drug products within their formularies.

Employers provide group benefits in the interest of keeping employees healthy and productive, and as part of an employee's overall compensation package. An employer's decisions regarding which drug to cover may be defined by union contracts or by the desire to maximize employee productivity—making sure they are at work and productive and not away sick—and to minimize disability claims, while ensuring they are providing a competitive compensation package. As a result, employer plans typically provide quite broad baskets of drugs on their plans. However, as employers are funding this coverage directly, they are well aware of benefit costs and the need to ensure plan sustainability.

Individual health plans—which are a rapidly growing segment of the benefit plan market in Canada, as more and more individuals are self-employed, working on contract or part time, or retirees—are self-funded by the individuals who pay for them. Individuals still want to have good coverage, with a focus on overall cost control, with formularies that are typically more narrowly defined or have more cost control mechanisms than a standard employer-sponsored plan.

All three of these market segments are faced with a common challenge—escalating drug costs and serious concerns about the viability of their drug plans.

We know there are a number of factors contributing to the increased drug benefit costs for plan sponsors. I'm sure you've heard them all. This includes an aging demographic and increasing prevalence of chronic disease, coupled with newer, more expensive therapies for currently treated diseases, as well as new drug therapies for diseases that had no drug treatments in the past.

As you know, more and more of the new drugs coming to the market are specialty drugs and typically cost in excess of $10,000 per patient per year, many treating common chronic medical conditions. Add to this the exorbitant costs of the orphan drugs to treat rare diseases.

While these drug cost pressures create significant challenges for benefit plans, we do recognize that many of these treatments can be life-changing, improving health outcomes and, in many cases, keeping patients out of the primary health care system. The challenge is how to fund these therapies in a sustainable manner on the benefit plan.

As our presentation comes in the context of the committee's already having heard from close to 80 witnesses, we have reviewed all prior presentations and concur with many of the comments that have already been made regarding the need for fundamental reforms.

We believe that, prior to the consideration of the value of a national pharmacare program, the following key policy changes should come first, as they advance the principles of pharmacare by promoting sustainable, more equitable access for Canadians.

First is a substantial decrease in Canadian prescription drug pricing. We believe that immediate action in this area will be foundational to ensuring that we have viable drug coverage in the future. We look forward to the work that the federal Minister of Health is already undertaking as part of her mandate to make sure drugs are affordable, accessible, and appropriately prescribed. The minister has stated that dramatic lowering of drug costs can be achieved with a few regulatory and guidance changes for the PMPRB, and we are fully supportive of her leadership in this regard.

We also see tremendous value in the partnership opportunities of the pan-Canadian pharmaceutical alliance and encourage this organization to work collaboratively to lower all drug prices for all Canadians.

Second is enhancing collaboration between the public and private sectors. With the current environment, we see many silos in public versus private, and we do believe there are many opportunities for streamlining administration and bringing efficiencies to the current processes.

For example, with our collaborative relationship with the Government of Alberta, we have been successful in establishing a process for securing consistent drug pricing across our public and private plans. In the Province of Alberta, we also operate under one pharmacy agreement that we have with the pharmacies, which provides for consistent dispensing fees and additional markups on drug costs for all our plan sponsors, both private and public. Albertans have benefited, as this has helped, to an extent, to control drug costs and increase plan sustainability for both sectors.

● (1110)

Now, moving to access, funding for high-cost orphan drugs is an area that poses substantial challenges to the sustainability of all drug plans, whether public or private. For these drugs, collaboration between public and private payers will be required to establish national coverage policies to ensure that the relatively small number of Canadians who need high-cost orphan drugs will have equitable access.

For other drugs, the topic of what is appropriate access is one that we struggle with, as how one defines medically necessary, appropriate, or equitable access may be determined by the objective for providing coverage. As an example, if your objective for providing benefits is to ensure that your employee is not on disability, you may think that a formulary with a small basket of drugs, one that does not include coverage for medication that will get your employee back to work faster, does not provide an appropriate level of access.

We recognize that the mandate of the committee is to consider national pharmacare, with a focus on drug benefits. However, as a provider of not only drug benefits but other extended health, dental, life, and disability benefits, and with our legislative mandate to serve the health and wellness of Albertans, we are cognizant of the implications of looking at the issue of drug benefits in isolation.

Any changes to the funding model for drug coverage should consider the potential implications it could have to the coverage level for other health benefits. These benefits include things like diabetic supplies, psychology services, physiotherapy benefits, wellness initiatives, and a host of other medical services that address individuals' health needs holistically.

In closing, Alberta Blue Cross congratulates the committee for undertaking a study into the value of national pharmacare. After reading all the information, we appreciate that this is a massive undertaking.

We sincerely thank you for the opportunity to bring forward and share our perspectives today. We welcome the opportunity to answer your questions and to be an integral part of the solution going forward.

The Chair: Thank you very much for your presentation and for being on time.

We'll go to the Department of National Defence, Commander Sylvain Grenier, senior staff officer, pharmacy services.

Commander Sylvain Grenier (Senior Staff Officer, Pharmacy Services, Department of National Defence): Thank you. I'll try to be on time as well.

First, thank you very much for giving me this opportunity to appear in front of your committee.

By way of introduction, I am Commander Sylvain Grenier, as mentioned before, senior staff officer for pharmacy services in the Canadian Armed Forces, which I'll refer to as the CAF from now on. I am also a full-time military pharmacist.

[*Translation*]

I am the current president of the Military and Emergency Pharmacy Section of the International Pharmaceutical Federation. I am also an adjunct professor with the University of Ottawa and work one evening per week as a community pharmacist in Gatineau. I am here today in relation to my duties with the CAF. I have no conflict of interest to declare.

In the next 10 minutes, I'll provide you with a quick overview of the CAF's drug benefit program.

[*English*]

Last year, the CAF spent $26.6 million on medication, with 90% of these prescriptions being dispensed by our 23 military pharmacies. This is quite small when compared with the $30 billion spent annually on prescription drugs in Canada.

With a total of 71,000 eligible patients, this equates to an average cost per CAF member of approximately $375. The total expenditure has remained constant for the last five years.

[*Translation*]

In the documents tabled, you will find a graph comparing the average cost of prescriptions processed at CAF pharmacies versus those processed at private sector community pharmacies.

On average, the CAF saves $25—or 38%—per prescription filled by a CAF pharmacy. This figure takes into account the infrastructure costs and the salary and benefits of the military, public servants, and contractors who work in military pharmacies. This works out to savings of almost $14 million annually.

[*English*]

The principles upon which the CAF drug benefit program is based come from the CAF spectrum of care, under the authority of the commander of military personnel command. The spectrum of care delineates which health benefits will be covered for CAF patients. Since CAF members are excluded from receiving care from the provinces under the Canada Health Act, the spectrum of care includes many medical conditions covered by the various provinces.

I'd like to touch briefly on the process whereby medications are included on or excluded from the CAF drug benefit list, which we call the DBL.

Our process is evidence-based and relies heavily on the review conducted by the common drug review, the CDR, of CADTH. After the drug has been reviewed by the CDR, the CAF pharmacy and therapeutics committee, which we call the P and T committee, will review the recommendations and determine the drug's applicability to the military context.

The P and T committee comprises clinicians: physicians—both general practitioners and specialists—as well as pharmacists, nurse practitioners, physician assistants, and other health care providers.

After being evaluated, a drug will be placed into one of the three classifications. The first is inclusion into our DBL as a regular benefit, meaning that there are no criteria or specific requirements governing its prescription. The second is as a special authorization drug, meaning that the patient needs to meet criteria established by the P and T committee in order to receive that medication, which is often the case for second-line therapy agents. Third is exclusion of the drug from the DBL, which we often refer to as a non-formulary drug, which means that it could be dispensed with the approval of our drug exception centre.

For drugs that are not reviewed by the CDR, which include many over-the-counter medications and older medications, the P and T committee will conduct its own analysis. Similar to civilian hospitals, the CAF benefit program also covers select non-prescription drugs that are not normally covered under other public plans. These include smoking-cessation agents, antihistamines, topical antibiotics, and over-the-counter pain medications, just to name a few. Although they are classified as over-the-counter medications, in our organization, they require a prescription by an authorized prescriber.

The CAF benefit list currently includes 1,065 different drugs out of the over 13,000 drugs available on the market in Canada, with 78% of these drugs covered under regular benefits.

● (1115)

[*Translation*]

As mentioned earlier, CAF patients can have their prescriptions filled by military of civilian pharmacies.

However, our policy states that the prescriptions must be filled by a military pharmacy, except for after-hours emergency prescriptions, or if the patient does not have access to a military pharmacy, since not all bases have military pharmacies.

Our program does not require deductibles, premiums, copayments, or user fees. There are no annual limits for medically necessary coverage. And this is true for both military and civilian pharmacies.

When a patient presents at the pharmacy, if the drug is a regular benefit or a special authorization drug, and the patient meets the criteria for that drug, it can then be dispensed.

If the patient does not meet the criteria, or if the drug is non-formulary, the Drug Exception Centre, located here in Ottawa, will review the request. The pharmacists working at the DEC will look at the request on a case-by-case basis and will provide a decision.

In the end, there will always be coverage, either because the request is supported, or because there is an acceptable alternative available. Our patients are never left to pay for their medication, unless the condition falls outside the spectrum of care.

As part of our drug benefit program, we have a drug use evaluation cell, which is responsible for reporting on drug usage. It produces reports related to costs and statistics, like the ones I mentioned earlier, as well as clinical reports focused on helping the health care team make optimal treatment decisions.

For example, the cell generates reports on specific classes of medications and subsequently verifies that patients prescribed these medications have the appropriate military employment limitations.

Currently, we are working on a series of reports on opioid use, in order to identify potential risk to our patients.

[*English*]

Finally, we employ several cost-saving strategies in addition to our rigorous formulary management.

In the CAF, we have a policy on the use of generic drugs, which directs the use of generic equivalents over the use of brand name drugs. Since 90% of our prescriptions are filled at our military pharmacies, we also procure medications. We therefore have several contracts with manufacturers that are negotiated by Public Works as part of the federal, provincial, and territorial contracts. We are also considering looking into joining the pCPA.

[*Translation*]

I'd like to thank you again for inviting me here today.

I look forward to answering your questions.

[*English*]

The Chair: Thank you as well for being within time and for presenting some very interesting information.

Now we're going to go to our seven-minute questioning with Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you very much.

Thank you for taking the time to come today to provide your testimony to the committee. It's been wonderful to hear the different solutions and the work you're doing in the area.

The committee has heard one study that said 10% of Canadians do not have the means or the ability to receive pharmaceuticals. Then we heard from a survey that about 24% of Canadians either can't afford to fill their prescriptions or are unable to complete their prescriptions. Knowing how important pharmaceuticals are to the course of therapy and recovery and treatment, to have that many Canadians unable to access a pharmacy the way the rest of us would is unacceptable. We need to find a solution.

Dianne, does the non-group coverage benefit program deal with...? Is that consistent with what you believe are the uninsured and the people who can't quite afford the drugs? Does that ring true to you for Alberta? Is there anything unique that Alberta has done to cover that population?

● (1120)

Ms. Dianne Balon: The non-group drug plan is a Government of Alberta drug plan open to any Albertan. No medical conditions prevent coverage. Anybody can apply and go on. The intent of that plan is therefore to allow any Albertan, whether they go under the regular premiums or the subsidized premiums in the province, to have coverage if they wish. They can simply apply. I believe that's the intent of the Government of Alberta, to be able to cover anybody who wishes to be covered.

Mr. John Oliver: But they have to pay for that coverage. It's through Blue Cross, so they would be paying a premium for it.

Ms. Dianne Balon: That's correct, but the premiums are set by the Government of Alberta. They are totally in control of those premiums.

Mr. John Oliver: There's a set formulary for those coverage plans. Who sets that?

Ms. Dianne Balon: Again, the Government of Alberta sets the drug formulary through their expert committee. Margaret can perhaps speak to this a little further. The province has the Alberta health services provincial drug formulary. That is used for all their programs, including the non-group program and the seniors and all their human services programs.

Ms. Margaret Wurzer (Senior Manager, Benefits and Product Development, Alberta Blue Cross): That formulary is the Alberta drug benefit list. Typically, when a new drug comes to market, it goes through the common drug review process. From there, Alberta Health will make a decision as to whether they follow the common drug review process. At times, they may have another layer of review through the Alberta health and wellness expert committee. Between those two bodies, recommendations are provided to the Minister of Health, and the Minister of Health makes a determination of coverage on the Alberta drug benefit list.

Mr. John Oliver: It's evidence-based.

Ms. Margaret Wurzer: That's correct.

Mr. John Oliver: If people can afford it, they buy it. If they are unable to afford the premiums for that benefit, does Alberta provide...?

Ms. Margaret Wurzer: Yes, there are subsidies.

There is a family rate and a single rate. For people meeting certain lower income thresholds, the premium rates are subsidized and are lower.

Mr. John Oliver: Is there a residual population that doesn't have insurance and isn't able to afford drugs, or do you feel that all burdens are covered through those subsidized...?

Ms. Dianne Balon: The Government of Alberta also has several programs under their human services. You're able to apply for a number that are dependent on your current financial state. Again, the number who do not have coverage is very interesting. I think that varies as well with the economic conditions. There are multiple options in the province of Alberta, right through from what the non-group program offers if a person chooses to have their own individual coverage.

Mr. John Oliver: You mentioned the work on decrease in pricing, which is absolutely a part of the mandate of the government and it's in the minister's mandate letter. I know there's work under way there. The federal government has joined with the provinces and territories now with the pan-Canadian pharmaceutical alliance. I think you've mentioned you're joining it.

In addition to the work they're doing there, were there other strategies that you used with the Department of National Defence? You lowered costs quite remarkably. Are there strategies you've been employing beyond what the Canadian alliance is doing?

Cdr Sylvain Grenier: I believe the two main points for us are the contracts we have with specific drugs. With the bigger items we have on the list, we negotiate price with the drug companies. Also, the generic policy we have helps us to reduce the price.

The way our drug benefit list is designed is that we don't go with a specific brand on the list. We go by molecules. We have roughly 1,000 molecules that are considered for approval. Any brand for that molecule will be there. With internal, because we have contracts, we can go and direct a specific brand. When our patients go to civilian pharmacies, we can't direct the pharmacy to only buy from one company and therefore the cost cannot be controlled.

● (1125)

Mr. John Oliver: In respect of formularies and how we approach those, provinces are responsible for delivering health services as it's not a federal role. Would you see a benefit in having a national formulary that all provinces, territories, and associations are part of? It would certainly give us a much better negotiating stance as New Zealand and some other jurisdictions have shown.

How complex is it? Do you see advantages to it? How much variation is there between provinces and territories in what's covered under different formularies?

Cdr Sylvain Grenier: Of course, I have a bias as a federal organization. We have to sometimes deal with the complexity of the coverage between the different provinces. Our spectrum of care as set out in our P and T committee is that when we look at different drugs we also have to look at what's being covered by other provinces to provide some kind of equity to our members. Some areas—not all, and I can't really put a number on it—are more challenging than others.

For example, fertility drugs, are we covering them or not? Some provinces are and some are not. With the more common diseases such as hypertension and diabetes, it's not a problem. For the more common diseases, there's going to be a wide floor that is going to be there. The CDR, which is being followed by all the provinces and the departments, is going to be there.

I think it will be a huge advantage to have one national pharmacare or formulary. Currently, the hospitals are trying to align their formularies with the provincial benefits. If you're hospitalized, they start medication in the hospital, then you're released into the population, so your coverage needs to extend there.

If each province has a different formulary, then the hospitals also have to adapt to it. The hospital may benefit and they have already benefited from doing bulk purchasing through contracting. If we had a national formulary, there could be opportunities for all the hospitals across Canada to negotiate as one entity rather than doing it by province. Similar to what we are doing in the military, we could have a procurement power as well as the agreements we get with pCPA.

If we had one national formulary, there would be many more benefits to be had. There might be more political challenges to get there, but I think the end result would be better.

Mr. John Oliver: Thank you.

The Chair: Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair, and my thanks to you three for being here today and presenting to us.

I would particularly like to thank Alberta Blue Cross for the work that you do. I've had coverage by Alberta Blue Cross most of my life. I can tell you that any experience I had with Alberta Blue Cross was a pleasant one, so you are obviously running your show very well in Alberta.

Ms. Balon, you talked a bit about streamlining your administration in Alberta. I was curious about the administrative costs associated with both the private plans and the government-sponsored plans provided by your company. Do you have any figures on what your costs are on an annual basis for administering this?

Ms. Dianne Balon: I'll speak from the perspective of a not-for-profit. I can say that Alberta Blue Cross is very effective and efficient because we deliver services on behalf of the government and it is imperative that we constantly prove to the government our value for money. I can say there's no profit there; it's on a break-even perspective.

On our corporate basis, as a not-for-profit, if there are any remaining funds from collective lines of business, they have to be reinvested in keeping premiums competitive and in offering our wellness programs to promote prevention. We believe we need to ensure that we reduce the burden of disease and lower costs to lessen the cost factor in the future. This is something I haven't heard too much about, and it is very important to us. Of course, any additional funding would go back into innovation and systems, into some of the new things that everybody wants an app for.

I looked at the CLHIA-stated industry averages. I can say that we are much lower when it comes to cost than what they have quoted. Being a not-for-profit and having no shareholders, we have a mandate that is quite different. Everything needs to be reinvested or kept at a lower premium.

● (1130)

Mr. Len Webber: What would be some of your key cost drivers, then, in this prescription drug insurance program offered by Alberta Blue Cross?

Ms. Margaret Wurzer: When we look at prescription drug costs, I can probably speak to two key buckets. One would be related to the cost of the actual dispensing of the prescription, so that's your drug cost along with your dispensing fees and your markups.

With that, there's a number of plan management things that we offer to our plan sponsors to try to keep the number of dispensing activities at a reasonable level. For example, if you're on a chronic disease medication and you're stabilized on it, we have programs to try to encourage use of less dispensing, such as dispensing a three-month supply as opposed to monthly dispensing. Those are some of the cost drivers in terms of the dispensing.

We also, as Dianne alluded to, have a pharmacy agreement with our Alberta pharmacies whereby we have caps on the dispensing fees and the markups that they can charge. Through those mechanisms, we're able to control the cost.

The challenge, though, with the drugs that are now being dispensed is the very high cost drugs, the orphan drugs, the specialty drugs. More and more, we're seeing these biologics being used for very chronic common diseases. We have drugs now for treating cholesterol that used to be hundreds of dollars per patient per month. Now we're at between $7,200 to $22,000 per patient per month.

Another cost consideration and the second bucket of costs is really the mix of drugs. As I'm sure many of you have heard, if we look at drugs for treating diabetes, there are some that are in the cost range of 18¢ a day versus some that are $3 per day. At Alberta Blue Cross we put in processes similar to what was talked about with the Canadian Forces, things like step therapy and special authorization. Those are processes that we use to try to manage the cost and, at least hopefully, influence prescribing maybe some of the more cost-effective therapies.

Mr. Len Webber: That's great, thank you.

Commander Grenier, I have a question for you just with respect to what you had indicated to us about spending $26.6 million in medication. You say the average cost per member of approximately $375 has been consistent throughout the last five years. But of course, we've all heard in media reports and such about the use of medicinal marijuana with veterans and how that's increased significantly.

I just wanted you to chat a bit about why these costs have remained constant, yet there is such a high demand for medicinal marijuana.

Cdr Sylvain Grenier: In the Canadian Armed Forces, our drug formulary is evidence-based, as I mentioned. We do cover the majority of the conditions that would be causing problems for our patients. The case of medicinal marijuana is unique. First of all, it's not considered to be a medication. If we look at the evidence.... I'm not an expert in the area, but I can tell you I've been to many conferences. From one conference to another, the studies contradict each other at this time. Until they can come up with clear evidence of the usefulness of medicinal marijuana, it's going to be hard to determine where it fits.

In our formulary, we do cover nabilone, which is a synthetic cannabinoid. There is evidence in some situations, and we have criteria to use that. Currently if patients had a need for that, they could get that prescribed without any problem.

For medicinal marijuana, because of the access the Supreme Court came out with a few years ago, we have a policy that of course if members have a need and it's recommended by their physician, then they would be allowed to use it. Then they have to be assessed, as with any other medication, to see if they need to have military employment limitations. Of course, if you have a patient using medicinal marijuana, there might be impact on whether they can pilot a plane, use weapons, and things like that. Those things have to be considered.

We don't have specific rules for medicinal marijuana compared with any other drugs or medical conditions.

● (1135)

Mr. Len Webber: That's interesting.

The Chair: The time's up.

Go ahead, Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair.

Thank you to the witnesses for being with us today.

I have a number of questions about Alberta Blue Cross. I was born in Edmonton, and I was also a beneficiary of the Alberta system for several decades. Thanks for being here and for your work.

I want to talk first about copayments. According to Dr. Braden Manns, a researcher with the University of Calgary's Cumming School of Medicine, he estimates that up to 30% of Alberta's low-income seniors report regularly not taking preventative medicine for conditions like high blood pressure and diabetes because of financial barriers. I know that in Alberta, Blue Cross provides 70% drug coverage for seniors, but according to Dr. Manns, the 30% copay may be having an impact. He says oftentimes people are taking six to 10 medications. What we understand is that the average out-of-pocket cost per year is in the range of $300.

In your view, what impact do copayments for prescription drugs have on cost-related non-adherence? Would you have any advice to this committee, if we were to set up a universal system, on what role copayments should or should not play in that system?

Ms. Dianne Balon: First of all, Dr. Manns is actually currently doing a research project with the Government of Alberta in that particular area. They are offering to a trial group of seniors no copayment, so that they're able to go back and see whether or not there is any evidence in the end. That's currently under way.

I'm going to turn to Margaret in one minute, but I think the question of copay has been around for quite a while. In the group business that certainly does have an impact and it is a plan sponsor's decision. I know over the years, being with Blue Cross for 29 years, that even the government should choose because currently they have the 30%, to a maximum of $25 per prescription. No one pays more under the government program, under that particular seniors' program or non-group, than $25 per prescription regardless of the cost. The 30% does have a cap associated with it as well.

Ms. Margaret Wurzer: I'll just add one thing to the government plan and the structure for the coverage for seniors. The way that copayment structure is modelled, so 30%, up to a maximum $25, I had spoken earlier about trying to encourage a maintenance supply of medications for use in chronic diseases. Really, if you look at that copay structure, it does really incent seniors to fill for a longer day supply, so a three-month supply, for example, instead of a one-month supply, because their copay is capped at $25 per prescription. That is a consideration. Certainly when we talk to our private plans, a lot of times they don't have a cap on their copayment structure. So, really, having a cap in that way does encourage, I think, the use of chronic medications being filled less frequently.

Certainly we do have plans on the private side that have 100% coverage, with no copays. We have plans that have fairly high copays. I would say that when it comes to the issue of compliance or adherence to medications, I think financial is one of the factors, but there's a number of other factors. Even on those plans that have 100% coverage for conditions like blood pressure or diabetes, where maybe you don't feel the effects of the disease itself, we still do see people not filling their prescriptions. Sometimes the side effects of those drugs are nasty and they're not feeling the effects of the disease.

Mr. Don Davies: Right. Thank you.

I want to move to the formulary. As you've said, Alberta Blue Cross offers supplemental health insurance plans for individuals and businesses, and is also responsible for managing three prescription drug insurance plans offered by the government, including the non-group coverage benefit program, the coverage for seniors program, and the palliative care benefit program. I'm wondering if you could tell us how broad or restrictive the formularies offered by Blue Cross's private plans are in comparison to the government-sponsored plans.

Ms. Margaret Wurzer: Sure.

If we look at the Government of Alberta plan in terms of the number of drugs—we call them drug identification numbers—that are covered on the plan, roughly 5,000 are covered on the Government of Alberta plan. In contrast, if we look at one of our typical private plans, what we consider our managed formulary, we're looking at roughly 8,500 DINs that are covered on those private plans. From a numbers perspective, there certainly is more coverage on those private plans.

● (1140)

Mr. Don Davies: How do you handle brand names versus generics on the formulary?

Ms. Margaret Wurzer: Plan sponsors have a choice in terms of what they do around coverage for brands versus generics. I would say that the vast majority of our plan sponsors, and certainly government, have adopted the policy to enforce generic pricing. I would say that probably upwards of 80% to 90% of our private plans also follow that model.

Mr. Don Davies: Thank you.

Commander Grenier, I'll address the same question to you. How does your plan handle brand names versus generics on your formulary?

Cdr Sylvain Grenier: When it's filled in the military pharmacies, we always go with the cheapest one we can get. If we do have a drug in the contract, whether it's a brand name or generic—because sometimes we get brand name drugs cheaper than generic drugs—our pharmacies are made aware. Centrally, we just inform them of the brand they have to buy. If we don't have a contract, the local military pharmacist will go through whatever is available from the supplier and go with the cheapest one for the formulary.

For civilian pharmacies, because we can't really control what they have in stock, we basically have to open it up to whatever they have. If they give a brand name versus a generic, they will still be paid.

What we've seen, because we're so small a player across the country, is that as soon as we implement new rules that make it more restrictive, the patient has to pay out of pocket because the pharmacy doesn't want to do the necessary process to get paid. Then the patient claims it, for which they will be reimbursed, but it just adds a layer for the patient because they don't get it right away.

The Chair: Mr. Ayoub.

[*Translation*]

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

Thank you, ladies and gentlemen, for being with us today.

Perhaps I'll ask a simple question to get a quick overview of the drug reimbursement process on the well-known list that is accepted by the insurance companies and the armed forces.

In Alberta, the final version of this list is approved by the Alberta minister of Health, on recommendation from experts, of course. However, the minister has the final say.

How do you see the acceptability of this list and its evolution over the years in relation to the drugs? In Alberta, we see that there are specific programs for catastrophic drugs and specific diseases. It's a little different from what we saw elsewhere and from what I know in Quebec.

How do you see the evolution of this list? Perhaps we could start with Ms. Balon.

[*English*]

Ms. Dianne Balon: The Government of Alberta decides what is covered, so it is inappropriate of me to speak to what is covered under their plan, but I will say that it certainly has evolved over the years I have been there. They have moved to add different variations, different products, different programs.

The programs have certainly grown in the province in the last several years, especially the programs that you spoke about. They cover the human services programs. I don't have the list in front of me, but there are significant programs that they do cover. I'm going to let Margaret talk a little bit about the expert committee and what is there, but I certainly think it's very important to say that it has evolved.

I want to make sure. There is sometimes a misconception in the province because we administer the programs. We administer the programs for the government, and they use their formulary, but we also have, under our 5,700 groups, probably thousands of variations of formularies as well. Everyone in the province doesn't follow exactly the same one. They have what one could refer to as the core base, as Margaret said, the 5,000, minus some of the speciality programs. Then the private ones have their own formularies outside of that.

Ms. Margaret Wurzer: To the question on the Alberta health process. Certainly they use the recommendations of the common drug review and they have local experts that sit on the Alberta expert committee. Those local experts are doctors, pharmacists, and so on, who work within the province of Alberta.

I think the fact that they have this extra committee that really starts to understand the environment of Alberta sometimes shapes some recommendations going forward to the minister that are more Alberta-specific.

● (1145)

[*Translation*]

Mr. Ramez Ayoub: I'm going to interrupt you so we can open up the discussion.

With respect to the pan-Canadian study conducted by the committee on the national pharmacare program, it is obvious that there are particularities. Some provinces approve certain drugs, and the lists aren't always the same. They are not comparable among the provinces.

My question is general. I would like to know your assessment of what drugs are approved in Alberta. I don't want to put you in the hot seat on the government's acceptance of drugs, but we still need a general view on this. We are here to look at the situation in Canada as a whole, which is why I'm asking this question.

Could you give me a 30-second answer, because I would also have a question for Mr. Grenier.

[*English*]

Ms. Dianne Balon: Absolutely I would say that, generally speaking, we see a population that is very pleased with the formulary that is there for the government-sponsored programs. There are private groups that want to mimic it because they do feel that it is efficient.

[*Translation*]

Mr. Ramez Ayoub: Okay.

Mr. Grenier, the list is established by the Canadian Forces Pharmacy and Therapeutics Committee, the CFPTC, and is therefore even more limited. The list is drawn up by the Canadian Forces itself.

Could you tell me more about that? Who makes these decisions?

We were talking about evidence-based science. How is the situation in your small group compared to the rest of Canada?

Cdr Sylvain Grenier: We use the services of the Canadian Agency for Drugs and Technologies in Health—the CADTH—to assess medications. The agency uses a program called the common drug review, which we are also adopting. Once the program makes a recommendation regarding a drug, it is sent to the CFPTC. At that point, we determine whether additional restrictions should be imposed for recommended drugs in the military community.

We don't have statistics on that. However, I can tell you, based on my experience, that about 95% of recommendations are followed in our case. On thing we could look at, for instance, is that one drug is cheaper than another, but it may need to be refrigerated, which would not be the case for another product. This would have an impact on our activities because we can't necessarily ensure refrigeration in all circumstances. So these are the kinds of factors we consider.

Mr. Ramez Ayoub: Thank you.

The table you presented shows that there are significant savings in the comparative cost of prescriptions, but obviously your expenditures may be more closely monitored.

Have the armed forces ever been called upon to publicize this formula, which appears to be more cost-effective for prescriptions? Have you ever been asked to share this information with other levels of government or other bodies?

Cdr Sylvain Grenier: No. It was communicated only within the Canadian Forces.

In terms of budget cuts, the information is a very useful tool for showing that by providing the service ourselves, we have more control and save much more money. However, so far, these figures have never been made public.

Mr. Ramez Ayoub: It might be something to consider eventually.

Cdr Sylvain Grenier: Indeed.

Mr. Ramez Ayoub: Thank you.

[*English*]

The Chair: Thank you.

Now we'll go to our second round, starting with Ms. Harder.

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

I'll start with Blue Cross.

I'm wondering if you can talk a little bit about your administrative costs with regard to the costs associated with your private plans, and those associated with your government-sponsored plans. Do you see a difference in the administrative costs for each of those?

Ms. Dianne Balon: That's a pretty broad question. Certainly from the government perspective, the way we organize.... Maybe I'll preface that by saying that I've heard the question asked often about whether or not a decrease in revenue affects administrative costs. Our role with the government is to help them decrease revenue, and that has nothing to do with the way we're paid administratively by the government. Our overall administrative cost for the government programs is a public number. It is published through the commitment that we have with the government.

● (1150)

Ms. Rachael Harder: Just in comparison with you running the private side of things, which one is cheaper?

Ms. Dianne Balon: I can't say which one is cheaper, because it isn't just about a drug program. It depends on whether or not in the private plans they have more benefits associated with the programs. I would never do a comparison. I look at the bucket that we do. Also, the services we provide are quite different for the Government of Alberta from the services that we would provide....

Ms. Rachael Harder: But you don't know which ones are more administratively costly?

Ms. Dianne Balon: They're both extremely efficient, and I—

Ms. Rachael Harder: I'm not asking that. I'm just asking for cost. Is there a higher cost associated with one over the other, or do they both cost the same?

Ms. Dianne Balon: I would say that our private plans have more variability than the government plan does.

Ms. Rachael Harder: Okay.

Now you talked a little about the formularies and their being determined. We use generic drugs first, but if a generic drug doesn't work for a patient, then what happens in that case?

Ms. Margaret Wurzer: I can answer that.

Again, back to the plan sponsors, they can decide how they want to handle those exceptions. In the case of government, they have a generic price policy. If a person has tried the generic and has had adverse effects or it's not working, that individual is allowed to go through the special authorization process. The individual's doctor sends in a request and asks for coverage, and if there is a legitimate need for it, then that person will be granted authorization.

On the private plan side, again, those plan sponsors have adopted that policy. There are a number of different mechanisms that can be used. One is that some plan sponsors will actually allow the pharmacist to override the prescription, so if the prescription comes into the pharmacy and it says “no substitution”, then the pharmacist can actually enter a code at the time of claim and then the brand name is paid. They also have the special authorization process as an option, if they choose to go there.

Ms. Rachael Harder: If they go through the special authorization process, is the drug fully covered or only the same as what a generic would cost?

Ms. Margaret Wurzer: Yes, what we do with that is pay up to the level of the generic. Then the plan member is only paying the difference in the costs between the brand and the generic.

Ms. Rachael Harder: I understand, thank you.

Over to you, Commander. How does this work in your...?

Cdr Sylvain Grenier: If it's a generic that doesn't work and the brand name works better for the patient, because it's the same molecule, the pharmacist at the base has the authority just to switch it. The policy is that they will use the generic first, but if the generic doesn't work for a specific patient, then they can go with the brand name.

If it is a change of the molecule itself.... Let's say a patient doesn't respond well to one blood pressure medication and requires a second line one. If that second line one is not listed in our benefits, then that requires a drug exception centre intervention. What they'll do is look at the patient's case specifically—it's case by case—and if the patient has looked at all the other drugs, then they can approve it in that case.

Just quickly, as well, I wanted to say that the advantage of having a very strong exception process is that when it's time to access medication.... We review medication, and it takes time for a drug to be listed on our benefit list. However, on day one, if a drug is available on the market and if a patient gets a prescription and there's a clear need, that patient could get it on day one because of the exception process we have.

Ms. Rachael Harder: Thank you.

My final question goes to Blue Cross. Right now, private drug coverage programs cannot access the pCPA. In your estimation, if they were to have access there, could that be of benefit? Could that solve the problem? Could that bring our drug costs down?

Ms. Dianne Balon: Absolutely.

As I said in my opening remarks, if the pCPA was able to do all drugs on behalf of all Canadians, I think that would certainly make a difference. I know there are mechanisms that the private side has tried to put in place behind the scenes as well. Certainly, there is some work, I understand, with pCPA moving forward, and I also know that it sounds like it's very difficult. I think they've been able to lower prices for 129 drugs, or something like that, in six years.

For sure, that would be extraordinarily helpful, but it's the broader...the 8,000 in the basket of drugs that we're talking about that would be significant to get to a base cost for all Canadians.

● (1155)

Ms. Rachael Harder: Right, thank you.

The Chair: Dr. Eyolfson.

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

Commander Grenier, from what I understand—and if this was addressed, I apologize if I missed it—this January 19, federal drug programs like the military's and several others joined the pCPA. Can you give any estimate on cost savings that have been realized by the Department of National Defence's drug program since joining the pCPA?

Cdr Sylvain Grenier: Currently, we have not joined the pCPA.

Mr. Doug Eyolfson: Oh, you have not?

Cdr Sylvain Grenier: No, the Canadian Armed Forces have not joined it. About a year ago, Health Canada asked us to evaluate that. The challenge we have is that, because 90% of our medications are procured, we already have a series of contracts in place.

As you know, the pCPA process is very secretive, so it was very hard for us to get the information necessary to make sure that joining pCPA would not put us in conflict with the current contracts we had already signed with other companies.

We have evaluated that, and because there is always an opt-out option with the pCPA with the product listing agreement, it is clear to us now that there will be some benefit for some drugs that are not on contract right now. We're looking at the process now and getting involved, so it's a matter of months before we're going to get there.

Mr. Doug Eyolfson: All right. Has anyone looked at what the potential savings would be once that happens, or is there not enough information yet?

Cdr Sylvain Grenier: It's a very rough estimate, because we can't get the real values, but for us—because, again, we procure 90% of our medication—the cost savings would definitely not be as big as what Health Canada and Veterans Affairs have seen, because they rely much more on the rebates from the pCPA negotiations, whereas we have many more contracts because we do our own procurement.

Mr. Doug Eyolfson: All right, thank you.

Ms. Balon and Ms. Wurzer, regarding Blue Cross and public versus private plans, would you be able to give any estimate of the impact on the private insurance industry if there were a national, public, universal pharmacare system?

Ms. Dianne Balon: In what context...?

Mr. Doug Eyolfson: Financially. What would it do to that industry from a financial business perspective?

Ms. Dianne Balon: Certainly. I think the question of impact to business has been an ongoing strategic exercise, for sure, because you need to look and determine what type of model or scenario it's going to be. I'll use some examples.

For example, if the principles were that it was based on a basket of drugs that were required by insurers and governments across Canada, and then employers were able to still have wraparound coverage for that, then that would be one impact to the benefit carriers.

There would be a different impact, for sure, if the principles were that there was a direction to have one national payer. Then, of course, there would be a major impact to the benefit carriers. I would say that, as a not-for-profit organization with capabilities, we would look at that as an opportunity as well, from the Blue Cross perspective. Again, it depends on what the scenarios are and which way you go.

Mr. Doug Eyolfson: All right, thank you.

If there was a national system, would you foresee a role for private insurance industries in that? Is there a possibility for that? Would that be an efficient way of going about it?

Ms. Dianne Balon: Absolutely. As CLHIA indicated, infrastructures, several of them, are already in place coast to coast. We do this for a living, and we do it very efficiently. Certainly, I can say that from our own perspective. Yes, there would be an opportunity, and there would be no need to rebuild and replicate the systems that already work in Canada today.

Mr. Doug Eyolfson: That's all I have. Thank you.

The Chair: Thank you very much.

Mr. Paul-Hus, go ahead.

[*Translation*]

Mr. Pierre Paul-Hus (Charlesbourg—Haute-Saint-Charles, CPC): Thank you, Mr. Chair.

Commander Grenier, you gave some explanations about the cost of drugs for the Canadian Forces. The cost of drugs for military pharmacies is lower than that of civilian pharmacies, since civilian pharmacies have higher operating costs. Savings are possible because military pharmacies are on military bases. I understand that.

You said that 71,000 CF members are covered. The system covers members of the regular forces and class B and C reservists, but it does not cover class A part-time reservists. If we disregard reservists, how many permanent CF members are covered?

● (1200)

Cdr Sylvain Grenier: Currently, about 66,000 members of the regular forces are covered under our plan.

Mr. Pierre Paul-Hus: Does that include class B and C reservists?

Cdr Sylvain Grenier: Including those reservists, the number is 71,000. That's everyone who is covered.

Mr. Pierre Paul-Hus: Right. That's the total number of people currently covered.

Cdr Sylvain Grenier: That's right.

Mr. Pierre Paul-Hus: Are the families of CF members covered, too?

Cdr Sylvain Grenier: No, but there is one exception to that. We have a military base in Germany, and we provide medications to the dependants of CF members, but they have to pay because the costs aren't covered. That is the only case where we provide medications to dependants.

Mr. Pierre Paul-Hus: If the families of military members are included, the 71,000 increases two- or threefold. Those people don't have coverage. Dependants of CF members living in Quebec City, Valcartier, or elsewhere, aren't covered by any plan and must get insurance from Blue Cross or another company.

Cdr Sylvain Grenier: No, because CF members have access to the Public Service Health Care Plan. It's the same plan that public servants have access to. So, the families of CF members are covered as dependants under that private plan.

Mr. Pierre Paul-Hus: Right.

Do these people make their purchases in military pharmacies?

Cdr Sylvain Grenier: No, they use civilian pharmacies.

Mr. Pierre Paul-Hus: They can't buy their medication in military pharmacies?

Cdr Sylvain Grenier: No. As I explained earlier, Germany is the only exception. It's a matter of supply. The products in Germany aren't the same as we have here.

Mr. Pierre Paul-Hus: Okay.

The cost of drugs is quite low in the Canadian Forces. However, as we know, these are people who are generally healthy.

Do the Canadian Forces provide drugs to treat allergies or other problems like that?

Cdr Sylvain Grenier: This is clearly the case. The cost per CF member is much lower than the national average. We're talking about $800 as the national average, compared to $375 for members. As you said, our population is generally healthier. It's also younger. So they aren't big users of medication.

However, biologics are putting pressure on our drug plan. Even though the population is healthy, many health problems are being treated with extremely costly biologics. But these individuals are entirely functional as CF members. The share of our budget currently allocated to these drugs is 15%.

The other drugs that are extremely costly, which my colleague talked about earlier, are for treating rare diseases. Since they are less frequent in the Canadian Forces, it affects us a little less.

Mr. Pierre Paul-Hus: We're talking about active members, but when they get sick, they are discharged from the Canadian Forces and are then covered by Veterans Affairs Canada.

Are you required to support veterans, as far as drugs are concerned, or are you completely not responsible for that?

Cdr Sylvain Grenier: Under our current policy, we allow members who leave the military up to three additional months of coverage to help them to transition to civilian pharmacies, to find a doctor, and so on.

My section also deals with the transition of members. We print the complete drug profile for all members who are transferred to Veterans Affairs Canada and send that profile to the department. Veterans Affairs Canada then tells us what will and won't be covered for these people who will now be veterans.

We pass on the information to patients so they can determine whether they will be adequately covered when they leave the military. In our case, it's full coverage, but it isn't necessarily for the veterans. For them, health problems related to service are covered. There are other aspects that are also covered, but I'm not sure which exactly.

Mr. Pierre Paul-Hus: Is there specific federal funding to pay for veterans' drugs or is it a private plan that is associated with the public service?

Cdr Sylvain Grenier: There is a drug plan for veterans. As with the Canadian Forces, Medavie Blue Cross manages this. However, as we also do for coverage, veterans make the decisions about coverage.

Mr. Pierre Paul-Hus: Thank you.

[*English*]

The Chair: Your time is up.

We'll have Ms. Sidhu, please.

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

Thank you to all the presenters.

I would like to bring up an issue close to my heart, both as the co-chair of the all-party diabetes caucus and as a former diabetes educator. I have heard that people presently serving actively in the military can be discharged from active duty if they contract type 2 diabetes. Is that correct?

● (1205)

Cdr Sylvain Grenier: It depends on the situation. What will determine if the patient can stay in the military or not is whether they can meet the universality of service requirement. In the case of diabetes, it is not the condition that is necessarily the issue; it is the medication they take that is required to maintain their health. If the patient can function with oral medication, then there is normally no issue unless there are other conditions for that patient, but there is no issue with staying in the military.

If they are at the stage where they require insulin, because the complications of not taking their insulin can be dramatic for a patient.... In our military operation we may be in a situation where the patient may not get access to their medication for days, and that may not allow the patient to stay in the military for that reason. This is not only for diabetes. It is true for any condition.

In a case where a patient gets a medical condition, physicians would be looking at the medical condition first and then the drugs. They would see, based on that, if the patient could still meet universality of service. We do not have a black and white rule. All of them are assessed case by case.

Ms. Sonia Sidhu: There are other military programs abroad, such as one the CDC runs in the U.S., to help those working to prevent diabetes. They speak to those who are pre-diabetic or high risk—high risk can be due to lifestyle—to improve their lifestyle.

Do we have that type of program so we can prevent it?

Cdr Sylvain Grenier: We do have health promotion programs in the forces. Just to name a few, we have smoking cessation programs. We have programs to lose weight. We have multiple programs in the forces under health protection. Many programs I'm not even aware of, but they exist.

Ms. Sonia Sidhu: Can DND confirm that its drug benefits list provides as much patient choice as other provincial and territorial plans do? Can you advise on how you consulted patient groups within the military to ensure there was enough choice and to reflect issues related to rare diseases?

Cdr Sylvain Grenier: In the case of the coverage of the medication, as I said, we always end up having 100% coverage for our members. If it's not part of our benefits list and our patients have a need, because of the exceptions process, they will always have a solution for those patients.

With regard to how our programs compare to the provinces, when we do our evaluation, after the CDR evaluation we do our P and T evaluation. We look at the drug to see where it's covered across the country. Based on that coverage, we determine whether or not we will include it in our formulary. We do take into consideration the coverage across the provinces.

Sorry, the second part of your question was regarding...?

Ms. Sonia Sidhu: I asked if there were enough choices reflecting issues related to rare diseases.

Cdr Sylvain Grenier: The rare diseases don't happen very often in our population. We're really a subset of the population. In cases where we might have a patient who has a rare disease who would still meet the universality of service—and we'd have to look at that because of the exceptions process—there would be a vehicle to make sure the patient received the medication they required.

Ms. Sonia Sidhu: Thank you.

My question is about Alberta. What have some of the challenges been with Alberta Health providing some streams of drug coverage and Alberta Blue Cross providing others? Has any consideration been given to consolidation?

Ms. Dianne Balon: Yes and no.

Certainly in the province, as with other provinces, we have coordination of benefits with the programs. If the government offered a program, we would ensure that the individuals went to that program and then used their private coverage insurance as well, so we would have the coordination of benefits.

From a program perspective, they are quite separate in the sense that the government runs its programs and private programs run theirs separately, and then the individual programs are separate from that. There is also collaboration, of course, as I said earlier, in the way we procure the drug costs in the province of Alberta, for both public and private, those who are covered under Alberta Blue Cross. As well, collaboration with the pharmacies has occurred around the dispensing fees in the province so that for both public and private they pay the same.

I hope that answers your question about integration. We work carefully to make sure than an individual has access to all the programs possible.

Ms. Sonia Sidhu: Thank you.

The Chair: Time's up.

Mr. Davies.

Mr. Don Davies: Thank you.

I heard Commander Grenier say, if I understood correctly, that he was a proponent of having a national formulary so that we have national bulk buying. I'm just wondering if Alberta Blue Cross shares that position. Would that be helpful?

● (1210)

Ms. Dianne Balon: Yes, for sure. I will certainly say that we support the principles of a pharmacare program. Certainly for us the definition of that needs to be clarified. The first step, as I said before, is that we think the value for money with regard to access is to substantially reduce the costs for all Albertans.

Mr. Don Davies: Obviously, a national formulary with national bulk buying would be one factor that would, obviously and logically, help to reduce costs.

Ms. Dianne Balon: Certainly.

Mr. Don Davies: Second, a drug survey conducted by Mercer Canada found that 65% of employers that continue to provide retiree benefits are likely to eliminate drug coverage for future retirees if drug costs and liabilities continue to escalate. Of course, there's the aging of the population and the reduction of coverage by public drug plans. We also, in that study, see that 33% of employers may attempt to eliminate or reduce coverage for current retirees as well.

Alberta Blue Cross, have you noticed a reduction in the number of employers offering supplemental health insurance to their employees in recent years because of rising drug costs, or have you seen employers in Alberta opting for more restrictive or limited drug plans for their employees as a result of rising costs?

Ms. Margaret Wurzer: I'll answer that question in the context of your initial comment about the senior population and employers potentially backing out of coverage there. We have seen that, not so much for the people who are over 65, because in Alberta you get pretty good coverage under the coverage for seniors program, but we have seen that as it relates to early retirees. With our legislative mandate, we're there to help promote the health and wellness of Albertans through all stages of their lives. Right now we are designing plans for the employer groups as well as the individual market for those individuals who are retiring off their group plan to provide them with options for coverage when they're early retirees without coverage under the coverage for seniors.

To your second question about whether we are seeing scale backs in coverage in general, I would say, given the economic situation in Alberta, that we are having some challenging discussions with employers. They see their benefit line as a cost on their budget, and they're making some tough decisions about whether they have to scale back on the benefit coverage or potentially lay off employees. I have been in those discussions. We do everything we can to try to get the cost of those benefits down so that they can stay on it, but tough decisions are being made by those plan sponsors.

The Chair: Your time is up, Mr. Davies.

That completes our round of questions. I want to thank the witnesses. You could stay for a few more hours and we would learn a great deal more, but we have another presentation that we are about to hear. I just want to thank you on behalf of the committee for coming and providing this information. We may come back to you with more questions, but in the meantime, thank you very much.

We'll adjourn for a few minutes, and then we'll have our presentation on blood donations.

● (1210)

_____(Pause)_____

● (1210)

The Chair: We'll resume our meeting. Now we have the very distinguished member from Edmonton-Centre to make his first presentation at committee, Mr. Randy Boissonnault. He's going to tell us about the events that happened in January at the meeting on the blood donation restrictions on men who have sex with men.

Randy, you have 10 minutes.

[*Translation*]

Mr. Randy Boissonnault (Edmonton Centre, Lib.): Thank you, Mr. Chair.

Ladies and gentlemen, colleagues, it gives me great pleasure to be here today. This is the first time that, as senior advisor on these issues, I have had the honour of addressing a House of Commons standing committee.

[*English*]

Thank you for this great opportunity. I think I will remember this moment for quite some time. Thank you all very much.

I want to give an overview of what happened at the Canadian Blood Services and Héma-Québec conference held in Toronto regarding the blood ban for men who have sex with men. I was honoured to bring opening greetings to that conference on behalf of the Minister of Health, the Honourable Jane Philpott. The reason is that Health Canada provided the funding for researchers to actually look at closing the gaps in this population of men who have sex with men. This conference was an opportunity to bring together leading researchers from Canada and around the world in terms of the leading best science.

What I thought I might do, Mr. Chair and colleagues, is to give you a couple of highlights from the remarks, and then also share some of the feedback that I received from stakeholders and people who attended that conference.

The whole theme of the speech was on pursuing research to make sure we have the safest blood system possible, and also making sure that our donor supply can be as inclusive as possible. We care about this as Canadians because blood safety is paramount. Our interest as a government—we ran on this—is that we want to know the best research to close the knowledge gaps on donor screening of men who have sex with men. We're going to talk about that term later, because I've had some pushback from the community on the actual term itself.

The call to action is that everyone has a role to play in the blood screening process and in making sure we have enough blood for people who need it. However, there are some perverse effects that have stemmed from the fact that we have the blood ban in place. We need to reconcile the need to protect the safety of Canada's blood supply with the need to make sure that the donor system is as inclusive as possible.

Where the blood ban came from, as you all know as members of this committee and as Canadians who lived through this, was in the response to the Krever inquiry. In the early days of the blood ban, it was a lifetime ban. If you were a gay man who was involved in any sexual activity with another man after 1977, it was a lifetime ban. More recently, that lifetime ban was reduced to a five-year ban. Then, as a party, we ran on getting that five-year ban down to zero. We now have the blood suppliers, Héma-Québec and CBS, who have declared a one-year deferral period.

Now, it's clear to members of the community, although the distinction is not always there, that it's not the government saying that the deferral period is in place. It is CBS and Héma-Québec who have put those restrictions in place.

What I wanted to convey, and what I did convey at the conference, is that we have to talk about the central role that evidence needs to play in protecting the blood supply, but also making the blood supply as inclusive as possible. If you look at the microbiology, at the science, what is the reason for having blood in the supply for two months after nucleic acid tests, knowing what's in the blood supply, and then not allowing people to use that blood or give that blood for a year, five years, or 20 years? The microbiology doesn't support it.

One of the analogies I used—it wasn't in my remarks but I used it because I hear this all the time as a member of the community—is how it is possible that a young college student, of any gender, with multiple partners can give blood as a heterosexual, and all of that student's partners can give blood unrestricted, but two monogamous gay men living in partnership cannot, unless they declare that they have not had sex together for a year. Show me the science that shows that makes sense, because I don't have many explanations for the community to explain how that makes sense.

We have two choices as a community, and this was hotly debated by researchers and members of the community. We get to a behaviour-based analysis where we look at the population of men who have sex with men and at populations within that large basket of people—takings labels aside—and the risk factors, or we take a look at increasing our screening so that regardless of who you are or the risk factors that come to bear, the screening technologies provide the safest blood system possible. Those are the two largest areas that the researchers were debating. Do we have a world-class screening system that doesn't exclude anybody, or do we look at a behaviour-based process?

I just did my first western tour as special adviser, and we were in Winnipeg, Toronto, Vancouver, Saskatoon, and Edmonton. I can tell you that in talking with members of the community, we had several men in the community who objected to the very term “men who have sex with men”.

● (1220)

They said, “I'm just a person, and like other people, I have sex. Why am I a part of the subgroup? Why can't we just talk about risk factors for all populations regardless of sexual orientation or gender?”

When we take a look at the restrictions that CBS and Héma-Québec have put on the trans community, it is even more onerous. We are actually forcing people to go back to their birth gender to determine if they can give blood or not. I had one trans activist in Vancouver who said she is now 14 months after surgery, and as of two days ago her blood is fine, but if she was another gender, her blood wouldn't be fine. We have gotten ourselves into this kind of perverse way of defining populations and sub-populations when it's clear to the community and it's clear to me as a parliamentarian that I want a safe blood supply, but I also want an inclusive blood supply. I can't give blood, as a gay man, unless I say that I haven't had sex for a year. I lived in the United Kingdom from 1994 to 1996, so I may never be able to give blood because that was the time of the tainted blood scandal.

We have to take the blood supply seriously, but we also need to make it the most inclusive blood supply possible. With that in mind, $3 million was put on the table for researchers to move forward and take a look at this issue. I have to give a shout-out to the Canadian Blood Services—congratulations—and to Héma-Québec for the work they did in bringing several organizations, stakeholder organizations, from across the country to the conference.

Héma-Québec and Canadian Blood Services have done a great job of reaching out to members of the community, leaders of the community, including Egale Canada, including various organizations across the country. That partnership, if you will, that advisory role that members of the community play, is a very important role for us to know as parliamentarians. What the community wants, and what we would like to see, and what I urge you as parliamentarians to push us to get, is the data that will help us get to a behavioural approach so that we can de-stigmatize gay men who are in committed relationships, because I think it's important that we de-stigmatize the population.

I mentioned this in my opening remarks. We know that there are allies who are long-time friends with members of the gay community who do not give blood because of the blood ban. That is perverse. When Canadians who are allies to our LGBTQ community aren't giving blood because they disagree with the science and the fundamentals around the blood ban, and those units are not in the system, we are losing out as a country.

I think there's a way forward. The Minister of Health and I have talked about this. As an evidence-based government, it's important for us to have the data, but it's also important for us to make sure that we are not acting in the absence of data. That's why this $3 million and this conference room was important.

The other thing that came up, and I would encourage members of this committee to consider in the future, is to invite Héma-Québec to present to this committee. They indicated to me that they had not presented in some time and that CBS had, so that may be something you would like to explore.

● (1225)

[*Translation*]

With regard to this whole issue, I think that, with the help of science, it is possible to have a very inclusive Canadian blood system, while maintaining the security of this system. It is very important that Canadians be more involved in their blood system and that this system be very inclusive.

[*English*]

I think what I would say, having heard from stakeholders after the conference, is that this is emotional. We heard from members who lived with tainted blood before the Krever inquiry. We absolutely have to get this right. We have to balance the needs of patients who are receiving blood, Canadians who are receiving blood, with the overwhelming desire of members of the LGBTQ community to contribute to the blood supply.

Mr. Chair, members of the committee, this was a good first start. There is much research that needs to be done. I urge you to pay close and constant attention to this issue. I think that when we are able to work with researchers and scientists to demonstrate the true risk factors of gay men living in committed relationships and we can get this one-year restriction reduced, you will see an increase to the blood supply and one of the safest blood supply systems in the world.

[*Translation*]

Thank you for your attention.

[*English*]

The Chair: Thank you very much.

Now we're going to have one round of questions, five-minute questions, and we're going to start with Mr. Kang.

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

I want to thank the member from Edmonton Centre for coming and shedding some light on this very important issue.

You raised a few questions here. My first question is that the Canadian Blood Services and Héma-Québec put in place a policy allowing men who have sex with men to only donate blood after a year of abstinence. Where does the rationale to implement this policy come from? How did this come about? Before it was five years. Where did the rationale come from?

● (1230)

Mr. Randy Boissonnault: It's my understanding that when Héma-Québec and Canadian Blood Services looked at their most recent research, they were able to make a case to reduce it from five years to one year.

The push-back that I would offer, and that I explained at the conference is, how does the microbiology change? If you have the blood, and after two months, you do a new nucleic acid test and you know exactly what is in the blood supply, why is it one year? Why is it two months?

The answer is that they don't have the science to say why it's one year versus no years. If we're going to have a behavioural approach that encourages people to defer the blood from the system because of behaviour, then it's important that we understand any risk factors associated with that population. I would like to see, as a government, that we have the data to analyze all populations that would pose a risk to the blood supply, and that we don't use a broad brush stroke on one community.

You would have to ask Héma-Québec and Canadian Blood Services why they advocated for one year, when we have seen other jurisdictions around the world have no deferral period or a deferral period of two months.

Mr. Darshan Singh Kang: Thank you, sir.

My second question is, why do you think those men who have tested negative and have identified as being in a long-term relationship with another man are not considered to be safe to donate blood?

Mr. Randy Boissonnault: The short answer is that we don't have the data to distinguish between high-risk homosexual men who have riskier sexual practices, either through not using condoms or through any sort of intravenous drug use or any other behavioural risk profiles, and a different part of the community who are in monogamous, long-term, committed, safe relationships.

With the tools at our disposal as a government and as a scientific community, we have used a very broad brush stroke—and we know the community has many more different elements to it—so all gay men got lumped together. That's why I stated earlier that the original deferral wasn't a deferral, it was a lifetime ban. As the science has been able to demonstrate risk factors, and connected that to behaviour, we have been able as a country to get this blood ban closer and closer to no ban at all.

Mr. Darshan Singh Kang: In your opinion, what else could we do to make this blood supply inclusive? You said the blood supply will definitely increase if we lifted the ban, like the one-year ban. What kind of number would you put forward? By how much would the blood supply go up if there were no ban? Is there any data?

Mr. Randy Boissonnault: It's a great question, and it's one of the notes that I made at the meeting to see if we can quantify how many allies are out there withholding blood from the system. I don't have an answer for you yet, but it's a question that is an open question.

Again, as a community, as a country—and this came up in the scientific discourse—we have two choices. We can have an infallible screen that applies to everybody, regardless of behavioural factors, and that is about the science and about testing what's in the blood; or we can have a system that first imposes a behavioural screen.

Where we are now is that we have a process that imposes a behavioural screen, and the choice that CBS and Héma-Québec have made is that a one-year period, where a man does not have sex with another man, satisfies their criteria for safe behavioural practices to then allow that blood into the system.

Does the science bear a difference between a two-month deferral, a six-month deferral, a one-year deferral? Many scientists will tell you no, and they did so at the conference. That is why it's important for the research that comes out of this conference to show us what the behavioural risks really are.

Mr. Darshan Singh Kang: Is there some screening process in place now? If there's none there, if you were to put some screening processes in place, has any cost study been done?

● (1235)

Mr. Randy Boissonnault: All of the screening processes that regulate the safety of the blood supply are in place, and have been put in place by CBS and Héma-Québec. They are among the world's leading screeners for safe blood supply. We can always do better.

The Chair: Time's up.

Mr. Webber.

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

Thank you, Mr. Boissonnault, for coming here today. Good luck with your new appointment with your government. I wish you well on that.

Back in 2013, the Canadian Blood Services received approval from Health Canada to reduce the deferral period for men who have sex with men from indefinite down to five years. Of course, since then we've had an election, and I know through running against my opponent in my riding that the Liberal Party ran on this goal of reducing that five-year ban right down to zero.

In 2016, your government reduced that ban from five years to one year, and I applaud you for that, but you ran on an election platform that you were going to reduce this down to zero. Here we are in 2017, and we are working on this scientific study right now. We've spent $3 million to date on this two-day meeting we had and the research that has been done. You were at the meeting. We wanted to be there to sit through these meetings that we were not as a Conservative caucus invited to. We found this quite insulting, as we had been working on this for quite some time as well.

In light of of your promise of going down to zero, I want to know the time frame. When do you see this happening? This is a decision that you will have to make as a government. Is this something you are now backing off on? Please let us all know. Let Canadians know where you are going with this blood ban. Is it going down to zero?

Mr. Randy Boissonnault: What is important to know about this conference is that the $3 million was used to bring the officials around the table and also to literally set the scientific agenda for the research that has yet to be conducted. We have yet to see the research. We have yet to see the results of the research.

What's important for Canadians to know is that there is a separation between the blood regulator and the government. What happened during the campaign—this came from our youth wing, and you would have seen it at the doors—is that the youth wing and many coalitions from around the country pushed very hard and we ran as a party to get the blood ban down to zero. When you look at the science in other jurisdictions in the rest of the world, this position is supported.

We are moving as fast and as well as we can as a government. We cannot tell CBS and Héma-Québec to reduce this to zero. That's not how this works. The blood regulators, with the best science they have at their disposal, make a recommendation to Health Canada. Then Health Canada approves that reduction in the deferral period.

The conference is an important first step in getting the data. At best, LGBTQ2 Canadians are invisible in the data. When you talk sub-populations of the LGBTQ2 population, the data isn't any more forthcoming. We need to understand the behavioural risks of populations. We also need to empower scientists who believe they can have a blood-screening system that can unequivocally tell us what is in the blood supply.

As to participation, I wasn't informed about the inability of Conservative MPs or other MPs to be involved. My role as special adviser is non-partisan. I'm here to advance the causes of LGBTQ2 Canadians regardless of political stripe. I want Canadians regardless of political stripe to give blood and be able to get blood.

If we can get more blood in the supply and it's more inclusive, that's what I'm here for. I can tell you the Minister of Health is moving fast on this. As an evidence-based government, we need to see the data and that's why this was an important first step. I appreciate your work on the file.

Mr. Len Webber: Thank you, Randy.

I want to stress the fact that this was an election promise to bring it down to zero. Is this another one of these promises your government has made that you will not be able to move forward with?

● (1240)

Ms. Rachael Harder: You make it easy.

Mr. Len Webber: It was something that certainly affected the Conservatives in the ridings we lost, these promises, and the fact that now you can't keep these promises is disturbing.

I would suggest that come 2019 the Liberal government should hold off on promises unless they can keep them.

The Chair: Thank you very much, Mr. Webber.

Mr. Davies.

Mr. Don Davies: Thank you.

I'm a little unclear, Mr. Boissonnault. I'm trying to understand your position. Is it your testimony that the current one-year blood ban on men who have sex with men is discriminatory and not based on science, or not, or are you unsure? What is your position?

Mr. Randy Boissonnault: I think if we stigmatize any population based on sexual orientation, it can lead to discrimination and prejudice that can be harmful to that population.

Mr. Don Davies: Is the current one-year ban based on science, yes or no?

Mr. Randy Boissonnault: The current one-year ban, according to CBS and Héma-Québec is based on the best science they have available. What we saw at the conference is that there is science in other parts of the world that supports a deferral period of two months or none. We don't have Canadian data to support getting to zero, and that's why this conference was important.

Mr. Don Davies: You've chosen to come before this committee, not as an MP but as a witness, and in a non-partisan role, so I'm asking for your position. Is the one-year ban discriminatory or not?

Mr. Randy Boissonnault: My position is that it discriminates against sub-populations for which we have no data, and I want to see data that shows if we're going to continue to have a deferral period that there is a reason, a risk to the blood supply, that justifies that exclusion of the population.

Mr. Don Davies: Is the current one-year ban based on science, in your view, or not?

Mr. Randy Boissonnault: I think Héma-Québec and CBS will tell you they want to see more data.

Mr. Don Davies: I'm asking what you believe. I know what Héma-Québec and CBS say.

Mr. Randy Boissonnault: I believe that the current blood ban excludes me and an entire population of Canadians who, because of their sexual orientation—

Mr. Don Davies: Is it based on science or not?

Mr. Randy Boissonnault: I think it's based on the best science that was available at the time.

Mr. Don Davies: Okay. Number two, I think you have mischaracterized the case. There is no doubt that this decision that's been made by CBS and Héma-Québec can absolutely be overridden by the minister. There is no question that the Minister of Health has the power to remove restrictions on donations that are no longer required. Do you agree with that?

Mr. Randy Boissonnault: We would disagree on that.

Mr. Don Davies: You think that the Minister of Health does not have the power to change the current restrictions on men who have sex with men?

Mr. Randy Boissonnault: For the safety of the blood supply, it is critical that we work with CBS and Héma-Québec to recommend any deferral period to the government.

Mr. Don Davies: I respectfully suggest you're wrong. The Minister of Health does have the power to override that if she wants to.

You also are aware that 17 countries around the world have zero deferral periods for men who have sex with men donating blood?

Mr. Randy Boissonnault: I am, and I referenced that in my opening comments.

Mr. Don Davies: What you said in your campaign, as Mr. Webber pointed out, and I'm quoting from the Liberal Party's campaign literature:

> Currently the Canadian Blood Services (CBS) and Héma-Québec (HM-QC) ban men who have been sexually active with men at any point in the previous five years from donating blood, even if it has been entirely safe and monogamous. This policy ignores scientific evidence and must end.

I put it to you, sir, if you have men who have sex with men who have been monogamous and engaged in entirely safe same-sex practices for one year, is that not also ignoring scientific evidence to prevent them from donating blood?

Mr. Randy Boissonnault: That is a really good question that you should put to CBS and Héma-Québec. I agree.

● (1245)

Mr. Don Davies: Dr. MacPherson and Dr. Wainberg, a professor of medicine at the McGill University AIDS Centre, both are former presidents of the International AIDS Society, believe that Canadian Blood Services should simply include questions about donor behaviour. According to Dr. Wainberg:

> If you're a man in a long-term, stable relationship and you and your partner are both negative, then the risks are exactly the same as those of a heterosexual couple....

That being the case, do you agree or disagree with that statement, that the risks are exactly the same for men who have sex with men in a stable monogamous relationship as those for heterosexuals? Do you have any evidence to dispute that?

Mr. Randy Boissonnault: Dr. Wainberg and I spoke at the conference. He spoke very forcefully in plenary about following the microbiology, and the fact that after you've tested the blood, after you know after two months, it doesn't matter whether the blood is there for two months, five years, or 20 years, the microbiology doesn't change. I agree with Dr. Wainberg's comment about behavioural risks.

We need data to support the blood regulators so we can assure Canadians that the blood supply will be safe, so we can have an inclusive population. I want to see the blood ban at zero tomorrow. I want Canadians to know that the blood supply will be safe when we do that.

Mr. Don Davies: Dr. Paul MacPherson, another HIV researcher, says there's no good data to say that it needs to be one year.

You seem to be suggesting that data needs to be shown to prove that it's okay to have this blood, when I would say the opposite. If we're going to adopt a practice that discriminates against Canadian men who have sex with men, then I would say it's incumbent upon those who assert that to supply data to show why that's necessary. All we're seeing from experts and doctors is that there is no data to support that policy, yet your government refuses to keep its promise made during the election campaign and reduce it to zero, even when there's no data to support keeping that discriminatory restriction in place.

Mr. Randy Boissonnault: It's important to note, and I applaud and share your passion on this matter—

Mr. Don Davies: It's just logic and science.

Mr. Randy Boissonnault: There's logic and passion and science, and what's important is that Canadians came at this issue from a different place. We are working very hard to make sure we get this blood ban to zero, and that's why getting the data is important. Canadians need to know the blood supply is safe, and it's also important that we demonstrate, as Dr. Wainberg said, the very low to no risk factors of a monogamous gay couple.

Mr. Don Davies: Have you asked any of the 17 countries if there's any data?

The Chair: Mr. Davies, you're considerably over time.

Dr. Eyolfson, please.

Mr. Doug Eyolfson: Thank you, Mr. Boissonnault. Thank you for coming. We really appreciate your work on this.

Now this goes back a while and we talked about the Krever inquiry and the recommendations of the Krever inquiry. What was the scientific data at the time that made them conclude that there should be a lifetime ban?

Mr. Randy Boissonnault: I'm not privy to the data that required the lifetime ban. I think it was that any perceived risks to the blood system were excluded. My sense, Dr. Eyolfson, is that at that time any perceived threat to the blood supply was not something that Canadians would tolerate, so CBS and Héma-Québec excluded an entire group based on the data of the day. Thankfully, we have more research to support where we are now.

Mr. Doug Eyolfson: Okay. Thank you.

In regard to the CBS, they have their scientists, their data collectors, and the people who interpret the data that they have, and there's been the suggestion that the health minister might have the legal power to simply direct CBS and Héma-Québec by saying, "You shall do this."

If you had the experts of any arm's-length organization—and I should preface this by saying I haven't looked at their data in detail at this point—saying that at this time they believe this is the best available science and the best available evidence, would it be appropriate or acceptable for a minister to just come in and override that and say, "We don't care what you believe to be the best available science. We made an election promise, so don't do this"?

Mr. Randy Boissonnault: I think the question is a good question. The system that we have set up is that the blood regulator regulates the blood system and the blood supply to make sure we have the safest blood supply possible.

What this conference was intended to do was to start the conversation around how we make that blood supply more inclusive. How do we get data in the men who have sex with men category, to show that the risk is low to non-existent? I think the answer to your question is that the system we have now is one in which the regulators petition and inform the Department of Health of their science and advocate for a deferral period or not, and then the minister approves it. To do otherwise would be political.

Mr. Doug Eyolfson: All right, thank you. I have no more questions.

The Chair: Thank you very much.

That concludes our session on this subject. I want to thank Mr. Boissonnault for coming on short notice. We had actually invited the parliamentary secretary. He was not available to come, but I think you brought a new dimension to the subject and brought some good information to us. I want to thank you.

This was Mr. Webber's original motion, moved, I think, in September or October, quite a long time ago, so thanks very much for your information and your addition.

We'll just suspend for a couple of minutes, and then we have some committee business to do on this and other things.

● (1250)

Mr. Len Webber: Just a correction, it was Mr. Davies' motion that was passed.

The Chair: Oh, it was Mr. Davies' motion? Sorry. I'd better be careful.

● (1250)

_____(Pause)_____

● (1250)

The Chair: We'll reconvene.

Just a few quick things we want to do on committee business. Last night we passed C-37, an act to amend the Controlled Drugs and Substances Act. Although we had talked about it, we hadn't decided how to handle it. Does anybody have any suggestions on how to handle it?

Mr. Oliver.

Mr. John Oliver: I think everyone at committee is in agreement that we are in a national public health crisis with the introduction of fentanyl and the opioid crisis. The government has already taken action.

There is a five-point action plan to address opioid misuse and to deal with prescribing practises. Naloxone was introduced, which is a very powerful antidote. It is generally available to communities. The minister co-hosted a conference and a summit on opioids that resulted in 42 organizations making very concrete commitments to address the crisis. Then we had Bill C-37 introduced to the House.

Bill C-37 proposes to ease the burden on communities that wish to open supervised consumption sites, while putting stronger measures in place to stop the flow of illicit drugs and strengthening the systems in place for licensed controlled substance facilities. I think we were all delighted when the NDP joined with the government side yesterday to send this to our standing committee for line-by-line review.

I think we would all agree that we are ideally situated to deal with this review. We have heard from witnesses. We have already done our work on the opioid crisis. We did our report. We made our recommendations. We heard from the witnesses how critical it is that we move quickly and forthrightly to get these recommendations in place to ease what is happening at the community level.

Bill C-37 is highly consistent with our recommendations, dealing with both harm reduction and law enforcement in border security. I actually mentioned in the House that the bill is quite well aligned with us.

Given that we are ideally situated to move forward with this, and given the urgency of dealing with this in our communities and putting a stop to this crisis, I would like to bring forward this motion. I move:

> That, with respect to Bill C-37, An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts:
>
> a. the Clerk of the Committee write immediately to each Member who is not a member of a caucus represented on the Committee and any independent Members to inform them that the Committee will begin the study of the Bill and to invite them to prepare and submit any proposed amendments, which they would suggest that the Committee consider during the clause-by-clause study of the Bill;
>
> b. members of the Committee as well as Members who are not a member of a caucus represented on the Committee and independent Members should submit their proposed amendments to the Clerk of the Committee no later than Tuesday, February 7, 2017, at 4:00 p.m.;
>
> c. the Committee proceed with the clause-by-clause consideration of C-37 no later than Thursday, February 9, 2017;
>
> d. the Chair may limit debate on each clause to a maximum of five minutes per party, per clause; and
>
> e. if the Committee has not completed clause-by-clause consideration of Bill C-37 by 5:00 p.m. on Thursday, February 9, 2017, all remaining amendments submitted to the Committee shall be deemed moved, the Chair shall put every question, forthwith and successively, without further debate or amendment on all remaining clauses and amendments submitted to the Committee, as well as each and every question necessary to dispose of clause-by-clause consideration of the Bill, as well as all questions necessary to report the Bill to the House and to order the Chair to report the Bill to the House no later than Monday, February 13, 2017.

We need to get this done. We need to get this back to the House so we can make a difference in this crisis across Canada.

● (1255)

The Chair: We have a motion.

Mr. Webber.

Mr. Len Webber: Mr. Chair, this motion is a lot to take in. I am just reading it for the first time. I believe we have to have unanimous consent around the room as to whether or not Mr. Oliver can table this. Otherwise, he would have to table it and give us the 24-hour notice, from what I understand. Maybe you could clarify.

The Chair: This is committee business and it is legitimate.

Mr. Len Webber: Okay.

The Chair: We had originally said that we were going to debate this next Thursday in any case. It nails it down a little more elaborately, but it's about the same thing we agreed on last week.

Ms. Harder.

Ms. Rachael Harder: I need a clarification from Mr. Oliver.

Are you suggesting that our committee be extended beyond the normal two hours? You say that it has to be completed by 5 p.m. I am just looking for some clarification in terms of how you're suggesting we move through this quickly.

Mr. John Oliver: Yes, our committee would continue to work until 5 p.m., at which point the chair would move through the remaining business and the line-by-line review.

Ms. Rachael Harder: Okay, thank you.

The Chair: Mr. Davies, go ahead.

Mr. Don Davies: I speak in great support for this. Twenty months ago, I was in the House when Bill C-2 was introduced, and although perhaps we have different views around the table on that bill, the bill came before the committee. There were five meetings and 20 witnesses, who all discussed and debated all of the issues around supervised consumption sites. There was significant testimony on the issue of what criteria ought to be considered in determining an exemption. It was well-canvassed, under 24 months ago. Four months ago, we had the opioid overdose crisis study. We, in this room, heard evidence from a number of witnesses on a wide range of issues concerning the opioid crisis, including the need for supervised consumption sites and their impact.

We know that 40 to 50 Canadians are dying every week from overdoses in this country. I pointed out before that when SARS hit this country, the total number of deaths across the whole country was 40. We are losing that many people every week. We all now agree that this is a national public health emergency. All parties are using that term now, if not the declaration. Bill C-37 provides essential measures to address the crisis—not only supervised consumption sites, but necessary legislation regarding interdiction for CBSA and limits on the production of illicit opioids with respect to pill presses.

I am fully in support of expediting this bill. I don't think this committee can move fast enough.

I just want to end by saying that yesterday someone sent me an article about the situation in Estonia, which suffered from a very similar outbreak over the years. They had a fentanyl overdose crisis in that country. What it says here is that they were asked about the advice they would give Canada and what they said was, “The most important thing is you don't waste time. If you really want to learn from us, that's the mistake we made.... Don't look for some new solutions, because you have them.”

I know there are a lot of issues to debate, but it's not the time to debate and waste time when Canadians are dying and we know that we can take measures that will save lives. I'm asking all my colleagues to support this.

● (1300)

The Chair: All right. We have the motion on the floor, and no more speakers.

(Motion agreed to)

The Chair: Now, we wanted to deal with, Mr. Davies, your motion on the blood donation—

Ms. Rachael Harder: I'm sorry. I have a point of order, Mr. Chair.

It is 1 o'clock, and this committee is supposed to be wrapped up at this time. Perhaps we could do committee business at the end of our next meeting.

The Chair: I don't think there's any rush. That's fine.

Mr. John Oliver: A point of clarification on this.... I believe the committees continue to meet unless there is assumed consensus to adjourn or a motion to adjourn. Otherwise, we can continue to do our business for as long as we wish to do our business.

Ms. Rachael Harder: As long as you take a vote from the committee....

Mr. John Oliver: I understand—

The Chair: It's a consensus. There is no urgency on this, Mr. Davies, so we can do it in committee business. We'll all work together on this and keep moving forward.

Thank you very much, everybody.

The meeting is adjourned.