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Chair

Mr. Bill Casey

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● (1105)

[*English*]

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

Welcome to our February 23 meeting. Today we're to hear two witnesses on constitutional issues, followed by about half an hour of committee business.

Today our witnesses are Dr. Amir Attaran, professor in the faculty of law, University of Ottawa; and Mr. Bruce Ryder, associate professor at Osgoode Hall Law School, York University.

We're going to ask Mr. Ryder to go first. You have 10 minutes. That will be followed by a seven-minute question period. You're on.

Professor Bruce Ryder (Associate Professor, Osgoode Hall Law School, York University, As an Individual): Thank you very much, Mr. Chair. It's an honour and a privilege to have the opportunity to participate in your extensive study of a national pharmacare program.

My area of expertise is constitutional law, including the division of legislative powers. I will be confining my remarks today to that subject. I'm hoping I can be of some assistance to the committee in thinking about the constitutional pathways that are open to the federal Parliament if you were to decide to move ahead with a national pharmacare program.

I'll talk about several of the most important constitutional powers that are relevant to this discussion. I'll speak about both the opportunities they provide and the limits of proceeding pursuant to particular federal powers.

Let me begin by saying a few words about the federal spending power, which I think is central to this topic. From reviewing some of the transcripts of previous testimony and briefs that have been received by the committee, my sense is that many who have appeared before you to support a national pharmacare program are essentially assuming that the federal spending power and the mechanism of the Canada Health Act will be the route that Parliament would choose to move forward on a national pharmacare program.

The federal spending power is not set out anywhere explicitly in the Constitution, but it has been recognized by the courts as implicit in Parliament's power to levy taxes, which is class 3 of section 91 of the Constitution Act, 1867, put together with Parliament's power to legislate in relation to public property in class 1A, and to appropriate federal funds, which is section 106 of the 1867 act.

In Prof. Hogg's words:

> ...the federal Parliament may spend or lend its funds to any government or institution or individual it chooses, for any purpose it chooses; and that it may attach to any grant or loan [of federal funds] any conditions it chooses...including conditions it could not directly legislate.

The spending power has been the subject of quite a lot of controversy over the years, including in academic circles. There are many scholars who deny its existence or who question its validity, particularly when it comes to conditional spending in areas of exclusive provincial jurisdiction.

However, the courts have not shared the doubts of the scholars who question the existence of the power. On the few occasions in which the courts have been called upon to discuss the spending power, they have recognized its existence, have stated that Parliament is not constrained, when spending funds, to acting only within areas of federal jurisdiction. In other words, spending can take place in areas of exclusive provincial jurisdiction, and it's possible for Parliament to attach conditions to funds that it makes available to provinces.

I go into some of the case law in more detail in a brief I have provided to the committee, but the essence of it is that in a number of rulings, as I've said, the courts have recognized the spending power, recognized that federal governments can spend in areas of provincial jurisdiction and attach conditions to it.

It's not an unlimited power, and the precise nature of the limits on the federal spending power haven't really been spelled out in the case law, apart from the general principle that any federal legislation that is in pith and substance—meaning it has as its dominant characteristic—the regulation of a matter that falls within exclusive provincial jurisdiction is ultra vires the federal Parliament.

That's the fate, for example, that befell the unemployment insurance act when it was first put forward or proposed by the federal government back at the time of the Depression in a bundle of cases that we refer to as the New Deal cases, released in early 1937. The Privy Council struck down a number of federal legislative proposals, one of which was an unemployment insurance act.

● (1110)

Lord Atkin wrote in that opinion that the law that the government sought to defend as an exercise of the federal spending power was, in fact, in pith and substance the regulation of a provincial matter—employment contracts—and therefore was ultra vires Parliament.

More recent decisions from the Supreme Court of Canada have confirmed the existence of the spending power but have reiterated that limit: that at some point, federal spending can be too great an intrusion into provincial legislative jurisdiction and amount to the regulation of a provincial matter.

It's hard to know exactly where that limit is, but I would summarize the case by suggesting that while attaching general conditions like those set out in the Canada Health Act to federal spending in areas of exclusive provincial jurisdiction is acceptable—that's just a law that is in relation to the spending of federal funds, and general conditions can be attached to the receipt of those funds—at some point, if the conditions become too detailed, too precise an interference with or a dictation, if you like, of how the provinces should deal with matters that fall within their exclusive jurisdiction, like health care, then it will be ultra vires the federal Parliament.

That's the federal spending power. It's recognized. It exists. It has uncertain limits. I think the conclusion we can draw from the case law regarding it is that the least controversial route, I would say, to the implementation of a national pharmacare program is to amend the Canada Health Act so that it includes drugs that are provided outside of hospitals in the definition of insured services that have to be provided by the provinces. Currently, as you know, it's only when drugs are administered in the hospitals that they're covered under the Canada Health Act.

The scope and the details with regard to the funding and protection of drugs would be left primarily to processes of federal, provincial, and territorial negotiations if that amendment were put in place.

I'm not saying that it's uncontroversial in the sense that there wouldn't be any political resistance to taking that step, but from a legal point of view, there would be...I hesitate to say zero risk, but a very low risk of any uncertainty about the constitutional validity of proceeding in that manner.

What about other alternatives? The criminal law power is relevant in this context. Again, in my brief I go through the parameters of the criminal law power and some of the case law on it. There are several cases that have upheld provisions of the Food and Drugs Act and the regulations that have been passed pursuant to it, which, as you know, amount to very a extensive regulation of various aspects of the production and marketing of food and drugs. The courts have not doubted the validity of the Food and Drugs Act and its regulations from the point of view of the federal criminal law power.

The limits of the federal criminal law power are that it authorizes laws that are in pith and substance—that is, in their dominant characteristic—putting in place prohibitions, coupled with penalties, for a typically criminal public purpose, such as the protection of health or safety.

The Food and Drugs Act and its regulations meet that test, but any legislative response that seeks to go beyond a criminal law form—prohibitions coupled with penalties, or a criminal law purpose like protecting health or safety—would not be capable of being upheld under the criminal law power.

Parliament's power to pass laws in relation to patents is also relevant to the discussion of drugs. That's class 22 in section 91 of the Constitution Act, 1867. It's pursuant to that power that the Patent Act has been enacted. The Patented Medicine Prices Review Board is established pursuant to provisions of the act, and is tasked with regulating the prices of patented medicines sold in Canada to ensure that they are not excessive.

These are valid exercises of Parliament's jurisdiction pursuant to class 22 of section 91, but that power cannot enable Parliament to regulate the prices of unpatented drugs, so a comprehensive approach to the pricing of drugs can't be sustained pursuant to that part of section 91 alone.

● (1115)

More ambitious proposals to establish a new national agency that would regulate drugs, including the prices of both patented and unpatented medicines—and you've heard some ambitious proposals along those lines—could not be upheld under the spending power, the criminal law power, or the patents power.

One possibility that could be entertained by Parliament is the "peace, order, and good government" power, which is in the opening words of section 91, which can sustain legislation that is addressing a matter of national concern and also one that is not too diffuse or too broad. That seems counterintuitive, but the courts have been concerned that if we allocate to the POGG power matters such as health, pollution, or inflation, those subject matters are so broad and diffuse that to allocate them to Parliament's jurisdiction would upset the division of powers and would unduly interfere with the autonomy of the provinces.

A subject matter, to qualify under the national concern branch of POGG, has to be quite focused, narrow, and specific, and it's possible the national pharmacare program could meet that definition. It's highly debatable, I think, but it's possible that it's sufficiently discrete and focused to fall within the national concern branch of POGG.

Can I have one more minute, Mr. Chair?

The Chair: You're about two minutes over now.

Prof. Bruce Ryder: I've gone over; forgive me.

The Chair: Wind it up.

Prof. Bruce Ryder: There are other reasons to doubt whether the POGG power can sustain legislation in this area that I won't go into, but they are set out in my brief.

The final possibility that I'll just mention super-briefly is, of course, pursuing the establishment of a national agency with comprehensive regulatory powers through interlocking legislation that would give it plenary jurisdiction over the subject matter. The agency would receive powers in both Parliament and provincial legislatures, like the negotiations that are going on regarding the establishment of a national securities regulator.

Thank you very much.

The Chair: Thank you very much, and I'm sorry to have to cut you off, because you brought some new information that we hadn't heard before; we appreciate it very much. We'll have a chance to bring out more in question period.

Dr. Attaran, you're up for 10 minutes.

Professor Amir Attaran (Professor, Faculty of Law, University of Ottawa, As an Individual): Thank you, Mr. Chair.

I agree with very nearly everything that Professor Ryder just said, so I don't want to be repetitive. He did a great job.

You are putting both of us, however, in a somewhat difficult position, because we're asked to say whether pharmacare would be constitutional without real certainty as to what pharmacare is, which makes any opinion tough, right? You don't know what you're giving an opinion on.

If pharmacare means cheaper medicines for all, then it's motherhood and apple pie, and nobody could possibly say that's a bad goal or it's one that the constitutional scholars of the courts would be unsympathetic with. We're all sympathetic with it. The difficulty comes when you start asking how to achieve this.

Roughly speaking, in policy, there are three different ways. Option one is to amend the Canada Health Act, as Professor Ryder said, to make it include drugs given outside of hospital. Those currently are excluded from the Canada Health Act. Option two is for the federal, provincial, and territorial governments to co-operate in some way on drug pricing. Option three is for the federal government to legislate a national drug price regulatory system.

In brief, I think options one and two would be constitutional; option three is almost certainly not constitutional. The reason is that if one were to legislate a national drug price regulatory system, that's obviously a very complex regulatory scheme, and it would be looked at by the courts under the trade and commerce power of the Constitution, which is class 2 of section 91. We've had some adverse experience lately with that power in the Supreme Court. The reference re the proposed securities act, that case of about five or six years ago, determined that a national securities regulator, as was proposed in greater detail than pharmacare now is being proposed, was not going to withstand a constitutional challenge under class 2, section 91, the trade and commerce power. The reasons are that for something to survive under that power, to be valid as federal law, it shouldn't focus on a single industry—of course, pharmacare would focus on a single industry—and it should be a matter in which there's some demonstrated provincial incapability to act.

Of course, you already have the provinces, through the Council of the Federation, acting on drug price rather energetically. As an aside, I'll say they're not doing a very good job. Being a professor, I'm allowed to hand out marks. I will give them a D. However, they are being energetic and they're trying in such a way that you can't really say there's provincial incapability.

The other case from the Supreme Court that gives me pause is the reference on assisted human reproduction, which was again about five or six years ago, in 2011. That concerned a regulatory scheme for such things as in vitro fertilization. It too didn't survive constitutional challenge at the Supreme Court. It dealt with an aspect of the health care system that advocates wanted regulated for reasons of safety, quality, and appropriate clinical practice. Well, that's exactly the set of reasons offered for a pharmacare system.

What the Supreme Court said was that aside from the few criminal law sections of the Assisted Human Reproduction Act, most of the rest was unconstitutional. This echoes Professor Ryder's point that if something is in pith and substance purely criminal and takes the criminal law form, it will survive, but the regulatory scheme attached to it for human reproduction, and potentially for pharmacare, would be very constitutionally vulnerable.

● (1120)

In my final two minutes here, how would you do this? If you wanted a national pharmacare program, how would you do it? The spending power, as Professor Ryder said, matters, and you could do it by expanding the spending as well as the scope of provincial obligations under the Canada Health Act. That said, the Canada Health Act is very poorly policed by the federal government. If this were the approach taken, there is no doubt in my mind that provinces would flout whatever new mandate was put in place and the money would not be used in the best possible way.

Another way to go about this is perhaps through a series of contracts, because while legislation is constitutionally vulnerable, contracts are not, or very much less so. You could have the federal government and the provincial governments enter into a contract for how they would purchase medicines and agree on the modalities to do it, and perhaps designate a common buying agent. By doing this contractually through private law rather than legislatively through public law, you have certainly more latitude than you would otherwise. In fact, you would have so much more latitude, I think, that it would be foolhardy to attempt this under public law where that option exists.

Let me say one final thing, and it's an afterthought. I apologize, because it doesn't really fit with the rest of this.

My students and I have published research on the prices of drugs in Canada. The findings are scandalous. Particularly for generic drugs, we pay way too much. As a terse illustration of that, some drugs made by Apotex, a Canadian company, after the intervention of the provinces, cost more in Canada than they do in other countries. How can the product of a Canadian company cost more in Canada than, say, in New Zealand? And yet, that's happening in some instances with Apotex products, so there is a very serious problem here. In the Q and A, I would explain to you, if you wish, why I think there's a need for the Competition Bureau to look at some of the practices in this industry sector.

I'll leave it there, and thank you for hearing me out.

● (1125)

The Chair: Thank you for your presentation. On behalf of the committee, I'd like to ask if we could have a copy of that study you did. It would be very interesting for us if you could provide that.

Prof. Amir Attaran: Sure. I'll send it to the clerk by email.

The Chair: Thanks very much.

Now we're going to go to our seven-minute round of questions with Mr. Ayoub.

[*Translation*]

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

I'm very pleased to see another aspect of our study of the development of a national pharmacare program. The legal side is noteworthy. The study can go many ways, obviously, which explains the interest.

I'll try to ask specific questions to get some answers.

While listening to your presentations, I drew a parallel with Quebec's pharmacare and medicare programs. One of the goals of our study of the development of a national pharmacare program is to establish equitable coverage across the country. Currently, the situation doesn't seem to be equitable across the country, or even within the same province. Take Quebec, for example. Can we draw a parallel between medicare, which covers all citizens regardless of income or medical situation, and pharmacare, where income and the source of the insurance come into play when people are privately insured?

Isn't there inequality across Canada that should be addressed? Quebec is one example, but the issue should be examined across Canada.

Prof. Amir Attaran: You're right. There are many difference between the Quebec system and the Ontario system. For example, in Quebec, drugs are covered by public insurance, but not in Ontario.

[*English*]

That is the clearest difference between the two systems. However, it is not a safe assumption—I'm not saying you made it; I'm saying this for the benefit of others—that the rest of the country should adopt a Quebec-style system.

One interesting reality is that as the pan-Canadian Pharmaceutical Alliance has done its work—that's a project of the premiers, The Council of the Federation—Quebec has not been a participant in that, and it appears that in some instances the pCPA is getting cheaper prices than RAMQ is getting.

● (1130)

[*Translation*]

Mr. Ramez Ayoub: I specifically made the distinction between medical coverage and drug coverage. I also spoke about equality of treatment, as opposed to inequality with regard to life in general and people's origins, social class or economic means.

[*English*]

Prof. Bruce Ryder: I appreciate the question very much. It does seem to me that the distinction between the coverage we have of physician services and hospital services, in accordance with the principles set out in the Canada Health Act of universality, comprehensiveness, accessibility, and so on, and the failure to include drugs administered outside of hospital, are very troubling. That's one of the reasons it's so important that the committee is undertaking such an extensive and thorough study of this topic. The distinction between the two and the different treatment of the two have been challenged by a number of commissions and reports over the years. This goes all the way back to Mr. Hall's commission report in 1964, in which he didn't suggest different treatment of the two, and the Romanow report also recommended remedying that gap in the coverage.

My sense is that the exclusion of drugs administered outside of hospital was not a matter of principle, but rather a sense that we had to take incremental steps. The surprising thing is that we haven't taken this step yet, and here we are half a century or more later. I think Canadians are increasingly troubled by that and the burdens that it places on people in different parts of the country and in different situations within provinces. This is very troubling and has serious consequences for their lives and their health.

We need to explore this very seriously. We need to consider the best route to fix it, the most feasible and practical way of fixing it. That is certainly why I'm happy to be here today. The constitutional pathways and the need to explore them are important to discover how to fix this problem.

[*Translation*]

Mr. Ramez Ayoub: What do you think about the federal role, as opposed to the different provinces' role, in providing the required services? Should regulations be imposed or should the legislation be better enforced? Should the federal government have more power? Should there be broader federal legislation that enables the federal government to intervene despite the potential reluctance of certain provinces?

[*English*]

Prof. Bruce Ryder: I suppose one model, of course, is the Canada Health Act. The idea is that the Parliament of Canada takes the lead in establishing national standards, reflects values on which I believe there is great consensus in Canadian society, and then leaves the details to the provinces, in negotiation with the federal government.

Of course, there is an argument for a stronger federal role than the one that exists through the federal spending power. The argument relates to the kinds of considerations that Professor Attaran was exploring earlier, such as whether or not we're dealing with subject matter that is really beyond the capacity of the provinces to deal with effectively.

That's an idea that informs both the interpretation of the general regulation of trade branch of Parliament's trade and commerce power under section 91, class 2, as well as the interpretation of the national concern branch of the POGG power.

My view is that there is a case, and I'm not sure I'm quite as pessimistic as Professor Attaran is. I don't think it's—and I'm not quite sure how you put it—almost doomed to failure. I think there is an argument, and it may be a strong argument, under the national concern branch of POGG. This is not so much under the general regulation of trade branch of trade and commerce, because it doesn't allow regulation of a specific industry, and that's what we're dealing with here.

The national concern branch of POGG, as I discussed earlier, just asked if this is a question of national importance. I don't think there is any doubt about that. Is it a subject matter that's defined with sufficient focus and specificity? I think there is an argument that it is.

In thinking about that, is this something that the provinces can deal with effectively, acting on their own? There are arguments, of course, that while they have dealt with this subject for some time, there are serious problems in accessibility and in achieving affordable prices of drugs as a whole that can only be addressed through a national program.

If you accept that argument, then I think there is a powerful basis for using the POGG national concern branch, but it would mean going out on a limb that Parliament rarely climbs out on, and it's not completely sturdy.

● (1135)

Mr. Ramez Ayoub: I see.

Mr. Attaran, maybe you have a different opinion.

Prof. Amir Attaran: Professor Ryder is right: this is the one point on which I think we do disagree.

I am more pessimistic about using POGG for pharmacare legislation federally. I do not think it would work. "Doomed" is not the word that I would use, but "Hail Mary, faint hope" would be.

I would not encourage Parliament to try to solve this problem in such a way that—because it does need to be solved—would be hinging on a legislative basis of tenuous or very tenuous reliability.

The Chair: Your time is up.

Go ahead, Dr. Carrie.

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

I want to thank both professors for being here today. I found your testimony incredibly enlightening, a real eye-opener.

Professor Attaran, when you commented that we're putting you in a difficult position, we love doing that.

Voices: Oh, oh!

Prof. Amir Attaran: Thank you.

Mr. Colin Carrie: We're parliamentarians who love to put lawyers in difficult positions to see the different opinions because, really, it's essential.

You talked about defining what pharmacare is. I think it would be prudent for us, as a committee, maybe, to get the minister here, just to see how she sees that, because we have a huge scope here, which could go a number of different ways.

I think it was Professor Ryder who said that constitutionality is an important aspect, but I think it's an essential aspect.

I remember dealing with some of these issues years ago. I think it was a witness who said that to get agreement on how to amend the Canada Health Act, it might be easier just to get rid of the provinces and territories and have one central government do it.

Right now things are clearly defined, in terms of what is provincial jurisdiction and what is federal jurisdiction. I think we have some challenges because of the modern expectations that Canadians have—in other words, "a Canadian is a Canadian is a Canadian." We hear that a lot. Maybe in Ontario you should be treated the same as in Alberta, but there are certain realities out there that mean that Canadians aren't quite equivalent, depending on which provinces they're in.

I would like to follow up, Dr. Attaran, on some of the comments you made.

You mentioned that it might be best to follow through with a series of contracts. How would you see this? Could you expand a little bit on the idea of common buying agents, or private law versus public law? I was wondering if there are even any precedents for that. Do we have precedents?

Prof. Amir Attaran: An interesting precedent is in a place with far better weather than our own, the Caribbean. The Caribbean nations buy a lot of their drugs together because each of them is tiny. They pool their purchasing power and negotiate for the best possible price. What our provinces have done is not negotiate. There are about 15 medicines for which the pCPA has sought a lower price, but rather than negotiate for the best possible price, they adopted a rule, and the rule says that they will pay for the generic version of a drug 18% of the price of the brand version. Therefore, if the brand version of the drug cost $1, the provinces have said, for these roughly 15 medicines, they will pay 18¢. Not 19¢, not 17¢, but 18¢. That's an arbitrary price mechanism. If I offered you a lump of coal for $100, and you said, "You're robbing me blind. I'll only pay you $18", and I sold it to you for $18, I'd still be rather happy selling you a lump of coal for $18. I would have made a considerable profit. This is the foolhardiness of the system that now exists. The pricing between the provinces is set by fiat at the arbitrary 18% price point, not through negotiation.

You could do contracts that would create a negotiation structure. I think that's the best way to solve this.

● (1140)

Mr. Colin Carrie: I like that idea, but just as a little aside, Santa has been giving me a lump of coal for years for free, so that's actually the best price on that.

You also mentioned the Competition Bureau. I'm interested in that idea. I don't think anybody has brought that up. Could you expand on that?

Prof. Amir Attaran: Consider the provincial formularies right now. A formulary is a list of medicines that are reimbursed by the provinces. You'll often find for a given drug two, three, four, five, six—some number of suppliers—for that drug, and the price that the province is willing to pay to those multiple suppliers is always exactly the same. If you have suppliers A, B, C, and D, for example, the price for A, B, C, and D is the same, which suggests there's been no effort made to bargain A against B against D to arrive at the best price.

This is a kind of price fixing in which our provincial governments are ignorantly complicit, and it merits the attention of the Competition Bureau. The Competition Bureau did study this market. I believe it was in 2008. They produced some wonderful research. Since then the Patented Medicine Prices Review Board has also produced stellar research. Everyone agrees that Canadians pay far too much, particularly for generics, but no enforcement action through the Competition Bureau and Competition Tribunal has come about. That's got to be a missed opportunity.

Mr. Colin Carrie: That's actually a great idea.

Maybe I could ask Professor Ryder this question. We had a witness named Madam Flood here to talk about the national formulary, and she was suggesting that it could be created through a voluntary arrangement and that this would be the best way to do it. Would the Canada Health Act or anything along those lines have to be amended if the provinces and territories sat down and came up with these types of arrangements?

Prof. Bruce Ryder: I don't think so, because that could be agreed to as part of the negotiations between the federal government and the provincial and territorial governments. However, it might be a good idea to amend the Canada Health Act because if it's amended to provide coverage for drugs administered outside of a hospital, of course the obvious question is, which drugs?

If we're limiting coverage to drugs administered in hospitals, then there's a built-in control mechanism, in a sense, but if we extend it, then the question of the boundaries of which drugs are covered need to be defined, and they can be defined through negotiation and agreement, and not addressed through the act. It might be a good idea to have it specified in the act itself, so that, for example, the amendment could read something like "provinces are required to provide coverage in accordance with the principles in the Canada Health Act of drugs administered outside of hospital" and the drugs that are covered could be defined as those that are on a national formulary.

A national formulary could be established and maintained by the federal government. I'm not sure that there is any problem with that. The argument against it, of course, as I specified earlier, is that at some point you're not just passing legislation that's dealing with federal spending but you're getting a little too detailed. You're going beyond general principles. You're putting some nitty-gritty of the way this operates inside the legislation itself, and maybe that amounts to regulation of matters that fall within provincial jurisdiction.

Given the need to define physician or hospital services inside the Canada Health Act already, I don't think it's all that different from the existing structure of the act to say that we're going to extend coverage to drugs administered outside hospitals, and here are the drugs.

● (1145)

Mr. Colin Carrie: You pointed out something that I think is going to be a challenge regardless. I've seen different conversations over the years, and as I think was mentioned by Professor Attaran, sometimes Quebec has a separate idea about what's going on and what jurisdiction is, and about communicating and co-operating with the rest of the provinces and territories in areas that have been specifically for provincial jurisdiction.

Since we sometimes have these asymmetrical agreements with different provinces and territories, if we did go down this route, are there available options for provinces and territories that may not like what the federal government is proposing if they wanted to challenge it? How would you see that being brought about? Do they have mechanisms right now, or would we have to change them?

Prof. Amir Attaran: Professor Ryder is suggesting an option for sure, and it would require the legislative changes he described. I assume touching the Canada Health Act is politically very hard, so people would rather avoid it. This is part of the reason I suggest you could achieve exactly the same thing through a series of contracts. Provinces that wished to could enter into a contract with the federal government to have a formulary based on their relations under this contract and to take steps X, Y, and Z to negotiate prices on behalf of all of them. To make that powerful, they would each agree not to strike separate deals with pharmaceutical companies, so they could not be divided and conquered.

If contractually the provinces band together such that none of them can split and purchase medicines separately, you have just created a system in which the maximum bargaining power exists. Whatever supplier wins a negotiation will supply all the provinces. They get the biggest economy of scale, so they can afford to bring their price down the deepest, and it can be done without legislation.

The Chair: Mr. Davies is next.

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

Thank you both for being here.

Many of us around this table came to the conclusion quite a while ago that the need to provide some form of universal pharmacare coverage for Canadians is absolutely imperative. We know that Canadians pay about the second-highest drug prices in the world. We know, depending on who you talk to, that between 10% and 20% of Canadians have no pharmaceutical coverage whatsoever, meaning there are millions of Canadians walking the streets today who have zero coverage to get the medicine they need when they get sick. We're really trying to figure out how best to deliver that.

If I understand you correctly, it seems that there are three broad routes. One is by agreement of the provinces and federal government. Nothing would preclude them, I understand, from coming to an arrangement. You call it a contractual model. Number two, there could be an expansion of the Canada Health Act. Number three, the federal government could go it alone on a stand-alone national program under one of the potential constitutional heads of power. Do I have that correct about the three basic routes?

Prof. Amir Attaran: You do. I would say number one is the most desirable and number three is the least desirable.

Mr. Don Davies: Right. I want to explore each one of those.

In terms of agreement, I'm told that in 2004, at the meeting of the Council of the Federation in Niagara-on-the-Lake, the premiers unanimously agreed to transfer responsibility for pharmacare to the federal government. and there was also unanimous agreement that Quebec would be able to opt out of that plan with compensation.

I'm unclear about that. Is that a contractual agreement or is that an agreement by the provinces to upload jurisdiction to the federal government? Is either of you familiar with that?

Prof. Bruce Ryder: I'm not.

Prof. Amir Attaran: I am, to some extent. I'm not aware of any contractual basis. I think that was a press release agreement that the various premiers got into. It has performed abysmally, because although the goal at the outset was to band together, combine purchasing power, and negotiate with the maximum purchasing power and therefore get the lowest price, what the provinces instead did was what I earlier called fiat pricing, or command pricing. They would pay 18% of the brand name price, never mind whether that's a realistic figure. They did have the intention of working together; they just did so in probably the most fruitless way possible.

● (1150)

Mr. Don Davies: Mr. Ryder, how many Supreme Court decisions have there been interpreting the POGG power, to the best of your knowledge?

Prof. Bruce Ryder: I don't know what the exact count is, but it's remarkable how infrequently the court has had to engage with the POGG power. A few from the modern era that are most relevant to thinking about its scope. There was the anti-inflation reference from 1976, which focused primarily on the emergency branch of the POGG power. The Crown Zellerbach decision from the Supreme Court of Canada in 1988 was of huge significance because the court, by a narrow majority in that case, assigned the subject matter of marine pollution to the "national concern" branch of the POGG power. The test set out in that case is still the guiding one. It was the one that I recounted earlier.

There have been others that have discussed the power, but not upheld federal legislation pursuant to it. Perhaps the most important one to be aware of is the Hydro-Québec decision, which was released around the same time, wherein the Supreme Court of Canada said the toxic substances provisions of the Canadian Environmental Protection Act could be upheld under the criminal law power, but the court was very hesitant to even think about upholding them under the POGG "national concern" power, given the concerns that we have about the depth of the impact on provincial jurisdiction.

Mr. Don Davies: I want to focus on POGG for a moment. This is my summary of this test. It says:

> The courts have interpreted this residual power to be available primarily in times of emergency, or when a matter of "national concern" arises.

Both of you have mentioned the "national concern" branch.

> For an issue to qualify as a national concern it must be indivisible, such that it would either be impossible for the provinces individually to deal with it, or it would require the cooperation of all of them, without which the country would suffer.

One of the things this committee has heard loudly and clearly is that one of the key ways that pharmaceutical prices can come down so that we could afford universal coverage is to have national purchasing, bulk buying. I'm going to put it to you that this is impossible without the co-operation of all provinces or that it's impossible for the provinces individually to deal with because you can only have a national bulk buying program with all of them.

Mr. Ryder, you've indicated more optimism. Dr. Attaran, you've been less optimistic. Do you think that would provide an argument to the Supreme Court of Canada as to why POGG may be appropriately applied to get national pharmacare? It seems to me that it fits that test quite well. Can you comment?

Prof. Bruce Ryder: I think you'll hear two different stories. I agree; I think it does fit that test very well. We talked earlier about the securities reference, which of course was focused on a different power.

Similar arguments, of course, were made by the federal government in support of the proposed securities act—that is, that it would be more efficient; uniform regulation is desirable in the area, for a number of reasons; and that if we don't have 13 different securities regulators in each province and territory but one national securities regulator, there are real advantages.

The court essentially said that arguments based on efficiency and the value of uniformity aren't sufficient to take a matter that's been within provincial jurisdiction for so long and pull it into federal jurisdiction. The test that the Supreme Court of Canada has articulated for determining whether federal legislation fits under what's known as the general regulation of trade branch of the trade and commerce power is different from the test for the national concern branch of POGG.

The courts have articulated a provincial inability test as something that's beyond the capacity of the provinces to address effectively. It doesn't weigh quite as powerfully in the POGG national concern jurisprudence. In fact, the way it was phrased in the Crown Zellerbach decision from 1988, which is the leading case, was that it is “relevant to consider” provincial inability; it didn't say that the federal government had to demonstrate that it is met.

As a relevant factor about whether this a matter that's truly of national concern, requires national leadership, has transcended provincial capacities, and has sufficient specificity to not upset the balance of the federation, I actually think that's a decent argument, but there are reasons to be cautious because of how careful the courts are about preserving the balance and the division of powers between Parliament and the provincial legislatures.

● (1155)

Prof. Amir Attaran: Perhaps I can have just a quick response to that.

You've put your finger on absolutely the best constitutional hope for legislation to survive, and everything you said was correct, but despite that being the high-water mark of constitutionality, it's still pretty low because of how few cases have been decided under POGG and the fact that you do currently have nine out of 10 provinces co-operating to bring down drug prices. The only province that isn't co-operating isn't there because it doesn't want to be. That's Quebec.

While provincial inability isn't a hard test, it's a consideration, as Professor Ryder said. He's exactly right. That consideration is not on your side.

The Chair: Mr. Oliver is next.

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

Thank you very much for a very informed presentation from both of you.

I just want to say, Mr. Attaran, that as Mr. Davies said, many of us are seized not just with the fact that we're overpaying for pharmaceuticals. What's more important to me is that many Canadians are uncovered, uninsured, and cannot afford prescription drugs. I think that pool is growing with the changes in the workplace and the changes in jobs.

My questions, then, are not just about pricing strategies; they're about how to include all Canadians in a coverage model. If you could broaden your answers a bit beyond just pricing, that would be helpful.

It seems that we're dancing around a whole lot of things, yet we already have a very well-established mechanism at the federal level to ensure coverage, which is the Canada Health Act.

First, going back to the Medical Care Act and the 1984 CHA, have there been any constitutional challenges? As well, is there any reason to think that this vehicle is insufficient for us to redefine insured services?

Prof. Bruce Ryder: I'm not familiar, Mr. Oliver, with any challenges to the Canada Health Act as a valid exercise of the federal spending power. There have been a number of challenges to other federal spending statutes in a variety of contexts. There's a significant body of case law now in which, for example, in the context of the Canada assistance plan, in the context of federal spending, and in the context of housing, where the courts have approved the exercise of the federal spending power in areas of exclusive provincial jurisdiction with conditions attached, the implication of those decisions, even though they're not dealing with the Canada Health Act itself, is the same reasoning that would lead to the conclusion that it's a valid exercise of the federal power.

Mr. John Oliver: I understand the intrusion and the problems we have when we intrude into provincial jurisdiction. Do you feel that simply broadening the definition of insured services under the Canada Health Act to include prescription pharmaceuticals would violate provincial jurisdiction?

Prof. Bruce Ryder: No, I'm quite confident that would be a valid exercise of the federal spending power. Of course, it would depend on the degree of specificity that's build into the act. Right now we have general principles and general definitions, and much of the detail is left to negotiations. If that kind of structure were to fall out, I think there would be zero doubt, but if you decided to go further and seek to define with some specificity which drugs are covered, through the inclusion of, for example, a national formulary as part of the regime, there may be more doubt. However, I still think that would be consistent with jurisprudence on the federal spending power.

● (1200)

Mr. John Oliver: What would the federal government have to add to that to make it a federal spending authority decision or a federal power? If we redefine what's insured, is there a need then to also address a spending allotment with that? Can you or Mr. Attaran broaden that out for me a bit?

Prof. Amir Attaran: I want to rewind to something you said at the beginning. You very wisely said there are two issues on the table. One is getting prices down; the other is increasing the number of people who get drugs, increasing the coverage. Those are indeed two issues, but there is a question of sequencing that needs to be thought about.

We would all like the drugs to be cheaper. We would all like more people to be covered. We all agree it's a travesty that those realities evade us now. Instead of trying to attack the coverage problem first and the pricing second, I think you should do it the other way around, because any step you take to increase coverage, whether it is federally mandated or whether it is with a federal carrot in the form of the spending power, will meet with greater resistence when the prices are high. If you instead tackle the price reduction problem first, you effectively create a surplus of health dollars that already exist, because you've just saved money by reducing the prices, and that reduces the political friction about increasing coverage to more people.

In other words, if you bring the prices down first, you create some budget breathing room in which you can ask for more people to be covered.

Mr. John Oliver: My concern, though—and I might have the industry wrong here—is that the work that's being done through the provincial, territorial, and now federal efforts to lower prices is for the federally and provincially insured expense. The private drug costs are not necessarily captured in those. The first costing that's done by the PMPRB is national costing, so we miss lowering the cost of drugs for the people who need them the most.

I would argue that for a single mom with three kids, on a partial income, lowering the price of a round of antibiotics from $300 to $250 does not make it any more accessible to her and does not do anything to allow her to treat her children the way we would treat our children with a—

Prof. Amir Attaran: That's true, but when you do lower it from $300 to $200, you decrease the pain on either the federal government or the provincial government, or both, to bring her into a formal coverage scheme, because it's less expensive to do so.

I'm not disagreeing with you. I'm just trying to invite you to think about the critical path to the goal we both want. That path is to bring the prices down first so that the expansion of coverage is less costly and therefore encounters less political friction.

Mr. John Oliver: As we move forward with whatever the order is, we currently have a large insurance industry that is underwriting a lot of the pharmaceutical costs that are not federally or provincially covered. I am thinking back again to 1963 or 1964, when we introduced the Medical Care Act and we had all kinds of hospital insurance programs that all got set down to a single-payer model. Are there any barriers that they could raise to the federal government introducing the concept of a single-payer model, which is what the Canada Health Act really does? If you think about the other principles...it's publicly administered.

Prof. Amir Attaran: This again goes back to my point about asking what the critical path is. Of course we can imagine scenarios in which the insurance industry would not be terribly delighted with your plans, but if the project begins by making the drugs less expensive, you're helping the industry, so you're much more likely to get their buy-in. When they see that the very first thing that Parliament is targeting is to lower what they must pay out for drugs, you've begun the relationship on the best possible basis to win their co-operation for later steps.

● (1205)

Mr. John Oliver: I think that encompassing pharmaceutical drugs under public administration, which is a single-payer model, gives teeth to the negotiators of the provinces and territories that they don't currently have for this particular broad swath of uninsured people.

It's very difficult to have that negotiation happen across multiple, different insurance schemes. The single-payer model in the Canada Health Act would give them the authority to make those changes.

The Chair: Was that a question?

Mr. John Oliver: No. I thought I was out of time. I was just making a final comment.

The Chair: Okay.

Mr. John Oliver: I could phrase it as a question. Do you agree?

The Chair: If there's an answer to your comment, you're welcome to answer it.

Mr. John Oliver: Why not?

The Chair: Do you want to answer that or make a comment?

Prof. Amir Attaran: It was a sensible comment.

The Chair: All his comments are sensible.

Moving to our five-minute round, we'll start with Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you for being here today, Professor Ryder and Professor Attaran.

Professor Attaran, near the end of your presentation you made some comments that you didn't have time to elaborate on. First of all, you mentioned that the Canadian drug manufacturers are manufacturing drugs, but we're paying more here in Canada than in other areas around the world. You said we pay too much for generic drugs.

You mentioned the Competition Bureau and how we should perhaps have them investigate. Can you elaborate on what you were saying in your presentation?

Prof. Amir Attaran: As I mentioned earlier, when you have a single drug product on provincial formularies supplied by two, three, four, five, or some number of different companies, the agreed price is the same for all those companies on the formulary. Hypothetically it might be 50¢ for all four suppliers. That does suggest the four suppliers are not fighting it out for price.

Why is that? The reasons are murky at best. Part of the failure of the provinces to deal with the drug price problem is that they're secretive. How these prices are arrived at is not known. The agreements that pCPA has negotiated for product listings are entirely a black box. Anecdotally, what I've heard is that the prices in the formulary are fictions. The way the manufacturers compete against one another is in the rebates they give to various partners in the supply chain. “Rebate” is a polite term for kickback.

In Ontario, these rebates have been legislatively prohibited for some years now, but the drug manufacturers are very clever at finding end runs around that law. What really is happening in the industry, I'm led to believe, is that the nominal prices listed in formularies, such as the 50¢ I used in the example before, are really fictions. Suppliers one through four will fight it out with each other by how much they can slip to other partners in the supply chain to get their product instead of someone else's onto the pharmacists' shelves.

None of that smells to me as clean business. No professor is going to succeed in getting to the bottom of it. I've tried. Most of the information I'm using to relate the story to you is highly anecdotal. You would need the Competition Bureau, which has the power of summonsing documents and compelling witnesses, and likewise the Competition Tribunal, to better understand how this price-fixing system is working, but have no doubt that there is a price-fixing system.

Mr. Len Webber: That's very interesting. Maybe that's a project we can move into.

Mr. Chair, I'll make a motion....

No, if it's okay, Mr. Chair, I'm actually going to pass the rest of my time on to my colleague here.

● (1210)

Mr. Tom Kmiec (Calgary Shepard, CPC): Mr. Ryder, I have a question for you, and I'll take it from the securities decision rendered by the Supreme Court of Canada. I'm going to read the paragraph right before the one in which it rules in the negative. It says:

> It is a fundamental principle of federalism that both federal and provincial powers must be respected, and one power may not be used in a manner that effectively eviscerates another.

I assume this is judge-speak for you can't do this, ever. I would assume they don't use a term such as “eviscerate” very often.

It then goes on to say:

> Rather, federalism demands that a balance be struck, a balance that allows both the federal Parliament and the provincial legislatures to act effectively in their respective spheres. Accepting [the Government of] Canada's interpretation of the general trade and commerce power would disrupt rather than maintain that balance. Parliament cannot regulate the whole of the securities system simply because aspects of it have a national dimension.

How would that differ if a case were to go before the Supreme Court using POGG—peace, order, and good government—and how would they not use this principle that you cannot eviscerate the powers laid out to the provinces in the Constitution by using another section? The federal government can't shop around the Constitution for a section that it prefers over another in order to legislate a public policy goal. Could I get you to comment on that?

Prof. Bruce Ryder: I appreciate the question. The passage you've read is an important one, and it expresses themes that we can find in many different cases involving the interpretation of the division of legislative powers. The Supreme Court of Canada is very concerned about a balanced approach and prefers co-operative solutions, and the securities act reference is a prime example of that.

However, each head of power has its own distinct characteristics and the interpretation of its scope and limits is different, so the national concern branch of POGG is a little bit different from the general regulation of trade branch of the trade and commerce power. It's helpful in thinking about whether this a subject matter that could be upheld under the national concern branch of POGG. It's helpful to keep in mind those concerns for sure, but also to keep in mind what subject matters have been allocated in the past to the POGG national concern branch, what the features are that they share, and whether we could we say that elements of pharmacare share those features.

What are those subject matters? In the modern era, it's aeronautics, and not just international or interprovincial airline traffic, but all, including all the local aspects.

It's nuclear power.

It's the national capital region. The zoning of the national capital region would normally be provincial or municipal, but as you know, it is conducted to a large extent by the federal Parliament.

It's marine pollution in the Crown Zellerbach case.

What the court said, or has said, and what scholars have said about this handful of examples—because that's really all we have from the modern era—is that they're each specific and focused in their definition so that they don't upset the balance in the division of powers to a great deal if we allocate them to exclusive federal jurisdiction, because that's the effect of the POGG national concern branch. It's as if you had a new head of federal power. It's as though marine pollution is now written into section 91, as well as aeronautics and the other examples I mentioned. They're very specific in focus. The words the court uses are not too diffuse; they're not so lacking in definition that they have no bounds that we can identify.

The other argument that has been made in the scholarship and in the case law is that the provinces lack the ability to deal with the matter effectively. If we were to leave some aspects of the regulation of air traffic, for example, to local governments, there would be serious risks for the safety of travel by air, and there's a strong case for national, and indeed international, regulation.

The Chair: Thanks very much.

Now we have Dr. Eyolfson.

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

I found this very interesting. This is outside my training. I'm a physician, although I was raised by a lawyer. In retrospect, he's right. After listening to this, I know I would have enjoyed law.

I've been looking at this from a physician's standpoint. I see things like the first-hand adverse effects on the patients who can't afford their medications and the data as to the potential cost to the health care system. This has been very near and dear to my heart, this whole study.

We've been going through these different points, which are fascinating, about the different routes we can take. You had the question, what would this look like? You would have liked having that question beforehand.

We'd like to have something to give you. I'd like to propose a scenario to review, to see if you see any bumps in the road with this arrangement.

If you started with a group of medical experts and you had an evidence-based formulary and they said, "These are the drugs that are essential, and they will be covered. We will only cover the generic versions of them. We won't cover anything more expensive than what has been proven safe." Now we'd have this evidence-based formulary. That's step one.

Step two, have the federal government negociate one bulk buy of all these items on the list for the provinces. Step three, apportion these drugs to the provinces. You will give these to people who need them, free of charge. We've paid for them. They're covered. Then, if the province wanted to offer additional coverage of any other drugs, you wouldn't be stepping on their toes on that. Can you think of anything under Canadian law, the Constitution, or anything that would prevent that or cause any legal challenge?

● (1215)

Prof. Amir Attaran: What a beautiful way of breaking it down. The short answer to your question is that all of the above points you mentioned are doable. The devil is in how you do it.

On the very first one of a national formulary, we do actually have that. We must remember that the common drug review and the pan-Canadian oncology drug review do exist. It's a co-operative federal and provincial project that decides which drugs, using the conventional tools of health technology assessment, are clinically effective and considered good value. Where that is not delivering its promises, even when CDR or pCODR, to use their acronyms, make a positive recommendation for a drug to be paid for by the provinces, is when the provinces say they won't, as they frequently do. There's an enormous gap between the evidence-based choice of drugs for a formulary and which ones actually get paid for.

As to your second point about the federal government doing a bulk buy, I would slightly modify it. I'd say that what you want is a contractual agreement between the federal government and the provincial governments to do the bulk buy through a shared entity. I don't think the federal government can do that without provincial support; otherwise, it would possibly be purchasing drugs in excess of what the provinces need, or too few. You'd want some coordination there.

If you did that—the second point contractually, and the first point by building on the CDR and pCODR that already exist—you're only left with a question of how you expand coverage. My point earlier to Mr. Oliver was that if you bring the prices down first, you will find it much more politically acceptable, at all levels of government, to increase coverage. No one wants to increase coverage with expensive drugs. People would be much happier to increase coverage with cheaper drugs.

Mr. Doug Eyolfson: Thank you.

I was expecting a longer answer, but that's such a great answer. I was expecting a longer answer because I thought there had to be some holes in my reasoning, but there didn't seem to be that many.

Prof. Amir Attaran: It was an elegant way of framing it.

Mr. Doug Eyolfson: Well, thank you.

Getting on another topic, this is off to the side. From the point of constitutional law, I guess it's section 7 of the Canadian Charter of Rights and Freedoms that says, "Everyone has the right to life, liberty and security of the person...." When between 10% and 20% of Canadians can't afford their medication and face possible adverse health outcomes because of that, is there a possibility that someone could make a case under the Charter of Rights and Freedoms that they're being denied those rights by the absence of a program to help them?

● (1220)

Prof. Bruce Ryder: Thank you, Dr. Eyolfson. That's also a good question. There are, of course, charter implications to this topic. They rise not just under section 7 but also potentially under section 15 of the charter, which prohibits discrimination.

Let me say a quick word about each. I don't think there's a strong chance of a challenge succeeding pursuant to section 7. The main reason is that the courts have defined it as exclusively a negative right and not a positive right. This means that it prevents governments from putting barriers in the way of access to medicines that are necessary to people's physical and psychological health, which is how the court defines security of the person. However, it doesn't require governments to provide access to necessary health services or medicines. That's a negative right, not a positive right. Therefore, the argument that there are existing economic barriers and other barriers that prevent people from accessing the medicine they need will only work as a section 7 argument if the claimant can point to government action that has created that barrier. This, I think, is the stumbling block.

Where section 15 can potentially come into it is that once governments have undertaken to provide benefits, they have to do so in a non-discriminatory manner as a result of the protection of equality rights in section 15. This includes in a manner that avoids discrimination on the basis of mental or physical disability. That's more likely to be the context in which a charter challenge could arise. That's because it's a mix of a negative and a positive right, in the sense that once government has undertaken or initiated a program, it has to follow through in a non-discriminatory fashion. That's the positive aspect of it, if you like. Government can be compelled by the courts to go further and provide further benefits or further access than it has.

That's a possible argument, but it's always hovering over the provision of any benefit.

The Chair: Time's up. Thank you.

Mr. Kmiec, go ahead.

Mr. Tom Kmiec: I'm not going to continue reading from the court decision, but I want to ask questions about this provincial inability versus provincial inaction. Both of you have referenced these two different things, and it sounds like our provincial cousins do try to manage the cost. They just do a bad job of it. I'm seeing some heads shaking.

There are other politicians doing something. They're trying to manage these costs. They're getting into agreements with companies. They're just not doing it very well, but they are acting in concert, so it's not that there's an inability; there's just slow action or poor action.

If government at the provincial level is not getting it done, why would government intervention at the federal level fix it? If government is getting it wrong, why would more government fix it? I always start from that point. I'm from Alberta, so I can't help but say that. More government doesn't seem to be the solution.

Professor Attaran, I think you said the price-fixing was by fiat. It just kind of happens. It's very nebulous. There's not a lot of information on how that goes. Wouldn't that then happen to the federal government? Whatever mechanism you use to move it to a federal sphere, jointly or co-operatively, wouldn't the federal government then experience those exact same problems? If you cannot pinpoint exactly where the issue is and you cannot define it, study it, look at it, and really understand it, then why would moving it to the federal sphere fix it?

Prof. Amir Attaran: Each level of government is susceptible to different sorts of pressure from different lobbies. What the federal government is susceptible to by way of pressure is very different from what an individual province might be susceptible to, and it varies province to province. Ontario has a rather big drug industry within its borders; Saskatchewan does not. Based on that, you might predict that Saskatchewan would be more willing or more capable of being aggressive on prices than Ontario before the premier's phone rang and threats were made to close a factory or that sort of thing.

I don't accept the premise of your question that simply shifting from one level of government to another replicates the problems in that other level of government. You would just create a different set of problems, but perhaps ones that are more amenable to being solved.

● (1225)

Mr. Tom Kmiec: What do you mean by “amenable to being solved”? Is it because the federal government, versus a smaller provincial government, would have greater powers to compel certain action?

A good example is Ontario. Ontario is not just another province; it is the biggest province in Canada, with far more ability to constrain companies within its jurisdiction. I can understand a small province, maybe in the Maritimes, not being able to. You know, you only have so many public servants who can do so many tasks. There's the scarcity of time, the scarcity of resources, so what would these problems be? You're saying they would be different and not similar. You just wouldn't shift the problem, but I just don't see how that would fix it.

Prof. Amir Attaran: I think it would change it. I'm certainly not meaning to say that if you removed many functions of medicine purchasing from provincial hands and placed them in federal hands, automatically the birds will sing, the sun will shine, and people who are ill will spring out of their beds. That's not my contention at all. Rather, my point of view is this. Each province is now doing a job of bargaining for price, and each one of them offers a certain market size to a supplier. The larger the market size, the more pressure they can bring to bear on the supplier for a volume discount. Obviously if you're buying 10 units of something or buying 100 units of something, you'll get a different price, and if you're buying more you'll get the better price.

If the provinces aggregated their needs and involved the federal government, without necessarily placing the federal government in charge but through a partnership that is contractual in nature, we would then have an aggregated national requirement that could be supplied in a single transaction—or maybe two or three, a small number. Plain economic theory says we're going to get a better deal doing that.

Thus far the provinces have not cohered in this way. They've tried to cohere, but they haven't done it well. I gave them a D as a grade. I would like to give them something better, but I think that will only come about with a greater federal role and perhaps some use of the spending power. As Professor Ryder says, where there's a carrot in terms of federal money, you'll get co-operation that wouldn't otherwise exist.

The Chair: Go ahead, Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, professors, for giving us testimony. It's very knowledgeable.

I know we've already discussed that generic drugs are very expensive and that Canadians pay the second-highest drug prices in the world. You also wrote an article in the *Toronto Star* entitled "Canada is Needlessly Bleeding Money on Generic Drugs". In that piece, you point to Canada's high generic drug prices and you mention Australia and New Zealand. We just heard from the representative from New Zealand in this committee. Can you point out why you think these countries have an easier time getting in competition? Also, you are giving a D grade. How we can get to an A?

Prof. Amir Attaran: I think that's the subject of our entire hearing and your entire study. I think it's tremendously important to get to an A, and I trust this committee will find a way.

The brief answer to how New Zealand does a better job or Australia does a better job is that they purchase medicines following a negotiation, and our provinces in many cases do not. When prices are set, they're set by fiat, by some arbitrary percentage of the brand name price. You'll set a generic drug at 18% of the brand name price. Formerly in days past, that was 25% or 35% or 40%. The percentage keeps dropping, but it's always arbitrary. Eighteen per cent of the brand name price may be a great deal for one drug and it might be a blatant rip-off for another drug. Why would you do it this way? What Australia and New Zealand do is bargain, drug by drug.

● (1230)

Ms. Sonia Sidhu: Do you recommend some kind of agency to do that, one agency or province by province?

Prof. Amir Attaran: As I said earlier, I think if the different provincial buyers came together under a federal umbrella and aggregated their needs, then you would have the maximum economic leverage. You would have what economists call a monopsony situation to procure drugs at the best price following a negotiation with all the suppliers who could meet your needs.

Ms. Sonia Sidhu: Thank you.

Mr. Ryder, you have written many articles and papers about Canadian federalism and have suggested an approach of greater provincial autonomy.

Can you speak to this view in light of the current discussion? How do you now classify the need for reformulated federalism and how would that impact a national pharmacare plan?

Prof. Bruce Ryder: How would a renewed approach to federalism do that?

Ms. Sonia Sidhu: Yes.

Prof. Bruce Ryder: I'm not sure I totally understand what kind of an approach you're imagining, but let me just speak to the direction in constitutional law about the nature of our federation, which I think is very well articulated by the Supreme Court of Canada. It is focused on an idea of co-operative federalism and balanced federalism that really leans towards negotiated solutions and contractual solutions and puts a high premium on intergovernmental negotiations.

An area like this, where there's both a strong demand for national leadership and the establishment of basic norms that express fundamental Canadian values as well as a long-standing tradition of provincial jurisdiction in relation to hospitals and the regulation of medical profession and the delivery of medical services, is a context that fits well with the conception. The only way that can really happen is through a co-operative approach of some kind, whether it's contractual or whether it's through interlocking legislation.

I think that's the dominant approach at the moment. Of course, there are many different approaches, and some would argue that it doesn't leave enough room for national leadership and that doctrines such as that the national concern branch of POGG need to be tested by Parliament. We don't really know what their boundaries are because we so rarely test them.

The Chair: Thank you very much. Time is up.

For our final round, we go to Mr. Davies.

Mr. Don Davies: Thank you.

I have only three minutes, so I'm going to ask you all to be as brief as you can.

Under what constitutional head of power is the Canada Health Act passed?

Prof. Bruce Ryder: It's a valid exercise of the federal spending power, so it's not any single explicit power, because it's not mentioned anywhere in the Constitution, but it's a combination of the federal taxing power in class 3 of section 91 and the power to dispose of public property.

Mr. Don Davies: However, health is mentioned in the Constitution, and it is explicitly provincial.

Prof. Bruce Ryder: Not the word "health", but hospitals, yes.

Mr. Don Davies: It strikes me after listening to all this that the very easiest way to do this constitutionally is to just expand the Canada Health Act, which already provides for universal, free, publicly administered services.

The example that I think of is that if I cut my finger, I go to a doctor. I walk in. The doctor looks at me. He treats me by sewing up my finger. I walk out of there. I never see a bill. The bill gets paid. It's done.

If I went into the doctor and got diagnosed and the treatment was not stitches but a pill, he would write a prescription. I go to the pharmacy. I pass the prescription. I walk out of there with my pills. I never see the bill.

Can we not just expand the Canada Health Act on exactly the same constitutional basis, on exactly the same principles by simply expanding the medical services to a different kind of treatment, which is pharmaceutical treatment as opposed to surgical or some other intervention?

Prof. Amir Attaran: That's one way to do exactly what you said. The other way to achieve exactly the same outcome is through the series of contracts that I mentioned. Both are equally possible goals to get to where you want to go.

● (1235)

Mr. Don Davies: Finally, Dr. Greg Marchildon, who is at the University of Toronto, has commented on the two options. The first is the one I just mentioned, which is the traditional program financed by the federal government under a few national criteria and administered and financed for the remainder by the provinces and territorial governments.

The second option, he says:

> is a national pharmacare program financed and administered entirely by the federal government. While jurisdiction in most areas of health care is principally provincial, pharmaceuticals are one of the only subjects in which the federal government has a secure constitutional foothold. Coverage would be provided to all Canadians by the federal government and would replace private and public coverage plans currently in place with a single universal plan.

He says the way to do that is to give provinces the right to opt out. Therefore, if they opted out, Bob's your uncle. Is that also a second possibility for the federal government or is that...?

Prof. Bruce Ryder: The difficulty with it is the suggestion that there's a secure constitutional footing. I'm not sure what Professor Marchildon was referring to. I read his testimony with interest and was wondering exactly what he meant by that. The existing secure constitutional footing is, of course, the Canada Health Act, the spending power; the criminal law power, which supports the Food and Drugs Act and regulation that's designed to ensure the safety of drugs and protect consumers from deception—those are valid criminal law purposes—and, of course, as I mentioned earlier, the federal patents power, which supports the Patent Act and the regulation of patented pharmaceutical products.

Those are the secure constitutional footings. What he's suggesting, it seems to me, goes beyond them. That's why we get into this debate that we've had today. Where's the home for that “beyond”? It's actually a new constitutional footing, and I don't think it's entirely secure, with all due respect for Professor Marchildon, because in my view it means, as I've suggested, testing the limits of the national concern branch of the peace, order and good government power.

The Chair: Your time's up.

Prof. Amir Attaran: Very quickly....

The Chair: Yes.

Prof. Amir Attaran: I agree with everything that has been said. I think the statement that there's a secure constitutional footing is a little too optimistic.

The Chair: That completes our hearing with our witnesses.

I want to say that we get some incredible witnesses here, but you two have brought a whole dimension that we haven't heard before. I want to compliment you on your presentation. If we do manage to get from a D to an A, you have helped us a lot.

I want to say to the committee members too that I think they have done a really good job of getting the right questions out and getting the answers.

Thank you very much for coming. It has been a very interesting meeting.

We're going to break for a second, and then we're going to go into committee business.

● (1235)

(Pause)

● (1240)

The Chair: Let's reconvene. I need the members of the committee to listen to me carefully, because I need some help. I want to try to accommodate everybody's wishes here and I want to explain where we are.

This morning when I came in, we had an agenda for our committee business. That entailed, first of all, passing the subcommittee report. That was my intention when I came in. Then I ran into Dr. Carrie, and Dr. Carrie asked if we could move the thalidomide report up and not do it in camera. It seemed like a reasonable request until the clerk reminded me that we have next week off and that if we don't pass the subcommittee report, nothing will get done in terms of arranging witnesses, writing reports, and all those things, because the whole week will be lost.

Here's a proposal. If we can pass the subcommittee report in public without a whole lot of debate, then that requires us to go directly to the thalidomide report, and we'll never go in camera through the whole thing. If we do get into a debate on the subcommittee report and talk about witnesses, we have to go in camera. I have to do the subcommittee report and get that done first.

Mr. Davies, you're first.

Mr. Don Davies: I move that the committee adopt the second report of the Subcommittee on Agenda and Procedure of the Standing Committee on Health, and then move to consideration of the thalidomide report.

The Chair: I have to hear Dr. Eyolfson, but thank you for your motion.

Mr. Doug Eyolfson: I think it would be more suitable if we went in camera at this point.

I would like to make a motion that we do go in camera for committee business. We often go in camera for committee business because we're often talking about witnesses and other confidential names. We've had issues with security. I think that would be best.

I don't know if Don's motion is on the floor, and we have to deal with that first.

The Chair: I think we do.

We have to deal with Don's motion first, but Mr. Kmiec, do you have an issue?

Mr. Tom Kmiec: If we deal with the subcommittee motion with no debate and just approve it as is—I'm sure the analysts and the clerk have done a fantastic job of reading the transcript—I would like to deal with the thalidomide motion in public.

I'm afraid that if we move in camera, it's all going to be dealt with there. This committee has done a great job, compared to some of the other ones—

The Chair: No. That's—

● (1245)

Mr. Tom Kmiec: —of dealing with everything on the record.

The Chair: That's what I'm trying to do, but we have a motion on the floor.

Mr. Davies is proposing that we pass the subcommittee report as it is. There is one thing on issue 4. We called for the minister to be here today, and she couldn't be here. Other than that, it outlines the work plan and everything for the future.

Is there any debate on Mr. Davies' motion about passing the subcommittee report?

Seeing no—

Mr. John Oliver: Could we have a moment?

The Chair: Yes. We will take a moment.

Mr. John Oliver: Could you ask the question again?

The Chair: Is there any debate on Mr. Davies' motion? I see none.

All those in favour of passing the subcommittee report as is, please so indicate.

(Motion negatived)

The Chair: The motion fails.

Now we go to Mr. Eyolfson's motion to go in camera.

Mr. Doug Eyolfson: I move we go in camera for discussion of committee business at this point.

The Chair: Is there any debate?

Go ahead, Mr. Davies.

Mr. Don Davies: This committee adopted a practice at the very beginning of our committee deliberations, in our standing orders, to have committee business dealt with in public, except in a couple of specific situations in which it's appropriate to go in camera. Those are when we're discussing specific witnesses or when there's an issue of a potentially confidential nature.

We agreed at this committee not to go in camera when we're simply discussing committee business as such. That is what we're going to be talking about, so I'm curious. If Doug has a specific reason, and if one of those exceptions applies, I'd certainly be open to hearing it, but it's not the practice of this committee to go in camera simply to discuss committee business.

The Chair: The intention was to go in camera when I walked in the door, because I thought we'd probably be discussing witnesses for the pornographic study and so on.

Anyway, the clerk just told me that this motion is not debatable, so we have to go to a vote.

All in favour of—

Mr. Tom Kmiec: I have a point of order, Mr. Chair.

I'm not a regular member of this committee, but I've had the distinct pleasure of sitting on several committees of the House. I sat on the foreign affairs committee, which deals with far more egregious things.

This committee has always dealt with things openly, according to the transcripts, which I have read. Why can't you deal with the motion?

Mr. John Oliver: Mr. Chair, on a point of order—

The Chair: What's your point of order?

Mr. John Oliver: This is not a point of order.

Mr. Tom Kmiec: This motion, which was moved at committee on December 13, should not be dealt with in camera; it should be dealt with on the record, so that the public can be aware.

The Chair: We're talking about this committee going in camera to discuss the agenda that was drafted by the subcommittee. It's not debatable. We have to have a vote.

(Motion agreed to)

[*Proceedings continue in camera*]