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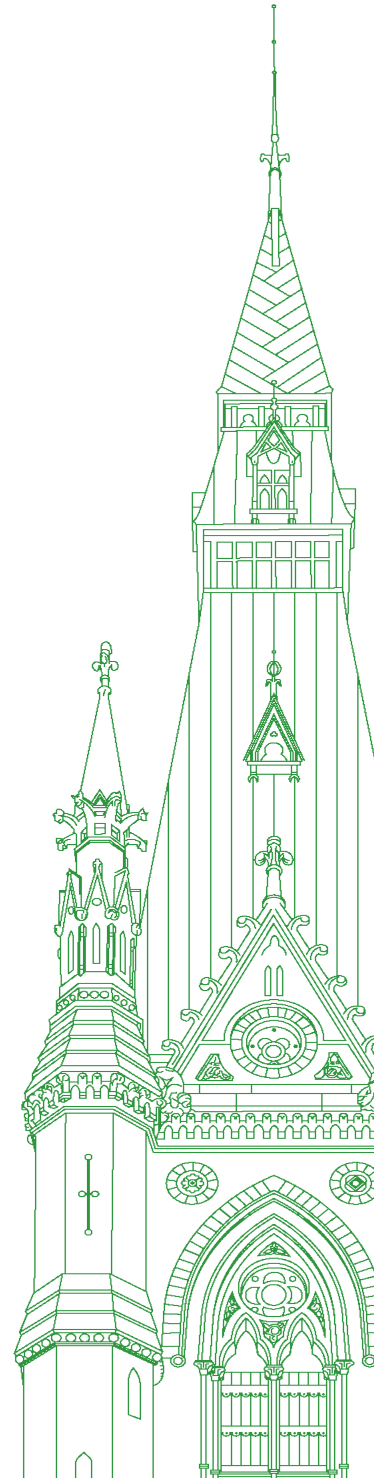

Chair: Mr. Sean Casey

Standing Committee on Health

Thursday, March 9, 2023

● (1105)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order. Welcome to meeting number 56 of the House of Commons Standing Committee on Health.

Today we meet with witnesses on our study of children's health. We'll then move to committee business at 12:30. One of the items we will consider is Bill S-203 and any other items that will come before the committee.

Today's meeting is taking place in a hybrid format pursuant to the House order of June 23, 2022.

To the witness we have via video conference, you will notice on the bottom of your screen that you have the choice of floor, English or French for interpretation. For those in the room, you have your earpiece and you can choose the desired channel.

Screenshots or taking photos of your screen is not permitted.

The proceedings today will be made available via the House of Commons website.

In accordance with our routine motion, I inform the committee that all witnesses have completed the required connection tests in advance of the meeting.

We'd now like to welcome the witnesses who are with us this afternoon.

[*Translation*]

I will now welcome Dr. Anne Monique Nuyt, chair and chief, department of pediatrics, faculty of medicine, Université de Montréal and Centre hospitalier universitaire Sainte-Justine, and Dr. Caroline Quach-Thanh, pediatrician and infectious diseases microbiologist, Université de Montréal and Centre hospitalier universitaire Sainte-Justine.

[*English*]

We have Cindy Blackstock, executive director of the First Nations Child and Family Caring Society of Canada.

Thank you all for taking the time to appear today.

Each witness has up to five minutes for an opening statement.

[*Translation*]

Welcome, Dr. Nuyt.

You have the floor.

Dr. Anne Monique Nuyt (Chair and Chief, Department of Pediatrics, Faculty of Medicine, Université de Montréal and Centre hospitalier universitaire Sainte-Justine, As an Individual): Thank you, Mr. Chair.

Good morning, everyone.

I'm going to give my presentation in French, but I can answer questions in English or French.

Thank you for having invited me to appear before you to discuss subjects of particular importance for us and our country. I'm a pediatrician who specializes in neonatal intensive care, and a clinician investigator. I also hold a tier 1 Canada Research Chair. As you pointed out, Mr. Chair, I am here before you as the chair and chief of the department of pediatrics, in the faculty of medicine at the Université de Montréal and Centre hospitalier universitaire Sainte-Justine.

I am also the president of Pediatric Chairs of Canada, an organization that represents 17 university pediatrics departments in Canada. Our mission is to train all of Canada's pediatricians and, for some of our departments, those health professionals called “subspecialists”, such as pediatrician-cardiologists and respirologists. Our mission also includes furthering knowledge through research, establishing best practices in pediatric medicine and enhancing the quality of care in our hospitals.

I'd like to speak to you more specifically about three key issues that affect children, for which we need your commitment.

The first of these issues is the number of subspecialists in pediatrics. I know that my colleagues have already appeared and mentioned the major problem of access to community care from nurses, family physicians and general pediatricians. But even if that problem were addressed, many children would continue to require specialist and subspecialty care. Unlike adult medicine, most subspecialty care is provided at university pediatric hospitals, because that's often where the small teams of doctors with the required expertise are concentrated, and able to provide and continue to provide a high level of care. As department heads, our role is to find, recruit and retain these specialists.

Most of our pediatric hospitals encounter major challenges in fulfilling this mandate. Of course, the places available in pediatric subspecialty training programs are a provincial jurisdiction. This means that there are a few programs in a number of provinces that train subspecialty doctors for the whole country. Without a national coordinated and collaborative workforce plan, it will be impossible to train enough specialists to deal with the needs of Canada's children. That means that we often look beyond our borders to recruit subspecialists.

For example, at the moment, 25% of the subspecialty doctors in my department at Sainte-Justine were recruited internationally. That in itself allows for rewarding exchanges of knowledge and experience that are beneficial to everyone. However, credential recognition can vary from one province to another, even in countries that provide recognized training, like Belgium, France and the United States. The immigration process around the world is, of course, slow and burdensome. That's why it will be important to adopt a coordinated interprovincial approach under national leadership.

The second issue I would like to point to on behalf of the entire Canadian university pediatrics community relates to the importance of access to quality data to accomplish our missions. We need data to support research into pediatric illnesses. We need data to set pediatric priorities for vaccination rates, obesity, developmental disorders and mental health in adolescents. And we also need data to monitor the quality of our specialist and subspecialty care

Every centre must, of course, compare itself to others to continue the provision and enhancement of care. Since we do not have many pediatric hospitals and because each specialty treats only a small number of children, it's often impossible to do comparisons between provinces, even the most populous among them. We believe that access to national data is a priority, particularly for quality pediatric care.

As for the third issue, I'd like to speak to you about access to children's medicine. As was clearly demonstrated by the work of the Goodman Pediatric Formulations Centre, under scientific director Dr. Litalien, Canada's regulatory arsenal is lagging well behind in promoting access to drugs for children in Canada, compared to other authorities like the United States Food and Drug Administration, the FDA, or the European Medicines Agency. The Goodman Pediatric Formulations Centre and the Institute for Safe Medication Practices Canada have in fact submitted a document on this topic to your committee.

There are two problems. The first is access to drugs, whether new or old, that could be used to treat children. For these to be available to children, companies have to request permission from Health Canada. Of course, the administrative burden of the process, combined with the small market represented by children, is not very attractive to the companies in question.

● (1110)

To address this, agencies like the FDA and the European Medicines Agency have, for more than 10 years now, introduced regulations requiring companies to submit an application for pediatric use, or to conduct studies on children, whenever they apply for approval of a new drug that might have a pediatric use.

We would like to point out that Health Canada has just set a priority on developing an action plan for pediatric drugs, and we are very grateful to them for this. We keenly hope that the experience of our international colleagues will be put to good use on behalf of Canadian children.

The second problem with medicines has to do with access to pediatric formulations—the syrups, if you will—of drugs that have already been approved for children.

It is of course important to have access to pediatric formulations for the treatment of children, and also important for the drug itself to have Health Canada approval, but it's equally important for the pediatric formulation to be tested, in terms of its concentration and stability, for example, in the syrup.

Here again, Canada lags far behind in its approval of pediatric formulations. To give you just one example of the scale of the problem, the pharmacy at our hospital, CHU Sainte-Justine, has to prepare its own in-house formulations for approximately half of the drugs, meaning that it has to crush the pill into a syrup. A formulation for this already exists commercially and has the approval of the FDA or the European Medicines Agency.

The pediatric community is therefore requesting that the regulatory structure based on decisions from trusted countries, and also currently being studied by Health Canada, be considered a priority for children's medicines, and in particular for pediatric formulations. Drug needs for children are different than those for adults, and deserve special regulatory attention, and a more rapid system for introducing regulations.

Thank you once again for your invitation, for hearing us out and particularly for your attention to this issue in your study. We believe that it is essential to have frank and open communications between you as the decision-makers and the pediatrics community working in primary care and specialty care. Right now, the health and care of children need your special attention. We, the clinicians and researchers, simply want to make you aware of the circumstances in which we operate and to provide you with the reliable data you need to make the best possible well-informed decisions.

Thank you.

● (1115)

The Chair: Thank you, Dr. Nuyt.

Dr. Quach-Thanh, I'd like to welcome you to the committee.

You have the floor.

Dr. Caroline Quach-Thanh (Pediatrician, Infectious Diseases and Medical Microbiologist and Physician Lead, Infection Prevention and Control, Centre hospitalier universitaire Sainte-Justine, As an Individual): Thank you, Mr. Chair.

I'd like to thank the members of the Standing Committee on Health for having invited me to appear in connection with its study on public health and the prevention of childhood illnesses.

I'm a pediatrician, infectious diseases microbiologist, and clinician investigator at the Centre hospitalier universitaire Sainte-Justine, and a full professor of microbiology and pediatrics at the Université de Montréal. I also hold the Canada Research Chair in Infection Prevention and Control: from Hospital to Community, a tier 1 chair.

I'm the director of the POPCORN network, which the Canadian Institutes of Health Research funded in 2022 for a two-year period. The purpose of the network is to make it possible to monitor the progress of a child's care in Canada's 16 pediatric hospitals with a view to strengthening national infrastructure, expertise and human capital in pediatric research, and studying the repercussions of interventions or events on the mental health and development of children in Canada.

The Canadian Institutes of Health Research had asked the network to study the impact of COVID-19 on children, and an initial national conference is scheduled in May 2023 to communicate preliminary results and plan the next steps.

I acquired my expertise as a clinician and researcher in the field of infection prevention and vaccination. I will therefore focus on these areas, to avoid hearing my children say, “Stay in your lane, mom.”

Although we all take vaccination for granted and have the impression that vaccine-preventable diseases are a thing of the past, it's important to realize the extent to which today's world is still experiencing a resurgence of illnesses that we thought had disappeared.

One example is poliomyelitis. Until last year, no one would have thought that a case might occur in the state of New York. But wastewater surveillance, here and elsewhere, has shown that the virus is being shed and that in the absence of vaccination, people are still exposed to the risk of infection. Most of us are too young to remember the harm caused by polio, and the deaths and paralysis suffered by children who had otherwise been in perfect health.

Similarly, measles is still affecting people, even in developed countries, when the vaccination rate falls below 95%. Almost 20,000 people were recently exposed to a case of measles in Kentucky. There is a risk that a case could enter the country, and young children are most at risk of experiencing a serious illness as a result.

Why is immunization coverage so low? In 2019, a survey of immunization coverage by the Institut national de santé publique du Québec showed that by the age of 15 months, approximately 95% of children had received all their vaccinations against poliomyelitis, measles and pneumococcal diseases. However, the vaccination records show that immunization coverage for measles is closer to 85%. The actual figure is likely somewhere between the two, but the assessment of how the pandemic affected immunization coverage remains to be carried out.

It would appear that concerns about the efficacy and safety of COVID-19 vaccines probably eroded the confidence of some parents in other vaccines that have been used for decades. This trust needs to be restored or we risk seeing a resurgence of these vaccine-preventable diseases and all the complications that come with them: meningitis, encephalitis, deafness, long-term side effects and deaths. Infectious diseases are also democratic: they will affect everyone, but will have more of an impact on those who are medically and socio-demographically most vulnerable. Health inequities are also reflected in infectious diseases.

A child who goes to a day care is expected to catch 8 to 12 colds a year. The pandemic led to the reappearance of many different respiratory viruses, the end result of which was a significant increase in secondary bacterial infections, such as orbital cellulitis, mastoiditis, pulmonary abscess, meningitis and intracranial abscess.

To date, the antibiotic resistance of these bacteria has remained relatively stable in Canada, but inappropriate use of antibiotics, the difficulty of diagnosing and differentiating a viral infection from a bacterial infection, combined with globalization, could be a threat to treatments that we now take for granted.

Antibiotic resistance is potentially the next pandemic we will have to face. Not only that, but more and more studies are beginning to reveal a link between exposure to various environmental contaminants and lowered immune response. This research needs to be continued from the standpoint of a concept based on a “one health” approach that promotes an integrated, systemic and unified approach to human, animal and environmental health.

Efforts are currently being made to determine whether the recent increase in viral infections is due simply to a cohort effect, with serious bacterial infections simply the outcome of the larger number of viral infections in circulation, or rather due to the emergence of more virulent bacterial clones.

● (1120)

It's therefore critical to establish surveillance programs, including genomic surveillance, for infectious diseases across Canada.

One of the cornerstones of infection prevention is ensuring that measures introduced do not cause any serious collateral damage. The subtleties involved are often difficult to communicate to the public. Research and evaluation are therefore essential in support of public health decisions. The POPCORN platform could answer these questions, but the best option would have been to factor in and assess child health earlier on during the pandemic.

I'll conclude by saying that it's impossible to overstate the importance of infection prevention, as well as the data and research required to maintain the current health status of children. More investment in this key sector would save lives and public funds.

It's important for us to understand and measure the impact of the pandemic on immunization coverage and to restore parental confidence, where needed, by using open and valid data.

It will be important to ensure that effective surveillance programs, including genomic surveillance programs, can measure the burden of infectious diseases and vaccine-preventable diseases, and to make the results available to everyone.

It's essential to make sure that children's health is factored into research priorities and that there is more than just short-term funding for networks.

The resources and measures required to prevent the emergence of antibiotic resistance must be allocated.

The “One Health” concept needs to be promoted in health decision-making and research with respect to children.

Thank you for your attention.

[*English*]

I'd be happy to answer your questions.

The Chair: Thank you, Dr. Quach-Thanh.

Next, I'm honoured to call on Dr. Cindy Blackstock, executive director of First Nations Child and Family Caring Society of Canada, to address the committee.

Welcome, Dr. Blackstock. You have the floor.

Dr. Cindy Blackstock (Executive Director, First Nations Child and Family Caring Society of Canada): Thank you, and a very good morning, Chair and members. I would like to recognize that this testimony is occurring on the unceded and unsurrendered territory of the Algonquin nation.

In 2008 the World Health Organization said inequality is killing on a grand scale. There are all kinds of inequality flowing from capitalist markets and other things, but there's also inequality that is directly sourced to the decisions that are made in this House and made in the Senate. That's the story I want to talk about today: how that inequality has killed first nations children, how it's contributing to the deaths of first nations children today, and, most importantly, what you all can do about it.

In 1907 there were headlines across the country such as “Absolute Inattention to the Bare Necessities of Health” and “Startling Death Rolls Revealed”. What were they talking about? Canada's own medical inspector for the Indian department had found that the federal government was underfunding health care for first nations children in those schools. “By how much?”, you might ask. Well, the people living here in Ottawa received three times the amount of health care funding that all “Indians” across the country did. That gross inequality, coupled with poor health practices, was resulting in death rates of 25% per year, growing to 50% over three years.

The Government of Canada accepted those statistics; they did nothing about the inequality.

Where does that inequality come from? It comes from the Indian Act, under which the federal government funds public services on reserve—everything from water to health to education to child care—and the provinces fund those for everyone else. Since Confederation, they have underfunded those services, creating a cascade of poor health outcomes for first nations children.

Now, that decision—it was a decision rather than a failure—by Canada to not remedy those inequalities created ripples that we saw, sadly, in the headlines of 2021 and 2022 about the children in unmarked graves.

In 2005 Jordan River Anderson was in the hospital in Winnipeg. At the age of two he would have gone home. His pediatrician said it was time, but he didn't go home, because he was a first nations child and there was a dispute between the Government of Canada and the Government of Manitoba about who should pay for his at-home care. Make no mistake: If he had been non-indigenous, he would have gone home. He died in the hospital because of who he was, having never spent a day in a family home.

In 2007 all members of the House of Commons—and I want to thank all members of all parties—stood in unanimous support of Jordan's principle, which is about first nations kids getting the help they need when they need it. It's something every Canadian could get behind, but it has taken now 16 years of litigation and 25 non-compliance orders to get the Government of Canada to a place where it's beginning to put a proper label on Jordan's principle. In the wake of that—in the non-compliance period—the deaths of two children have been linked to Canada's non-compliance as it refused to provide medical care for mental health to two children who later died by suicide at the age of 12. We don't know if those deaths could have been prevented, but we know that there would have been a chance to prevent those deaths of those sacred children had those children received the types of supports they could have had.

Jordan's principle is a very basic principle of Canadian health. We talk about universal health care, but actually when we get down to it, we really don't have that in Canada.

We've done some work to decide what can be fixed about Jordan's principle. What we're finding now, thankfully, due to the tribunal and the collective work of first nations leadership, is that we're now giving out about $2 million in services resulting from Jordan's principle—which is a good thing—in health, education and other social supports, but we're also finding that it's funding gaps in these other underfunded services. You see, since Confederation there hasn't been a comprehensive plan to cost out all of those inequalities and remedy them all.

We know governments are capable of doing this. In fact we, along with allies, did this in the Second World War with the Marshall Plan. We rebuilt Europe by creating a multidisciplinary plan. Surely this is something we can do here, and the Spirit Bear Plan is the way to do that. We want to put the hands of that calculation out in the public parlance and get someone like the Parliamentary Budget Officer to cost out all of these inequalities and put to bed for all time what amounts to an apartheid public service system with respect to first nations kids that contributes to their poor health outcomes.

• (1125)

In the case of Jordan's principle, a large majority of the requests that come in are actually for low dollar-value items. They are huge dollar-value items to that family but low dollar-value items for the government, yet a request for a 150 bucks to buy baby formula is put through the same red tape as a request for $5 million. That's not a good use of public servants' efforts.

We'd like to see that calibrated so that, like any business you might run, you have a certain dollar threshold below which it's nominally approved as long as there's a professional note saying the child needs that service. It's not without any check systems. These types of things would create vast efficiencies.

The other thing we're looking for is.... The litigation is ongoing, but we still don't have an answer for what is going to happen for Jordan's principle beyond year five. The agreement in principle is a positive thing, but we need to know that this discrimination is never going to happen again for any child in this nation.

When we all saw the children in unmarked graves and when we all wore the orange T-shirts, we were making a promise to the residential school survivors to make sure that what happened to them doesn't happen to their grandchildren. We have solutions on the books to be able to remedy this. This is not a problem without a solution. This is a solution without, so far, the political will to implement it. With all of you, I'm sure we can get that done.

Thank you.

The Chair: Thank you, Dr. Blackstock.

We're going to now move to rounds of questions, beginning with the Conservatives.

Dr. Ellis, you have six minutes, please.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you very much, Chair, and thank you to all the witnesses for being here today on the very important topic of children's health. There's certainly a nice range of opinions here today. I think it's very important that we understand that.

Dr. Nuyt, I will start with you.

You are someone with some expertise in this. You spoke specifically in your opening statement about it and, through you, Chair, you talked about finding, recruiting and retaining pediatricians. Of course, this is a very difficult topic that we're all very well aware of, not just in Canada but perhaps around the world as well.

Maybe you could share with the committee some of your thoughts around how we can best do that.

• (1130)

Dr. Anne Monique Nuyt: As I briefly concluded in that paragraph, even though I understand that this is a provincial jurisdiction, I think we need to have a global plan across Canada for planning the needs. When I talked about pediatrician retention, I specifically spoke about what happens in our tertiary care hospitals. I'm not talking about the community pediatricians; I'm talking about the specialists and subspecialists.

I think first we have to plan appropriately for the whole country how many we need to train—not just province by province. For example, in pediatric nephrology, 17 university hospitals need pediatric nephrologists, but there are just six or seven centres in three provinces that train them. Obviously, if the calculation is made only within the province, it won't be enough. That is needed.

I think it's very interesting to be able to recruit specialists from other countries who might not have all the expertise for every single little thing that we need. In a way, if this could be facilitated in terms of the recognition of diplomas, especially from medical schools in other countries that we know are of equivalent quality, I think that could be of great importance. I know certain provinces have made certain agreements with certain countries. That would certainly be of help.

Mr. Stephen Ellis: Thank you very much.

Through you, Chair, another thing you touched on was retention of pediatricians.

As we go through our careers as physicians, part of the difficulty is for people who work in a fee-for-service environment. Of course, there's no ability to have a pension plan other than what you save for yourself. Do you have any ideas on how we may be able to better plan ahead for when physicians might retire or how to retain them longer?

Dr. Anne Monique Nuyt: I won't talk specifically about salaries, but I will bring two questions to the importance of retention.

One is that many pediatricians and subspecialists in the university hospitals have tasks other than caring for patients. They have to teach the next generation of pediatricians and teach family doctors about pediatrics. They have to do research, because we're responsible for generating new knowledge. That part needs to be taken into account when we're thinking how much we pay those who are in university hospitals. That's number one.

Number two is that the major complaint I hear from my colleagues about pursuing their careers is the lack of multidisciplinary help. It's the lack of the other professionals they need to do their job, like nutritionists, nurses and respiration therapists. There is such a lack of all these professionals. They are essential to do the care that every specialist needs to do. It's burning them out.

Burning out is when you can't do the job you're supposed to do and you want to do it.

Mr. Stephen Ellis: Thank you for that.

The other topic I'd like to touch on is that you did mention the concept of data. Certainly it is something that we talk about a lot. We've talked a lot about it in this committee. We hear a lot about data and we know the importance of it.

Part of the difficulty, though, is how to collect that data. What systems do you use? How do you communicate among provinces and territories and the federal government to make this meaningful and, for instance, to understand exactly how many pediatricians we have? How many pediatric nephrologists do we have? They're perhaps easier to count because there aren't many of them, but general pediatricians in communities.... To understand exactly how many we have, how much work they're doing and when they might retire, etc., do you have any ideas around that?

Dr. Anne Monique Nuyt: I'm not a professional health service planner—I'm just a regular doctor—but I can see there's a problem, so thank you for bringing this up again. All these data are within provinces, and I think that to bring this topic to the interprovincial discussions could probably be.... It's just a matter of helping each other here.

Mr. Stephen Ellis: Through you, Chair, that's certainly one of the issues we've had—provinces working in silos. I think that perhaps we do need to look to the pediatric community. Perhaps you're a little better at this than adults' physicians are on that idea of camaraderie. Maybe we can get some better ideas on how to share things through the pediatricians, so I thank you for that.

If I have time, at some point I'll come back to medications, but with regard to medication shortages, especially in the pediatric world, whether it be acetaminophen and ibuprofen—over-the-counter medications, as you well know—or any pediatric oral antibiotics, at the current time we have a critical shortage, as all of you know as well. That's something I think that we'll need to touch on here at this committee to understand why those shortages exist and how to overcome them.

I appreciate that.

● (1135)

The Chair: Thank you, Dr. Ellis.

Next is Dr. Hanley, please, for six minutes.

[*Translation*]

Mr. Brendan Hanley (Yukon, Lib.): Thank you to the witnesses for being here today.

[*English*]

Thanks to all three of you for appearing here today.

Dr. Nuyt, I won't have time to ask you questions, but I appreciate your recommendations. They echo those of some of our witnesses earlier in the study, as well as in our important workforce crisis study.

Ms. Blackstock, it's pleasure to meet you. I know that you've been in the Yukon many times. I appreciate that you have never been one to mince words and I appreciate your frankness in this room as well.

In the Yukon, just last month we celebrated the 50th anniversary of "Together Today for our Children Tomorrow". That was the beginning of the modern treaty process, not just for Yukon but for the country. Over the next few decades, we came to realize self-governance in 11 out of the 14 first nations. I think the agreements on self-governance and the progress we've made so far in the Yukon in child health and well-being are not coincidental.

I want to pay a bit more attention to Jordan's principle. As an example of the many areas of progress since Jordan's principle—admittedly driven by the courts, but now we do have it—I was in Haines Junction just this past week at the Shäwthän Näzhi recovery support program, an amazing family support program for recovering adults to support those families in recovery. They said that this would not have been possible without Jordan's principle.

As we contemplate your recommendations on the Spirit Bear plan, do you see the ongoing Jordan's principle and the extension of it as a transition to something more comprehensive and enduring to continue to right the wrongs?

Dr. Cindy Blackstock: Yes. Thank you very much, member.

The type of story you're telling is something that echoes across the country in terms of the wonderful outcomes that can come from remedying these inequalities and getting services for kids. We know, for example, from the Nobel Prize-winning economist James Heckman, that for every dollar government spends on a child, it will save many times that number downstream. This is something that I know my colleagues will agree with.

Although we're spending money on Jordan's principle now, we can expect to get savings in the public purse downstream, but more importantly, this could be the first generation of first nation kids who never have to recover from their childhoods. That's the importance of Jordan's principle and the equality measures that it represents.

Jordan's principle is a legal requirement now in the country and is something that should be embraced. Especially those who are really fiscally prudent should embrace it and preserve it, but if we're able to continue on with it as a measure, we need to plug the holes in the other underfunded services, because that's really the answer, right? It's to make sure that when a first nation child goes into a school, it doesn't have black mould and that there are a number of teachers there who can support that young person. Also, as you're pointing out in terms of the tie to self-government, we need to make sure the services are culturally appropriate and take into context the culture and language of that particular student.

Mr. Brendan Hanley: Thank you very much.

I'm going to turn to Dr. Quach-Thanh.

First of all, congratulations to the translator for being able to keep up with you as you read through an encyclopedia of recommendations.

I want to focus on a couple of areas. As one, you did mention the importance of recognizing antibiotic resistance. This is such a huge area, and we have slowed down our attention on it over the pandemic, as with many other areas. Could you review very quickly a few key policy steps that we need to be looking at for addressing antibiotic resistance, particularly using the One Health concept that you referred to?

• (1140)

Dr. Caroline Quach-Thanh: Absolutely. Thank you.

Thank you to the translator for being so good. I know I speak quickly.

Just to set the stage, antibiotic resistance occurs when a type of bacteria that we were able to treat with a regular antibiotic is not treatable any more. In some countries, we're seeing more and more death associated with it because a urinary tract infection, which is something quite common, could be non-treatable and lead to death, which should not be seen nowadays.

The policy steps that have been taken and that we still need to keep on taking include, first of all, having data on what antibiotics are being used and what antibiotic resistance we're seeing with various infections. Again, as Dr. Nuyt was saying, it's not that easy to have access to data across the country.

There are a few programs that exist at the federal level. CNISP is one of those programs. It looks at nosocomial infections or health care-associated infections. We're able to follow antibiotic use and antimicrobial resistance. However, this program is limited to only 65 hospitals out of the 600-and-something that exist in Canada, so again, as Anne Monique said, particularly in pediatrics, if we want to have data that we're able to compare to, we need something that is national and not just provincial. That is the first step.

The second step, when we're talking about One Health, means that whatever you use or you see in animals will eventually end up in humans, whether that be through food or through close exposure. When we see antibiotic-resistant organisms arise in, let's say, chicken farms, it's very possible that people who are close to those chickens will acquire those organisms. Eventually there will be transmission between humans and we won't be able to treat those any more, so surveillance in both the veterinary world and the human world is necessary, and we really need to have the possibility to do genomics to understand if one strain is related to another or not.

At this point in time, these programs exist, but they are in specialized laboratories, in public health laboratories. We need to have better access to those and make sure that those programs are well funded across the country at the federal level and in the provinces, as well as in the national microbiology lab.

The last thing is to promote innovation in terms of new antibiotics. You are not going to see a lot of new antibiotics come up. Manufacturers and pharmaceutical industries are not tempted to put new antibiotics out on the market. It costs them a lot of money. It's labour intensive. Again, when a new antibiotic comes out, the last population that has access to it is pediatrics, so that's coming around to what Dr. Nuyt was saying in terms of the availability of drugs.

The Chair: Thank you, Dr. Quach-Thanh.

[*Translation*]

Mr. Thériault, you have the floor for six minutes.

Mr. Luc Thériault (Montcalm, BQ): Thank you, Mr. Chair.

We are privileged to have such knowledgeable witnesses with us here this morning. It would be extremely interesting to be able to speak to them for hours, but I have only six minutes.

First, Dr. Nuyt, my colleague Mr. Ellis asked you some of the questions I would have asked. I'll get back to you if I have time later, on your research into the impact of premature births, particularly on child health.

Dr. Quach-Thanh, you said something that struck me. You said that antibiotic resistance was potentially the next pandemic we would be facing. That's a rather chilling prospect.

Can you tell us more about this? I'm sure there are some facts we need to know about from the clinical, socio-demographic and socio-economic standpoints.

What do we have to do to prevent this from happening?

Dr. Caroline Quach-Thanh: Thank you for the question, Mr. Thériault.

I think I may have partly answered it earlier, but I would add that the World Health Organization, the WHO, did in fact put antimicrobial resistance on its list of 10 threats to global health. When a human being or an animal is exposed to antibiotics, the so-called “good bacteria” can develop resistance and transmit these genes to pathogens that will no longer be treatable.

Let's look at children, for example, particularly those who get frequent urinary infections because their urinary system is somewhat tangled and complex and there is reflux from the bladder to the kidneys. These children tend to be treated recurrently for urinary infections. As their care progresses, often even in their first year of life, they will be dealing with a bacterium that can't be treated with the usual orally administered antibiotics. So a urinary infection that should be easy to deal with will require hospitalization and the administration of very broad spectrum intravenous antibiotics for 10 to 14 days, and these may continue to contribute to antibiotic resistance.

It's therefore important to understand when to use antibiotics and when not to because it's a viral infection. Access to diagnostic tools, even remotely, is essential in family doctors' offices and in clinics, in order to be able to differentiate between bacterial and viral infections. Primary care doctors are very good, but they have to rely on their clinical experience. They may think it's a bacterial infection when it's only a viral infection. As I was saying, children may experience fever from 8 to 12 times a year because they will contract 8 to 12 viruses a year during their first years in a day care centre.

• (1145)

Mr. Luc Thériault: In these offices, do we have the technology required to rapidly make this distinction?

Dr. Caroline Quach-Thanh: For the time being, no, but I think research and innovation should be promoted so that remote biomedical examinations can be carried out. It would facilitate the work.

During the pandemic, there were rapid antigen tests to detect SARS-CoV-2. There are such tests for group a streptococcal illnesses, including pharyngitis, and also for other respiratory viruses. They're not perfect, although they are helpful, but they're not readily accessible yet. There are other very expensive tests based on the polymerase chain reaction, or PCR, method.

It's a matter of finding ways of providing access to these technologies in primary care centres.

Mr. Luc Thériault: It may be expensive, but if antibiotic resistance were indeed to become a pandemic, having failed to take timely and appropriate preventive action would end up being a lot more expensive.

Is that right?

Dr. Caroline Quach-Thanh: Yes, that's it exactly.

Mr. Luc Thériault: In your presentation, you said that one of the cornerstones of infection prevention is ensuring that the measures introduced do not cause significant collateral damage, that the subtleties are often difficult to communicate to the public, and that research and evaluation are essential.

You also talked about the POPCORN platform. Could you tell us more about the work being done by the members of this network to ensure that we can become better at conveying public health messages to the population?

Public health means mass medication. If the message doesn't get through, there's no more medicine.

Is that it?

Dr. Caroline Quach-Thanh: That's it exactly.

In that kind of context, you need to have supporting data to explain things so that people understand the repercussions of our recommendations.

Let's use Quebec as an example. On March 3, 2020, a decision was made to close all schools, and most of us wondered whether that was the right thing to do. Of course, at the time, there were no other options. We didn't have any data; there was no reliable information that would allow us to know whether it was serious or not, and the schools were closed.

But then without knowing what the impact of closing schools would have on students, how long can they be kept closed? How do we make up for the lost time at school afterwards?

The POPCORN platform includes all of the 16 pediatric hospitals in Canada except for the one in Thunder Bay. The members of this network can look at administrative data to see the impact of public health measures on the mental health of children following the pandemic.

They could potentially provide convincing data and make recommendations to decision-makers, who in turn could take steps to ensure that if there were a future pandemic—and there will be one—with people wondering what to do, it would be possible to assess the risks and benefits. Based on the assessment, decisions could be made about what has to be done, not only to prevent transmission, because we certainly don't want to clog up the hospitals, but also to address the potential consequences of the measures.

To get back to the educational side of things, tutoring would appear to be a highly effective option for making up the missed time at school. Professor Catherine Haeck may have spoken about this to you.

Being able to understand what's going on would allow us to make such recommendations.

● (1150)

[*English*]

The Chair: Thank you, Dr. Quach.

We'll go to Mr. Davies, please, for six minutes.

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

Thank you to all three witnesses for your extensive experience and wisdom.

Dr. Blackstock, I'd like to direct my questions to you to begin.

Broadly speaking, how do indigenous children rate in major health categories compared to non-indigenous children in Canada? Can you give us a couple of examples?

Dr. Cindy Blackstock: Unfortunately, first nations, Métis and Inuit kids are often at the top of every list you don't want to be at the top of and at the bottom of every list that you want to be at the top of.

We're seeing everything from higher rates of death due to accidental injury to death as a result of mental health issues. It really is crosscutting. Those inequalities put these families and these children in a difficult spot.

First of all, because you don't have clean drinking water and you have overcrowded houses.... For example, during the pandemic, a lot of the public health measures we were taking advantage of weren't available. Only 35% of first nations homes have broadband access, so even remote learning or telemedicine isn't an option in those kinds of circumstances.

It really is, unfortunately, a crosscutting disadvantage, and I think that part of the solution was mentioned by my colleagues. The other is addressing the fire that leads to all of those health disadvantages, which is largely the inequality.

Mr. Don Davies: In your written submission to this committee, you noted that “Jordan’s principle is working to advance formal equality, but is not achieving substantive equality.”

This is a two-part question. Has the federal government fully implemented Jordan's principle to date? Also, could you explain the difference between formal and substantive equality and outline why Jordan's principle is only achieving the former?

Dr. Cindy Blackstock: All right. I'll start with the second part.

There's a great quote from 1955 in the U.S. Supreme Court on this question. It says that “there is no greater inequality than the equal treatment of unequals”. Really, substantive equality is recognizing the disadvantage that's been foisted on first nations, Métis and Inuit children that is not experienced by other children. Therefore, you need to invest more to make up for that. That's what substantive equality is about. It's giving them the opportunity to have the same outcome that other people have, people who have not experienced those hardships.

In terms of.... I'm just thinking of the other part of your question, which I've lost track of—

Mr. Don Davies: It's whether the government has fully implemented Jordan's principle.

Dr. Cindy Blackstock: It's much better than it used to be, but it is not full compliance, in our view. That's what we need to work toward before the tribunal will end its jurisdiction in this case.

That's something we're hoping will happen soon. We'll be able to get these matters addressed and have a long-term approach for Jordan's principle that will meet the criteria that the tribunal legally requires, which is to stop the discrimination happening to first nations children and, most importantly, to make sure it doesn't happen again.

Mr. Don Davies: On that point, the Canadian Human Rights Tribunal has issued 24 procedural and non-compliance orders against Canada following the landmark decision in 2016.

Is the federal government currently in compliance with all tribunal orders?

Dr. Cindy Blackstock: No. That's why we're still in front of the tribunal.

Again, I would say there is greater progress, but no, there is not full compliance.

Mr. Don Davies: I want to shift a bit to access of indigenous children to culturally competent care.

Can you give us your thoughts on whether indigenous children are getting such access, and if not, what can the federal government do to address that?

Dr. Cindy Blackstock: I think this is one of the critical areas where there needs to be further work done. That would include, for example, ensuring that the good work done by Dr. Kent Saylor, a Mohawk pediatrician who developed training programs for pediatricians on working with first nations, Métis and Inuit children, is not only just provided to pediatricians but is rolled out writ large to every health care provider in the country so that people are better prepared to meet the distinct needs of these children.

The other, of course, is to ensure that in the communities there are primary health care providers and other secondary care that's culturally appropriate so that children can actually get services in their language. This is something that's very important across the country and something that is possible to do here.

● (1155)

Mr. Don Davies: I'll focus on one particular ailment. I know indigenous people in Canada continue to be disproportionately affected by tuberculosis. That's a disparity rooted primarily in factors such as poverty, and you mentioned crowded, inadequate housing and food insecurity. Children are especially vulnerable. They're more likely to develop disease and experience life-threatening conditions such as TB and meningitis.

Can you give us a flavour of what a culturally competent and community-driven TB elimination strategy would look like?

Dr. Cindy Blackstock: I think the Inuit Tapiriit Kanatami have really done a great job in documenting what that kind of intervention would look like. This is the good thing about these things: There are solutions on the books that just need to be mobilized and implemented.

As you're pointing out, the TB rate particularly for Inuit is just skyrocketing, but that's also the case for some of the first nations in the country. It was actually tuberculosis that Dr. Bryce raised the red flag about in 1907 that drove those children into the unmarked graves. Not all the children, but many of those children died because of tuberculosis. That's why he was calling for that inequality to be addressed too.

That's the opportunity we have right now. It's to not make those headlines happen. It's to actually keep those children well, because we can.

Mr. Don Davies: Mr. Chair, how much time do I have?

The Chair: You have about 15 seconds. Do you want to make a closing comment?

Mr. Don Davies: I'll give you the 15 seconds.

Dr. Cindy Blackstock: I would just say that Jordan's principle is one of the top TRC calls to action. When we look at the survivors' work plan for the country, which are the TRC calls to action, the top six are all about addressing the inequalities for their grandchildren. They wanted their grandchildren to not have to go through what they went through and they wanted the country to be better for it too. It's about the TRC as well.

The Chair: Thank you, Mr. Davies and Dr. Blackstock.

Next is Ms. Goodridge, please, for five minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair, and thank you to all the witnesses.

I'm going to continue a little bit along the vein of Mr. Davies. This is for Dr. Blackstock.

Canada has had a long-standing policy around birth evacuations in many of our isolated communities of moving, at very high cost, indigenous people away from family centres into urban centres to be able to just have a baby, which to me is insane.

I'm wondering if you could speak to that a little bit and how that impacts both the mom and the baby and their health.

Dr. Cindy Blackstock: This is a very important topic.

Imagine when you're having a baby. You want your family around you. That's the whole thing around the baby. It's a beautiful celebration of this new addition to the community. Traditionally, the birth of a child was not only very spiritual but a very important community moment as well. Removing that child and that mom from all their social support systems so that she can give birth to a baby hundreds of miles away, often without that support network, makes no sense to me.

I think this gets back to ensuring there's proper funding for health care services so that people can do the basic things, like have a baby in their home community, and not have the band-aid solution, which is the medical transportation. In fact, when we look at Jordan's principle, one of the top categories that Jordan's principle is funding is medical transportation. That to me is a symbol of how short we are in medical care in different communities.

Mrs. Laila Goodridge: I thank you for that. I live in an urban centre, in Fort McMurray. If I were deemed to be high risk at any point in time, I would actually have to go to Edmonton, 500 kilometres away, which is insane, because we simply don't have a NICU. Every single pregnant woman in my riding who lives in Fort Chipewyan is having to go to either Fort McMurray or Edmonton, away from family structures, just to have a baby.

I'm wondering if anyone on this panel has any idea or any thoughts around midwifery services potentially playing support and having some of that culturally sensitive care to help bring babies into the world in their communities.

● (1200)

Dr. Cindy Blackstock: I think they're really essential. I think having more schools that promote midwifery services and making them available in different communities is really, really important. That includes all elements of prenatal care and making sure that it's available.

Mrs. Laila Goodridge: Fantastic. I couldn't agree more. I'm very proud to have an amazing indigenous midwife who cared for me in my first pregnancy and who is now caring for me in my second pregnancy. I know that I have a better experience because of that.

[*Translation*]

Dr. Nuyt, I could see that you were nodding, so I'd like to hear your view of midwives and infant care.

Dr. Anne Monique Nuyt: I'm going to stick to my field of expertise. I'm a pediatrician and a specialist in neonatal intensive care. That means that my view of things is biased, because all I ever see are the cases when things did not go well. I think it's more of a question for obstetricians.

I know that, by definition, pregnancy is not an illness. If the number of perinatal deaths has declined considerably, it's because of care. Of course, care is not only provided in university hospitals, but the situation could nevertheless be improved. There are many countries where the experience of childbirth with midwives is well documented.

[*English*]

Mrs. Laila Goodridge: Fantastic.

I'm going to switch to English but still continue with you, Dr. Nuyt, because I have very little time.

How important is adequate prenatal care to overall infant health?

Dr. Anne Monique Nuyt: It's very important.

Mrs. Laila Goodridge: Fantastic.

Is the fact that many first nations families and children in communities can't get access to adequate prenatal care concerning to you?

Dr. Anne Monique Nuyt: I would say yes.

Mrs. Laila Goodridge: Thank you.

The Chair: Thank you, Ms. Goodridge.

Dr. Powlowski, you have five minutes, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you.

Dr. Nuyt, you talked about the delays in getting approval for pediatric medications that aren't approved here but are already approved by the FDA, and I think you said EMA is the comparable organization in Europe. You also talked about accessing pediatric formulas.

In COVID we saw jurisdictions around the world all independently having to decide on approving different vaccines and different treatments for COVID, which would seem to me to be a rather inefficient process. I don't know about you, but working as a doctor, one of the wonderful things I've found about medicine is that it's universal. People all around the world suffer from basically the same problems. When you open someone up, they're exactly the same.

Now I'm going to ask you a bit of a political question.

Given the delays in getting approval, and delays in smaller countries like Canada, which fall behind bigger countries.... The FDA, for instance, has more people and probably more ability to rapidly assess which drugs should be approved. Does it make sense that every country has its own regulatory process? Do you think we ought to be considering more of a global approach in terms of an international regulatory system to test and approve new vaccines and drugs so that when we have something like COVID again or when there are new outbreaks of antimicrobial resistance, we're better able to respond rapidly to these problems globally?

Dr. Anne Monique Nuyt: I think it's very logical. As you said, medicine is universal. We read the research from our colleagues from everywhere.

I think it's very important that within each country we have an entity that can be *le garant*, like Health Canada, so that whatever is sold and approved in Canada is good for Canadian children and all Canadians. What we're calling for is enhanced conversations and collaborations—exactly.

As to giving an answer on whether it's with one jurisdiction or many, I think facilitating jurisdictions goes beyond my competence. Certainly we need to help each other, and probably this is what happened also during the pandemic.

Dr. Quach-Thanh, who has expertise on what happened with the vaccine *approbation* between all the countries, could answer that better than I could.

● (1205)

Mr. Marcus Powlowski: Before turning to Dr. Quach-Thanh about the same question, the WHO is currently in the process of developing a new international treaty on the control of infectious disease. Do you think that should be something that is included in that treaty?

I'll ask you first, Dr. Nuyt, and then I'll turn to Dr. Quach-Thanh for the same question.

Dr. Anne Monique Nuyt: Certainly I think approval of medication and the sharing of expertise need to be accelerated. In fact, children from Canada are recruited for the initial studies for medications that end up being approved in the U.S. but not in Canada, but then they're not approved in Canada. It speaks for itself that we need to have some collaboration. To what extent, I'll leave to the political aspect.

Mr. Marcus Powlowski: Dr. Quach-Thanh, do you have a response to the same question?

Dr. Caroline Quach-Thanh: I agree that more collaboration is needed. I still have to say, though, that during the pandemic, Canada had approvals almost at the same time as the U.S. The reason that we sometimes make different recommendations is based on our population, on our epidemiology and other factors.

In terms of Health Canada, I have to say they were quite expedient during the pandemic. They worked rapidly. They changed their process. They allowed NACI to be able to look at the data at the same time they were.

Yes, collaboration is needed, absolutely. I know that the EMA in Europe has collaborations between all European countries. Still, once EMA makes a recommendation, each country still has to review it. As Dr. Nuyt said, I still think we need to make sure that what we approve for our country is what we want. The legal implication in the jurisdiction might be different.

I agree with collaboration, but again, I'm not a regulator, so you might as well ask Health Canada.

Mr. Marcus Powlowski: Mr. Chair, how much time do I have left?

The Chair: You have about 20 seconds, if you want to make a final comment.

Mr. Marcus Powlowski: No.

The Chair: Thank you, Dr. Powlowski.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Mr. Luc Thériault: Will I have another two and a half minutes in another round, Mr. Chair? Are these the last minutes available to me?

The Chair: They are your last minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

Dr. Nuyt, you've done research into the lifelong health consequences of premature birth.

To your knowledge, how many studies have monitored or studied cohorts of preterm or extremely preterm children in Canada, or even around the world?

Are there any, and if so, how many?

Dr. Anne Monique Nuyt: In Canada, I'm aware of two main ones.

One was carried out by Dr. Saroj Saigal in Ontario, and the other by me with Dr. Thuy Mai LUU in Quebec.

There have also been studies in Scandinavian countries. In fact, there are more and more studies being done around the world.

Mr. Luc Thériault: Over how many years did these studies track patients?

Dr. Anne Monique Nuyt: The patients we were looking at, meaning the cohort of young people who came back to our offices in adulthood, were aged 25 to 30 years. According to epidemiological data from the MED-ECHO databases of the Régie de l'assurance de maladie du Québec, some patients were in their mid-40s

Mr. Luc Thériault: So you are following up on patients from birth to 40 years.

How many people are in that cohort?

Dr. Anne Monique Nuyt: It represents approximately 100,000 preterm births.

Mr. Luc Thériault: What years were covered?

In what year did these studies begin?

Dr. Anne Monique Nuyt: Well, in Quebec, birth weight data are reliable since around 1976. As a result of the phase during the transition to the metric system, we are not always entirely sure whether weight data entries are in pounds or kilograms, hence the importance of having quality data. Sometimes, for example, we don't know whether the weight indicated was three pounds or three kilograms.

From 1976 onward, the data are reliable. This enables us to track people up to the present day. Since 1987 in Quebec, we have reliable data from MED-ECHO on the history and diagnoses made during hospitalization. However, we don't have reliable data on visits to the doctor. If someone went to the doctor's office because of diabetes, an ear infection or for any other reason, we have only a single diagnosis, the one drawn from the database.

There are areas that need improvement; hence the importance of data.

● (1210)

Mr. Luc Thériault: Given the advances in neonatology research, how many weeks is a fetus considered viable without any disastrous consequences?

Dr. Anne Monique Nuyt: We could have a separate discussion about the definition of “disastrous consequences” for three hours, but in most western countries, or the richest countries, children are generally resuscitated at 22 to 24 weeks.

Mr. Luc Thériault: Okay.

The Chair: Thank you, Dr. Nuyt and Mr. Thériault.

[*English*]

Next is Mr. Davies, please, for two and a half minutes.

Mr. Don Davies: Thanks.

Dr. Blackstock, I wasn't sure if you were referring to a historical figure, but is there a relatively accurate number about what Canada spends today per capita on indigenous children's health versus non-indigenous children's health?

Dr. Cindy Blackstock: I don't have that information.

Mr. Don Davies: When you referred to “three times” more, was that a historical figure?

Dr. Cindy Blackstock: Yes, that was a historical figure.

The Auditor General has done some reviews of health care delivery in northern communities, etc. This is why we want the Spirit Bear plan. It's to cost out those inequalities and propose remedies for them.

Mr. Don Davies: You anticipated my next question. I know that the Spirit Bear plan was adopted by the Assembly of First Nations chiefs and assembly in 2017.

Dr. Cindy Blackstock: That's correct.

Mr. Don Davies: Could you outline the federal government's response to the Spirit Bear plan to date? Have they committed to timely and full implementation of that plan?

Dr. Cindy Blackstock: No, they have not, and they have not proposed an alternative that would remedy those inequalities.

Mr. Don Davies: I want to turn a bit to food insecurity.

We've been hearing a lot about it at this committee. When we think of health and our health system, we often think of the treatment of illness once people are ill, but the determinants of health and preventive measures such as making sure children have access to good nutrition are also on our minds. Can you tell us what you think we should know about food insecurity and the impact it has on indigenous children in Canada?

Dr. Cindy Blackstock: I'm alive to the testimony yesterday of the large grocers and the impact that food insecurity has on Canadians.

I've been to many northern communities where a small jar of peanut butter is $16, and that was before the inflation element. Being able to make choices about feeding your family a healthy diet is almost impossible in northern communities, yet things such as cigarettes and booze are often subsidized.

I think we need better subsidies to make sure people in northern Canada who are living in these other areas are not paying prices for groceries that we are not even glimpsing at here in southern Canada, even with inflation.

Mr. Don Davies: We talked about data. Do you agree that Canada should have a national data strategy related to child and youth health, including, of course, an important focus on indigenous children? What is the state of data in this country on indigenous children's health?

Dr. Cindy Blackstock: It's not good.

The Truth and Reconciliation Commission pointed to that recommendation as one of the top calls to action. For example, in child welfare, countries like the United States, which has 50 different U.S. states, have national child welfare data collection systems so they know about the kids who are in care, what their needs are and how they're doing over time. Australia also has it. Canada does not.

What is the rationale? The rationale is that we have 13 different districts, but surely if the United States can overcome 50, we have the competency to overcome 13.

This type of data is going to be very important for making sure we are able to track whether the different interventions we're making, be they at the policy or the treatment level, actually are working for kids.

Mr. Don Davies: Thank you so much for your testimony.

The Chair: Thank you, Dr. Blackstock.

We have Dr. Kitchen, please, for five minutes.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

I'm so impressed. The panel we have here today is just amazing. Their answers are so succinct, so clear, and they're much appreciated by the committee.

In doing a study on children's health, where do we begin? There are so many avenues to touch on. How do we do that?

Hopefully, I can get a couple of questions in here.

Dr. Quach, thank you for your work with NACI and for your presentation to the committee in the past. We really do appreciate that.

Over the years since COVID-19 started, there have been lots of things. Today you touched on one thing that's of interest to me.

You mentioned polio being back in the U.S. for the first time. I've been to the polio centre in Islamabad, Pakistan, and I've seen the great work that they're doing and the great work that all Rotarians do in Canada in helping to fund some of that programming to deal with the polio vaccinations. We have measles. We're seeing parents who are not having their children vaccinated for measles. We're seeing tuberculosis back in Canada, and that's something that lots of Canadians don't even understand. In my hometown of Estevan, we had tuberculosis in the southeast corner of Saskatchewan. Most people think it's just in the north, and therefore they don't have to think about it; it's there, and we need to be touching on these things.

The concern we have is that when COVID-19 came, unfortunately, it was such a scramble. We got so much misinformation at the time, and there were so many decisions made in haste that were then retracted, etc. For example, the Public Health Agency of Canada was coming up with certain points and then changing those points.

My question to you, Dr. Quach, is this: What can we do to rebuild that trust? What would be one of the first steps we need to take to rebuild that trust with Canadians? They need to see that trust so that they can start recognizing the great value of vaccinations.

● (1215)

Dr. Caroline Quach-Thanh: That's the million-dollar question. If I had the answer, I would give it to you.

The first thing is for people to understand what decisions were made based on science and what decisions were made for political reasons. I don't know how easy that is. I don't know how to rebuild, except to start discussing and talking and be able to say that there are some things that we don't know but there are other things we have good evidence for.

One thing that is not about trust is the storytelling. As you said, you've seen polio cases, but most of us have not. Grandparents who used to go to the pool in the summer and not come back in the fall to school are not there anymore. How do we ensure that parents understand that we have the data to prove that vaccines are safe, but that on top of that they are a great help to our health and that in fact they save our health?

I think with the pandemic we were seeing more and more meningitis and other bacterial cases. Some of them are vaccine-preventable and some are not. It's just understanding that we still face infectious diseases. You're saying measles is back and syphilis is back. We're seeing congenital syphilis cases that we weren't seeing before. That's not a vaccine-preventable disease, but it's just a matter of understanding that these diseases are back and if you don't maintain a good vaccination coverage, they will be back and will have deadly consequences.

I don't know where to start to rebuild trust except to discuss and have frontline doctors and nurses discuss with their patients and make sure that those who are in contact with parents are able to have all of the knowledge they need to have that conversation and to ensure that in medical and nursing schools we do have those conversations and those classes to make sure that people feel well tooled—or *outillés*, I'd say in French—to be able to answer those questions parents will have, because in the end those people who we listen to mostly—“we”, as in parents—are the people who take care of our children.

I trust my physician. When my doctor asks if I've read about this and that for my child, I say, “No, I trust you. If you tell me that my child needs whatever medication, I will trust you.” Trust starts there with our health care workers.

Mr. Robert Kitchen: Thank you, and I appreciate that. I appreciate your comments on recognizing that there is a difference and that certain vaccines are of value with certain diseases and certain ones are not. Basically we're dealing with antibiotics that we need in order to deal with certain things, and you touched on that a little bit earlier.

Dr. Blackstock, I appreciate your comments. My colleagues touched a little bit on what I'm concerned about in basically competent care. I have a number of first nations in my riding, and in particular one great first nation, the Cowessess First Nation. The chief has done tremendous work there. They started up a home for young girls. The home has 10 young girls from 14 to 17. They have big challenges as they try to bring them back and get them to where they were taken away and now coming back to get that support. If you want to just touch on that, I would appreciate it.

As well, do you want to throw in a comment on how we can get that trust back? I would be happy to hear that as well.

● (1220)

Dr. Cindy Blackstock: For the member's information, according to 2019 data, first nations children are 17.2 times more likely to be in child welfare care owing to poverty, poor housing and caregiver substance misuse related to multi-generational trauma from residential schools. The work Cowessess is doing is about trying to address those drivers, which brings us back to the Spirit Bear plan, because that will be a good success under a self-government model.

It's very important for the long-term success of these initiatives that equity and self-government go together. Substantive equality and equity and self-government go together so that you can continue these culturally based programs. Really what we're doing is trying to address the trauma that has piled up since Confederation on these children and families and bring them back safely at home, but as you can imagine, Member, if you are in a community where there is a housing shortage, how do you bring these children in care back home? If you're in a community where there is no water, how do you bring these children back home? That's a part of it.

In terms of the trust aspect, it's always interesting when I hear people say that first nations don't trust them. I always say, “The beginning is acting in trustworthy ways.” I think that begins with carrying out your promises and acting with integrity as government. I think that goes a long way in being able to address this, and when solutions are put forward to government, it's to have them really engage and critique them and really implement them if they seem to be in the best interest of public policy, which they often are.

The Chair: Thank you, Dr. Blackstock.

The final question for the panel will come from Mr. van Koeverden.

Go ahead, please, for five minutes.

Mr. Adam van Koeverden (Milton, Lib.): Thank you very much, Mr. Chair.

Thank you very much to all of the witnesses. This has been an extraordinary meeting and really, really helpful. I'm glad that everybody was able to come. It's nice to have people in person as well.

My first question is for Dr. Nuyt. If you'll indulge me, I'm curious about healthy living and sustainable eating habits for young people. As you've stated, there's been a rise in negative eating habits and eating disorders. I think it's incumbent upon us to recognize that situation and to make sure there's an increase in services available for people who are suffering from eating disorders, but I also want to get at the root cause of those and try to prevent them if they're preventable and support people with any type of a strategy that would help people develop good eating habits, feel more confident, feel a sense of belonging and reduce the stress and anxiety that lead to those sorts of negative behaviours. Can you tell us some strategies we might be able to support or employ that would support that goal?

Dr. Anne Monique Nuyt: There are two elements to what you brought. First are the unhealthy habits that in general are linked to obesity, because unhealthy diet in general is linked to fatty foods, etc. This is very much linked to socio-economic inequalities, and it goes back to everything my neighbour Dr. Blackstock said specifically for first nation children, but it's also for all children in Canada who need to have access to decent living conditions, including access to decent food and therefore healthy food habits.

The problems with anorexia and eating disorders that we've seen rise, especially during the pandemic, are also bringing us back to first-line care. Youth have to be well in their families, and they have to be well in their schools. It's not going to prevent everything, obviously, as I said—there will always be children who will need specialized care—but if we make sure that in the families, the parents are not always away working three jobs rather than just one and if at school children have the services they need, then we will prevent them from needing health care and coming to the hospital. Where are children? They're in school, so we need to take care of the schools. I'm here as a pediatrician telling you to also take care of the schools.

Mr. Adam van Koeverden: I'm happy to hear that, as we're working on a national school food program that will support food security at schools.

I have a question about food insecurity. We know that food insecurity is not about not having enough food; it's a poverty issue. I want to make sure I'm clear on that.

Is there a relationship between socio-economic status and disordered eating? That relationship between disordered eating and food insecurity must be very complicated as well.

Dr. Anne Monique Nuyt: I do not know the answer to that question. I think these are really two different topics.

Mr. Adam van Koeverden: Okay. Thanks.

Dr. Blackstock, I'll turn now to you. Next week I'll be on my way to an event hosted by Spirit North, which is an organization that does physical activity programs for indigenous kids. It's in Canmore, and a lot of kids are coming from other regions and first nations communities in and around Canmore. Have you had a look, and what are your views on making sure that not just indigenous kids in particular, but also kids who live in remote communities or other disadvantaged communities, have access to those really positive social experiences that lead to better outcomes?

● (1225)

Dr. Cindy Blackstock: It's huge. I mean, we forget about childhood and the importance of play, right? Sometimes we pay a lot of attention to all of these things like risks and everything else, but part of being a kid is actually having the time to play, and play is important to children's development. Making sure that children have access to all kinds of positive activities in rural and remote communities writ large is really, really important. Even in Jordan's principle, we're seeing communities develop programs that involve culture as well. You embed the culture in the sport or you embed the culture in the activity so that it's meeting a bunch of developmental needs for kids, and they get to have some fun.

Mr. Adam van Koeverden: That's really great. I love that. I'd like to end on a positive note.

We spend a lot of time in this committee talking about health care, which, as we all know, is a system by which we take care of sick people, ill people, and I also like to focus a little bit on health. If I have any moments left—

The Chair: You have about 10 seconds, if you want to say goodbye.

Mr. Adam van Koeverden: Would anybody like to address the precursors to the social determinants of health to ensure that we're not just focusing on taking care of sick people?

A voice: It may not be a 10-second answer.

Dr. Anne Monique Nuyt: Take care of the schools as well. Thank you.

Dr. Cindy Blackstock: I would say equality across the board in services.

The Chair: Thank you, everyone.

Thank you so much to our witnesses.

It strikes me, actually, as a little bit unfortunate, with such expertise in front of us, that we only had an hour and a half with you, but it was absolutely quality if it wasn't quantity. Thank you so much for being with us. I'm sure you can feel the appreciation in the room for your experience and expertise and the manner in which you answered the questions. It will undoubtedly be of great value to us, as I think we have one more panel—or is this it?

A voice: We have one more.

The Chair: There's one more panel before we issue drafting instructions, so we're almost there.

Thank you all. You are excused.

To the members of Parliament in the room, we have half an hour of some other business that we need to cover, so we're going to suspend now, but for probably just three or four minutes.

Thanks again so much to our panel.

We're suspended.

● (1225)

_____________________(Pause)_____________________

● (1230)

The Chair: I call the meeting back to order.

Colleagues, we have a couple of things on our agenda, and there's a notice of motion by Mr. Davies, who has his hand up.

Go ahead, Mr. Davies.

Mr. Don Davies: Thank you, Mr. Chair.

As I've given notice, I would like to move that pursuant to Standing Order 108(2), the committee conduct a study to investigate reports that the Minister of Health personally intervened with the independent and arms-length Patented Medicine Prices Review Board to indefinitely suspend reforms that would have saved Canadians billions on drug costs; that the committee invite the following witnesses, in addition to any further witnesses the committee may consider relevant: Hon. Jean-Yves Duclos, Minister of Health; Matthew Herder, former member, PMPRB; Mélanie Bourassa Forcier, former acting chair, PMPRB; and Douglas Clark, former executive director, PMPRB; that the committee report its findings and recommendations to the House; and that pursuant to Standing Order 109, the committee request that the government table a comprehensive response to the report.

The Chair: Thank you, Mr. Davies.

The next item on the agenda was Bill S-203, but I'm advised by the clerk that your motion is in order, so the debate is on the motion.

I recognize Mr. van Koeverden.

Mr. Adam van Koeverden: Thank you, Mr. Chair.

I have an amendment to Mr. Davies' motion, and I'll read it.

I move that that pursuant to Standing Order 108(2), the committee conduct a study on the Patented Medicine Prices Review Board; that the committee invite the following witnesses, in addition to any further witnesses the committee may consider relevant: Hon. Jean-Yves Duclos, Minister of Health; Matthew Herder, former member, PMPRB; Mélanie Bourassa Forcier, former acting chair, PMPRB; and Douglas Clark, former executive director, PMPRB; and that the committee report its findings and recommendations to the House; and that pursuant to Standing Order 109, the committee request that the government table a comprehensive response to the report.

The Chair: Mr. van Koeverden, that doesn't sound like an amendment. That is actually identical to the original motion. Do you wish to amend the motion?

Mr. Adam van Koeverden: It's only slightly—

The Chair: What's different?

Mr. Adam van Koeverden: It's that we remove “to investigate reports that the Minister of Health personally intervened” and that we remove “to indefinitely suspend reforms that would have saved billions on drug costs”.

● (1235)

The Chair: Okay, so the witness list remains the same, but the scope of the investigation has changed.

Can you read up to the witness list again? That's the guts of the amendment.

Mr. Adam van Koeverden: Yes, it's just been shortened to, “That pursuant” and all of that, and then “the committee conduct a study on the PMPRB board; and that the committee invite the following witnesses in addition to” any others.

The Chair: Okay. The amendment is in order. If you have it to circulate, that would be helpful.

Mr. Davies has his hand up.

Mr. Don Davies: Mr. van Koeverden and I have had a chance to discuss the amendment and I would accept it as a friendly amendment. It gets at the same substance, which is simply to focus on the PMPRB and, obviously, hear from the relevant witnesses. It's broad enough to include the issues that were included in mine and it removes language that perhaps was more directive.

If it's a way to expedite this process, I'm happy to say that I accept that amendment.

The Chair: Is there any further discussion on the amendment?

Seeing none, is it the will of the committee to adopt the....

Okay. Please reread the amendment.

Mr. Adam van Koeverden: Yes. It is “That pursuant to Standing Order 108(2), the committee conduct a study on the Patented Medicine Prices Review Board; that the committee invite the following witnesses, in addition to any further witnesses the committee may consider relevant: Hon. Jean-Yves Duclos, Minister of Health; Matthew Herder, former member, PMPRB; Mélanie Bourassa Forcier, former acting chair, PMPRB; and Douglas Clark, former executive director, PMPRB; that the committee report its findings and recommendations to the House; and that pursuant to Standing Order 109, the committee request that the government table a comprehensive response to the report.

The Chair: Is there any further discussion on the amendment? Are we ready for the question?

(Amendment agreed to)

The Chair: The debate is now on the main motion, as amended.

Go ahead, Mr. Davies.

Mr. Don Davies: It's just in terms of scheduling, Mr. Chair. Of course this motion was stimulated by recent events, so I would suggest that we schedule one day, perhaps in early to mid-April, just to hear from these four witnesses.

I'll leave it to you and the clerk to maybe work this out for the next meeting. Then I think the committee can assess where we want to go from there, because the motion does permit us to consider hearing from further witnesses if the committee believes we need to. It leaves it open. I'm mindful of people like former chair Mitchell Levine as a another potential witness. There may even be a couple of people from civil society. I don't want to make that determination now, because maybe these are all we need to hear from.

I do think that before we break for next week, I would like to ensure that we have one meeting sometime in April to hear from these four witnesses.

The Chair: Is there any further discussion on the motion? Are we ready for the question?

All those in favour of the motion as amended, please raise your hand.

All those opposed....

Go ahead, Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: Excuse me, but I'm not sure I properly understood the interpretation earlier.

For the witnesses, are we only going to hear from Mr. Duclos, Mr. Herder and Ms. Forcier?

● (1240)

The Chair: No, the list of witnesses did not change in the amendment.

Mr. Luc Thériault: Okay.

I would like to propose an amendment.

The Chair: All right.

You can present it now.

Mr. Luc Thériault: I would like Mr. Clark's name to be withdrawn from the list. The reason is straightforward: three individuals were involved in an event and were present at the event, and there was a person who was not present in any way. Mr. Clark was not at the PMPRB at the time of the events. So if, at an initial meeting, in view of the testimony—

[*English*]

Mrs. Laila Goodridge: I have a point of order.

[*Translation*]

The Chair: Please wait a moment, Mr. Thériault.

[*English*]

Go ahead, Mrs. Goodridge.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

I believe we already voted on the amendment and the motion, so I'm not sure if it is in order to be discussing this at this point.

The Chair: Normally I would be inclined to agree with you, but Mr. Thériault indicated that there was a problem with the translation that affected his ability to participate. I think that in those circumstances, we may very well end up back in the same place, but I would like to extend to him the fairness that the situation calls for.

Mr. Robert Kitchen: On a point of order, Mr. Chair, the fact is that we voted and it's been a recorded vote. We either have to rescind that vote in order to do that.... We've already had that vote, even though there was an error. I get that. I understand about translation, but the vote was put in place. From a procedural point of view, I would call for the clerk to maybe give us a better understanding whether that can....

My understanding would be that we voted on the motion. It has been approved. This would have to be a new motion or we would have to rescind the vote that we did.

The Chair: I take your point of order.

First of all, it wasn't a standing vote, but you've asked for a ruling on it.

Mr. Thériault, did you have something you wanted to add on the point of order?

[*Translation*]

Mr. Luc Thériault: We voted on Mr. van Koeverden's amendment and, before voting on the amended proposal, I said that I wanted to propose an amendment. You can propose an amendment after having voted on an amendment. That's all. I think I'm explaining my amendment—

The Chair: Okay. A moment, please.

I need to rule on the point of order.

Mr. Kitchen asked if it would be possible to have the clerk comment. I invite him to do so.

[*English*]

The Clerk of the Committee (Mr. Patrick Williams): Typically, yes, a vote that has taken place would need to be rescinded by unanimous consent in order to revoke the decision and then put another amendment forward.

If it was clear to the committee that the vote on the main motion had taken place, that would be a typical way to proceed, for example, in the House. Unanimous consent to rescind could be granted to do that.

The Chair: Okay. What I'm going to do is reject the point of order and entertain Mr. Thériault's amendment. It is open to anyone here to challenge the chair if they don't like that decision.

Go ahead, Dr. Ellis.

Mr. Stephen Ellis: Certainly I will challenge the chair on that, in the sense that you were, sir, in the midst of counting the votes on the main motion at the time. I think it was very clear around the table that there was a consensus.

I'm fully respectful of the fact that Mr. Thériault missed the translation. I think that's very important. I think we all need to be respectful of that. I think Dr. Kitchen's point is also very important: We also need to be respectful of the rules of how this committee should operate. Therefore, I would respectfully suggest that the chair consider another course of action and perhaps ask for unanimous consent to reverse direction, simply because of the fact that I do believe that it's an exceedingly important point that Mr. Thériault is bringing forward.

Again, I can't comment on the translation. I wasn't listening in French. However, I would suggest that because we're at the point of counting votes on the actual main motion, the chair reconsider his ruling and move back to a different position.

Thank you, sir.

The Chair: A motion to challenge the chair is not debatable. We're going to proceed directly to a vote. Just so we're all clear on what we're voting on, I have ruled that the motion has not been adopted and that Mr. Thériault is to have the floor to move his amendment. That ruling has been challenged.

The question for you is whether the ruling of the chair shall be sustained.

Do we need to do a standing vote on something like this? No?

By a show of hands, on the ruling of the chair that Mr. Thériault is now allowed to present an amendment and the motion has not yet passed, is it the will of the committee to sustain the ruling of the chair?

All those in favour of sustaining the chair...one, two, three, four, five.

All those opposed...one, two, three, four, five.

Madam Sidhu, did you vote in favour or opposed?

● (1245)

Ms. Sonia Sidhu (Brampton South, Lib.): I support the chair, Mr. Chair.

(Ruling of the chair sustained)

The Chair: The ruling of the chair has been sustained, so the motion has not yet been adopted.

Mr. Thériault, you have the floor.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, there's an imbroglio at the PMPRB that involves the minister. Two letters of resignation have been received. I think we need to stick to that. At the first meeting, we will hear the testimony from these people. If, in light of their testimony, we feel that we should have other witnesses appear, we can do that afterwards. It's still possible, as the notice of motion states: “in addition to any further witnesses the committee may consider relevant”.

However, I repeat that Mr. Clark was not at the PMPRB at the time of the events. If we consider it relevant to have additional clarification, and perhaps even receive other witnesses, we can do so afterwards. However, for the time being, I would simply like to briefly review the history of the two people who resigned and the minister's intervention. That's why I feel it would be most appropriate to proceed in this manner. It would allow for a second meeting if we needed one to reach our conclusions.

That's why I am proposing this amendment. I had already spoken about it with Mr. Davies. He may oppose it, but my intent to present it was very clear, and I thought it was already in the amendment. I had not understood that this was not the case.

The Chair: Okay.

Just to be clear, Mr. Thériault, you wish to remove Mr. Clark's name from the list. Is that correct?

Mr. Luc Thériault: Yes, to begin with.

Mr. Clark was not there at the time of the events, even though he was still working at the PMPRB. When you want to have somebody intervene who was not there at the time of the events, it's because you want to get to the bottom of things. My view is that the issue now before us is why people resigned and what the minister's involvement with these resignations was.

There are also two contradictory letters of resignation. We therefore need to work with the main players, and only afterwards, for further clarification, invite other people to appear.

[*English*]

The Chair: I see Mr. Davies and then Dr. Ellis.

Mr. Don Davies: I suppose the easiest way to deal with this, with the greatest respect to my colleague, is that the one and only and paramount reason he's giving for not hearing from Mr. Clark is factually incorrect. Mr. Clark was there the whole time. He's still there, as a matter of fact.

Mr. Clark has given notice of resignation. He was with the PMPRB throughout the entire process. He is there today, were you to phone over. His resignation is effective in June. I may have what he's doing today wrong, but he was, throughout the entire exchange of documents and letters, the executive director of the PMPRB.

Second, the reason he's an essential witness is that as the executive director of the PMPRB, there is no one who is better placed than he to answer questions that may come from this committee about what was happening at the PMPRB. He's appeared before this committee before. He's encyclopaedic in his knowledge. He's extraordinarily fair. He has no axe to grind, and he would be a resource.

This committee, when we schedule witnesses, just about always schedules four witnesses. It's my motion that I put forward, and these are the four witnesses I want.

This committee is always better served by hearing more evidence than not enough. If my colleague Mr. Thériault doesn't want to direct any questions toward Mr. Clark, he doesn't have to. He can focus his questions on whomever he chooses, of course, but Mr. Herder and Ms. Forcier will be there.

Mr. Clark is an indispensable source of knowledge about what's going on at the Patented Medicine Prices Review Board, and I think he would be an indispensable witness for all members here to question.

The last thing I'll say is that you have some contrary opinions about what happened. To have someone who was the executive director of the board and responsible for the daily operations be there to answer questions and to have a person who is not intimately involved in the exchange of positions perhaps help us resolve this is, in my view, indispensable.

I would defeat this amendment and invite the four witnesses.

● (1250)

The Chair: Go ahead, Dr. Ellis.

Mr. Stephen Ellis: Thank you very much, Chair.

From a purely planning perspective, regardless of the "he said, she said" argument, I think it's important to this committee. We have a lot of work before us. I think that planning ahead and saying, "Let's have these specific witnesses" may allow us to not go into a second meeting with respect to this issue.

I think it's very important to be very cognizant of the time restraints we have. If we plan appropriately, then there's a good chance we may be able to move more legislation through the committee, which I think is, in essence, an important consideration as well.

I thank you for that.

The Chair: Thank you.

Go ahead, Monsieur Thériault.

[*Translation*]

Mr. Luc Thériault: We already heard from Mr. Clark in the study on the reform of medicine prices. He was among those who were saying that groups of patients were being bribed by the pharmaceutical industry. I believe that his opinions are well founded.

A careful reading of the two letters of resignation indicates that for at least one of those who resigned, there was an issue of internal resistance. I can't see why at the outset we would invite someone who resigned from their job. Whether or not that person was at the organization is one thing, but the person at issue is just someone who has resigned, and whose positions we are aware of, and if we need further testimony, we can hear it afterwards.

What I would like to know is why Mr. Herder and Ms. Forcier resigned and what the minister had to do with these two resignations. I don't need any clarification from a fourth person who did not produce any documents that would justify this study.

[*English*]

The Chair: Go ahead, Dr. Powlowski.

Mr. Marcus Powlowski: For some of us, this isn't our first time through the issue of the changes to the PMPRB. It is an exceedingly difficult topic for anyone to understand. I think that the last time around, Mr. Clark was very good at explaining some of the concepts to people who weren't familiar with this difficult and hard-to-understand area of regulation. I think he would definitely be a good witness to have before us, given his familiarity with this exceedingly complex subject.

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

Mr. Don Davies: I just want to mention a few things.

Mr. Clark also resigned, so we have three resignations from the PMPRB. It's immaterial whether he disclosed the letter in public or not.

There have been three high-profile resignations from the PMPRB, and the letters that have been sent out show that there are some issues we need to look at. I think trying to find out why the executive director of the PMPRB resigned in this context is relevant.

Second, we are not here to determine the merits of the substance of the PMPRB reforms. That's what Mr. Clark came to testify on before. That's not what we're looking into in this matter here; we're looking into the matters of the functioning of the board and potential issues of propriety.

My final point is this: The reason we almost have to have him is that he is referenced in Madam Bourassa Forcier's resignation letter twice.

I'm sorry; I just lost the quotes, but she makes specific reference to Mr. Douglas Clark, so it would be fundamentally unfair to hear from Mélanie Bourassa Forcier as she puts into evidence comments on Mr. Clark without Mr. Clark being here to hear that and respond.

I'll read you excerpts from her letter: "Following these two letters, I asked the executive director, who recently resigned from this position, if we had taken the time to meet with these stakeholders to understand their concerns in relation to the proposed guidelines, concerns that had not been brought to my attention as interim president. I therefore believed wrongly that our proposed guidelines posed no real problem. I then understood from the response of the executive director that he had met representatives of certain pharmaceutical companies and that he had never had any discussions with Health Canada in relation to the proposed guidelines."

The very subject matter before us, which is going to be how the decision came to be—and it had to do with whether pharmaceutical industry pressure did or did not play a role—involves the executive director, who is intimately involved in the discussions with the board members, and Madam Bourassa Forcier herself refers to these in her resignation letter. Not only is he an appropriate witness; he's an essential witness.

● (1255)

The Chair: Is there any further discussion on the amendment?

Mr. Jowhari, go ahead.

Mr. Majid Jowhari (Richmond Hill, Lib.): I have just a short comment.

Typically we discuss about a motion and then we ask each side to submit their witnesses. We don't sit here and argue about who's going to submit what witnesses and why or why not.

Let us simply consider the motion as put forward. We are in agreement about the amendment. Now we are asked to go back and submit our witnesses by the end of the day on Friday. The list of witnesses is in front of us, and everybody is agreeing—except for one of our colleagues—about whether Mr. Clark is relevant or not.

Our member from the NDP says he's relevant and he's going to submit his name on the witness list, so he's going to be on the list of witnesses to be called. It's as simple as that.

Thank you.

The Chair: Is there any further discussion on the amendment?

All those in favour of the amendment to remove Mr. Clark as a witness, please raise your hand.

(Amendment negatived [*See Minutes of Proceedings*]).

The Chair: We will go back to the main motion as amended by Mr. van Koeverden's amendment only. On the main motion, is there any further discussion?

I see that it is passed unanimously.

(Motion as amended agreed to [*See Minutes of Proceedings*])

The Chair: That brings us to Bill S-203.

On remarkably short notice, we have an expert here as legislative counsel if there are any technical questions.

Go ahead, Mr. Thériault.

● (1300)

[*Translation*]

Mr. Luc Thériault: There was no agreement among the leaders on the fact that we could discuss Bill S-203. We thought that there had been one, but I just learned that this was not so.

Unanimous consent would be required for us to discuss it today.

The Chair: Mr. Thériault, I was advised that I could add items to the committee's agenda. As you know, discussions were held, at the conclusion of which it was decided to add an item concerning the bill.

Unanimous consent is not required. We are now going to address this subject.

Mr. Luc Thériault: Mr. Chair, we spent some time organizing our work at our last in camera meeting. We only received your notice to the effect that Bill S-203 would be on the agenda at 10 a.m. Do you think it's acceptable, at only an hour's notice, to add an agenda item to study a bill for 15 minutes when a political party is trying to introduce some amendments? Do you believe that's acceptable?

You assumed, on the basis of information from I don't know who—surely not an official representative—that there had been an agreement between the parties, which is not the case. What I am challenging is not the outcome of the agreement, but the fact of introducing a clause-by-clause item on the agenda of the committee meeting at only one hour's notice. I've never seen that.

It has nothing to do with obstruction. I know that Mr. Lake is keen on this bill. I think that if we were to begin this study on Tuesday, when we return from the break, there would be enough time for him to achieve his goal, which is to have his bill adopted prior to World Autism Awareness Day.

However, I disagree with the fact that we should have taken time to organize our work, only to find that on only an hour's notice, after having been contacted unofficially, you should ask us to begin a clause-by-clause study. That's not in keeping with the usual practices.

The Chair: Mr. Thériault, you're absolutely correct. I'm not at all comfortable with the current situation, which stems from discussions hinting at the fact that there had been an agreement. However, we need to continue the debate.

Mr. Lake, you have the floor.

[*English*]

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): Listen, it's important to me that we move this forward in collaboration with one another.

We thought that there was an agreement. It's clear that there wasn't an agreement. I think it's probably more important to wait and have some sense of collaboration and consensus on this than to ram it through five minutes after the meeting's end time, so I am good if we wait until our next meeting to deal with it.

The Chair: Thank you so much, Mr. Lake.

I think we're now ready for a motion for adjournment.

Are you moving the motion, Ms. Goodridge, or do you want to speak?

Mrs. Laila Goodridge: I'm going to move the motion that we adjourn the meeting.

The Chair: Okay.

The clerk has asked me to see if I can get your agreement to adopt the budgets for the upcoming meetings, but the motion is not debatable.

All those in favour of adjourning the meeting?

Some hon. members: Agreed.

The Chair: I'm sorry, Clerk. The meeting is adjourned.

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