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Chair

Ms. Bonnie Brown

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● (1540)

[*English*]

The Chair (Ms. Bonnie Brown (Oakville, Lib.)): Good afternoon, ladies and gentlemen. It's my pleasure to welcome you all to the 21st meeting of the Standing Committee on Health. Our study continues on Internet pharmacies.

It's my pleasure to welcome our witnesses. We'll begin with the representatives of the Canadian International Pharmacy Association. The first presenter will be the executive director of that group, Mr. David MacKay.

Mr. MacKay, you have the floor.

Mr. David MacKay (Executive Director, Canadian International Pharmacy Association): Thank you, Madam Chair and members of the committee. We appreciate the opportunity to present our material to you today. Thank you for the opportunity to be here. We're grateful for that. We come bearing solutions.

I'd like to begin with a little bit of background on the Canadian International Pharmacy Association, also known as CIPA. Before I do, I'll just introduce myself as the executive director, and take a moment to allow this gentlemen, Randall Stephanchew, to introduce himself and his credentials as well.

Mr. Randall Stephanchew (Vice President, Canadian International Pharmacy Association): Hi. Thank you for having us here today.

My name is Randall Stephanchew. I'm a licensed pharmacist in Manitoba. I am the VP of standards for the Canadian International Pharmacy Association. My background, for relevance to this committee today and for the hearing, is that I worked for Health Canada for 14 years as a drug specialist and as one of their mutual recognition agreement officers. In the last couple of years before I left, I was acting as operational manager for Manitoba and Saskatchewan. Of particular relevance, I held the Internet pharmacy file, advising senior Health Canada officials and other regulatory authorities in relation to this very important topic.

Again, thank you for having us here today. I look forward to the discussion that will ensue.

Mr. David MacKay: If I could just add one more piece about my background that might be relevant, in addition to the current position, I had a one-year position with Canada Drugs, the largest mail-order pharmacy in Canada, as their director of business development, and 12 years previously I was with two pharmaceutical companies in Canada, Abbott Laboratories and Johnson & Johnson.

To begin our presentation, the Canadian InternationalPharmacy Association is a non-profit association headquartered in Winnipeg, Manitoba. We have 35 pharmacy members within CIPA that are mail-order pharmacies. Some share the provision of direct pharmacy to Canadians as well. The sector as a whole in Canada employs approximately 4,000 primary jobs, mostly in Manitoba—at least half, if not more—and you'd find the rest in Alberta and British Columbia, for the most part western. The pharmacies are provincially licensed by the regulatory authorities and are inspected as such.

Unquestionably, these pharmacies, over the course of the last four years, have become leaders in distance-based health caredelivery to American patients who are underinsured and uninsured, as well as elderly.

I'd like to give you a bit of situation analysis, if you don't mind. I'm aware that as a result of the completion of the first hearing last Monday, each of you understands the three different proposed changes Health Canada is considering under the Food and Drugs Act to address the alleged threats to the Canadian drug supply, the price regime, and the issue about doctor ethics. I'd like to point out quite emphatically that each and every one of those options would be lethal to the operations of our pharmacies. We are required by law to involve the Canadian physician to perform a secondary medical review, and as such, prohibition of that would be instantly lethal to our operations, catastrophic for us to be able to provide to American patients.

I would just like to highlight again those three proposed Health Canada changes of regulation, which are with respect to these three issues: an alleged threat to the Canadian drug supply, an alleged threat to the Canadian pricing regime, and an allegation that the Canadian physician conducts business unethically in performing a secondary medical review.

I note that even the Health Canada officials who were here on Monday struggled to give adequate evidence or explanation of these so-called threats and how they might actually occur. CIPA is equally confused about this drastic position. We have shared a two-year history of open communication and collaboration with Health Canada and have had no reason to suspect there was any issue up until a number of months ago, when their position suddenly shifted. We were just as confused as you were about the sudden shift in the position.

I'd like to address each of these threats individually, with some evidence of our own as to why they don't exist for Canadians.

One, is there a threat to the Canadian drug supply?

We do agree with the statement made by the health minister that Canada cannot be a drugstore to 280 million Americans. However, that certainly wouldn't be the case. We have no intentions of providing medications to 280 million Americans; in fact, we serve only 1.8 million Americans. A cap in that market exists today, naturally, at approximately three million patients. And three million to four million at best would be the most we could serve in a market capacity.

The mail-order pharmacies provide only chronic maintenance medications, which are in abundant supply. These are the drugs patients need to take on an ongoing basis for quality of life every day. Those are the top blockbuster drugs for the pharmaceutical companies. They're not likely to be in a position to have a short supply of them. That wouldn't be profitable for them.

These products exist in abundance. They are the chronic maintenance medications. I will demonstrate by pointing out that the top 100 drugs we sell actually comprise 75% of our total sales. So you can see it's a very select group of products that tend to be maintenance medications.

It's been established also by Health Canada in their analysis that sales have recently levelled off. It's also been established that over a four-year track record, there's been no evidence of a shortage for Canadian patients as a result of the trade known as Canadian mail-order pharmacy.

I'll also add that in my opinion the U.S. is not likely to legalize importation. I'd be happy to take questions in the Q and A portion to substantiate that.

● (1545)

Finally, I'd like to point out that the prescription trade is being shared by the European Union in this. There are no products coming from the European Union into Canada for transshipment, but American patients are being referred to pharmacies that are licensed in Europe. As a result, the demand on the Canadian drug supply is actually diminishing.

The mail-order market cap. I just want to back up my point by demonstrating why we believe there's a cap of three million to four million patients on personalized mail order. First of all, 75 million Americans are either uninsured or underinsured. The combination is actually 40 million uninsured Americans, with the balance being underinsured. It's a large pool, but not all of them take chronic maintenance medications. In fact, only two-thirds of them do. As a result, you're down to a pool of about 50 million patients who would ever wish to see chronic maintenance medications more affordable, and only 6% of those actually order by mail. If you check the IMS data—this is a company that provides outlet-level sales for pharmacies—you'll see their data shows it's only a 6% mail-order market share. Six per cent of 50 million is three million, and that's why we're fairly level at 1.8 million right now as we reach market capacity and maturity for our market segment. So there is a natural limitation.

U.S. patients, if they have any insurance, cannot integrate a Canadian purchase into their U.S. insurance program. That means it's only cash-out-of-pocket purchase for the American patient buying from Canada as they will have no integration whatsoever with the insurance program they have. As a result, the vast majority of American patients prefer to purchase and will purchase their prescriptions at their own local pharmacies in the United States.

Second, is there a threat to the price regime? In 1993 Bill C-91 provided a quid pro quo agreement with the pharmaceutical companies in Canada. That quid pro quo provided patent extensions for the pharmaceutical companies of up to 20 years in exchange for appropriate pricing, which was the international median; that is how the prices were set in Canada.

The Patented Medicine Prices Review Board is backed by law as a quasi-judicial body and does enforce price controls. They've been doing a great job. They are very capable and intact, and at this point I do not see how it is possible that they would be inundated by the U. S. demand and lose control of pricing when they are backed by the law to control that pricing and have done so very well for over 12 years.

I also want to point this out. As I recall from the position I was in with the pharmaceutical industry, a primary consideration in pricing your products competitively is pressure from the provincial formularies. You need to make sure you actually set your prices in a competitive manner for your products to be preferentially listed. If you don't do that, the doctors may not write those prescriptions and you won't be gaining any market share in those provinces.

Given that, I don't believe the pharmaceutical industry would risk losing some of the benefits of Bill C-91. I don't believe they'd want to go back to compulsory licensing. I don't think they want to risk the status they have right now with the patent extensions, so I don't believe there would be any threat to price controls.

Certainly, if you look at where else in the world this has occurred, you'll see that the European Union legalized parallel trade four years ago through the European Court of Justice. Have there been any price increases as a result of that? No, there haven't, and I have a statement to back that up by Mr. Donald Macarthur, former secretary general of the EAEPC. I have provided this to the clerk, who will be happy to get it translated and into your hands.

Third, physician ethics. Is there an ethical issue with a doctor who performs a secondary medical review, also known as co-signing, for an American patient's prescription? I want to emphasize that there is a doctor-patient relationship at the heart and core of every prescription for an American patient. That family physician has been chosen by the patient himself or herself in the United States. That physician will continue to follow up on, diagnose, and care for that patient on an ongoing basis, so there is no absence of a doctor-patient relationship.

The Canadian doctor is simply an additional medical consult required by law to convert the prescription into something we can fill legally in Canada. That is a technical redundancy; it's a secondary review. Twenty-nine U.S. states will directly accept a Canadian prescription as is, without conversion. Why not reciprocity with those 29 U.S. states? Are we saying we don't trust their licensing of physicians? I believe a doctor from the Mayo Clinic would have a hard time understanding why a country like Canada won't trust his physician's licence as authentic.

● (1550)

Canadians regularly receive prescriptions every day, thousands of them, without seeing doctors, without having examinations performed by physicians, based on eHealth in northern communities and remote locations, where every single day prescriptions are provided without examinations. It is a double standard if we continue with this change of the regulations.

In Manitoba, this process was looked at and analyzed extensively. The arbitrator, Wally Fox-Decent, and all of the stakeholders agreed that the elimination of the requirement under the Food and Drugs Act was the solution to this ethical dilemma. We agree with that.

I just want to quickly point out a pharmacists' code of ethics that is at play as well. Pharmacists do have ethical codes provincially that they must abide by, and each of these pharmacists, of course, is licensed. The ethical code, first and foremost, means they must protect the health and safety of the public, but the public is not defined by nationality. As a matter of fact, a pharmacist would be in an ethical dilemma if he or she were to refuse to fill a prescription based on the nationality of that patient. Therefore we are under an ethical obligation to fill an American prescription and go through the process of conversion, to make sure we keep that ethical code fulfilled. To quote from the Manitoba ethical code, “The pharmacist may exercise appropriate professional judgment in the application of the legal and ethical requirements”. I have the URL to offer reference to that.

Finally, on CIPA recommendations and solutions for the committee, you've probably heard them before, but they all rest on one very simple and basic solution. Minister Dosanjh and a number of his previous colleagues have mentioned there is no evidence of a drug supply threat in Canada today. I think we're talking about what might happen in the future. One way to ensure that is to ban bulk wholesale trade. That's something we do not conduct today. Although the Americans might try to consider that, we have not permitted that to happen. That is illegal for them at this time.

We also feel it's a natural extension of that to ban commercial contracts with U.S. cities, states, and municipal governments. That's all you would need to do, as a Canadian solution to prevent what might be the eventual threat—which isn't there today—and solve all of the issues we've been talking about.

In addition, we have some other ideas. Adopt a Canada-first policy nationally. CIPA already has this policy in place, whereby if the supply concerns are there for a particular drug, we make sure it's not provided to an American—always to a Canadian first.

Next, we would ask the committee to make recommendations to replace the requirement of the secondary medical review by the Canadian physician to actually then accept the American physician as an acceptable prescriber and have reciprocity with 29 U.S. states.

We would also request that the committee consider permitting the Province of Manitoba and all of the stakeholders there to develop a best-practice model, which they have already been considering and is in play at this time, and allow it to proceed unfettered. Let Manitoba set the benchmark standards for the rest of Canada. I believe they will tackle this issue and be able to guide the rest of the country very well on all of the issues, including the ethical debate.

Finally, there's a benefit for Canadians here. If you kill this now, you'll kill this potential opportunity in remote locations in Canada, where Canadians do not have access to adequate therapies because of the remote geographic locations. First nations and northern communities face this all the time. Central fill from pharmacies in Winnipeg and Vancouver can provide excellent access for these Canadians in remote locations. That's something we already have under way and would like the Government of Canada to consider in the future as an opportunity to help Canadians directly.

In conclusion, elimination of the mail order practice in Canada and the 4,000 jobs associated with it is just not necessary and does not make sense. There is no real threat to the drug supply or the price regime. Banning wholesale will contain the trade to a status quo level, which will be acceptable to all stakeholders.

There will be a win-win situation for everybody. Canadians will be protected while deriving an economic benefit and all of the jobs associated with this trade. It's an innovative industry that can survive in a free trade environment with open competition. The patients in the United States can be cared for well, and the pharmaceutical industry can benefit from the incremental sales and profits.

● (1555)

Thank you. That concludes my presentation. I apologize if I took too much time.

The Chair: Thank you, Mr. MacKay.

We'll now hear from the International Pharmacy Association of British Columbia. It's my pleasure to introduce Mr. Ankur Arora and Ms. Dawn Polley.

I'm not sure which of you is going to present.

Mr. Ankur Arora (Executive Member, International Pharmacy Association of British Columbia): We'll both present, but I'll be speaking first.

The Chair: Thank you. The floor is yours, Mr. Arora.

Mr. Ankur Arora: My name is Ankur Arora. I am the vice-chair of the International Pharmacy Association of British Columbia. I am also a lawyer and part owner in an international pharmacy service provider in Langley, British Columbia.

Ms. Dawn Polley (Executive Member, International Pharmacy Association of British Columbia): Good afternoon.

My name is Dawn Polley, and I am also the vice-chair of the International Pharmacy Association of B.C. I have been a practising pharmacist for more than 20 years, and I'm an owner of a pharmacy located in Vancouver.

Mr. Ankur Arora: The International Pharmacy Association of British Columbia represents the mail order industry of international pharmacy service providers in the province of British Columbia and the voices of their employees.

The province of British Columbia currently brings in more than $260 million a year in revenues because of our trade. That is more than one-quarter of the $1 billion being brought in nationally by this industry.

We in British Columbia are responsible for more than 700 direct jobs and several thousand indirect jobs in supporting industries. Just to give you a snapshot of the types of jobs we're talking about, these are not part-time or minimum-wage jobs; these are high-quality, high-paying, full-time jobs. Some of the more obvious ones are for pharmacists, for pharmacy technicians, and a substantial call centre staff. I think, most importantly, we really take advantage, being in a technology-based industry, of B.C's reputation as a high-technology centre and leader in Canada, so we do employ a lot of IT staff—technicians, computer programmers, website developers, and the like.

In terms of secondary industries that really benefit from us, let me give you one example. In British Columbia today, Canada Post—that is, B.C.-based Canada Post employees—ship more than one million pharmaceutical packages a year to the United States, so this is a huge boon for them. I'm sure you can imagine many more of the subsidiary benefits, which I won't go into here.

I think it's appropriate for me to turn over the presentation to Dawn Polley, as a pharmacist, to give you an idea of how the prescriptions are filled.

Ms. Dawn Polley: Thanks, Ankur.

As you know, most of our patients are elderly and don't have health or medical insurance. Our patients are on chronic or maintenance medications of the sort that would be taken for conditions such as high blood pressure, high cholesterol, arthritis, and diabetes. We don't provide any narcotics or controlled drugs or acute medications to these patients.

These patients have a direct relationship with, and are monitored regularly by, their U.S. physicians. They see their doctors regularly. They have annual exams and they have tests. Everything is monitored by their primary U.S. physician.

Once the patient has a prescription from the U.S. doctor, they contact us directly. I think it's a bit of a misnomer to use the words “Internet pharmacy” when in fact 80% of our patients contact us directly by phone. Less than 20% will place an order over the Internet. For those who do, we still require a U.S. prescription, and we have direct communication with them. Most of them phone our staff and talk to us about their medication problems.

Once they've obtained their U.S. prescription, we then require them to complete a detailed medical assessment. The medical assessment includes a list of all the medications they're currently taking, all of their medical conditions, as well as their allergies. They will complete this and forward it to us, either via fax or mail.

When we receive these, our pharmacy—which is a fully functioning, licensed pharmacy, regulated by the College of Pharmacists of British Columbia—has its pharmacy staff review the U.S. prescriptions to ensure there aren't any problems or any contraindications with the medication. If there is a concern with the prescription, we will contact the U.S. physician directly and resolve it with them.

Once we are sure that the prescription is valid and accurate and appropriate for the patient, we review the medical chart, forward it electronically to a Canadian physician, who reviews the profile and provides a secondary medical review. At this point, if the Canadian physician has any concerns, they will contact the pharmacist and communicate directly, or the Canadian physician will communicate directly with the U.S. prescriber.

Once this is done, the Canadian physician writes out a Canadian prescription, which is filled in the normal way by our pharmacy and packaged and mailed by Canada Post directly to the patient's home. We then contact the patient and provide patient counselling directly, as well as providing written information on this medication.

We're very happy to work with our College of Pharmacists of B. C., who have developed special practice standards for our pharmacies. We are working with them to define these standards for distance-based medicine, and we applaud our college for this forward-thinking action.

Ankur.

● (1600)

Mr. Ankur Arora: I'd like to reiterate that those standards are specific written standards applying to the practice of international pharmacy.

I'd like to address the issue of the drug supply for Canadians. I think it's really important to note that drugs are not a natural resource. They are made in factories that produce pills. When there is an increased demand for pills, the factories increase their output and make more pills. I also want to reiterate that both the federal health minister and Health Canada have stated time and time again that there has never been a shortage for Canadians relating to this industry whatsoever.

With respect to the market that we serve, I think it's really been sensationalized in the media to some extent that the entire United States is interested in purchasing drugs from Canada. In fact the actuality is that we serve a very small minority of Americans, the poor and the elderly who have no access to prescription drug coverage in the United States. To be more accurate, our market is actually a subset of this group and is quite a bit smaller because they have to be taking prescription drugs. An even smaller subset, and the one we actually serve, is that group of prescription drug takers who take drugs of the maintenance variety that the Canadian mail order pharmacies actually provide.

Patients are not going to order acute care medications via the mail, and they have to wait two to three weeks. If you have a bacterial infection, you need your antibiotic right away. And then, of those people who take the maintenance medications, I have to tell you that most of them, despite the cost savings from Canada, will prefer the convenience of going to their local drug store and attempting to access their medications there if possible.

So when you whittle this number down, you're looking at a group of three to four million Americans, the people who would go without, and that is our target market. And I think great evidence for this is that in the five years that this industry has been alive and vibrant in Canada, we still have fewer than two million American patients.

Another point I'd like to touch on is that of price controls for Canadians. The fact of the matter is that the Patented Medicine Prices Review Board, which was created by legislation with rules that are mandated by law, protects Canadians against price increases. This board sets those prices and also sets the criteria for increasing those prices, all of which are independent of the export of medications from Canada.

I'd also like to say that the IPABC actually met with Minister Dosanjh yesterday. Minister Dosanjh did express many of the concerns he has raised publicly in the media, but we were very encouraged to hear that he's not interested in shutting the industry down. Both the IPABC and Minister Dosanjh left with a commitment to keep the dialogue open. So again, we're very encouraged by that. All of that being said, Health Canada has outlined three options that I think would unfortunately have that exact effect of shutting the industry down.

The first proposal put forth by Health Canada was to prohibit Canadian doctors from prescribing for patients whom they haven't seen face to face. Of course, as Mr. MacKay has mentioned, the results of this would effectively eliminate our industry in Canada. And not only would it do that, but it would be a backward step for the advancement of medical care in Canada.

There are so many remote communities, particularly in first nations, currently underserved by health care providers. Many provinces are experimenting with nurse practitioners and other models where a physician does not actually see the patient. And to cut short the expertise that this industry has built in the delivery of distance-based health care would be a disservice to Canadians.

● (1605)

One of the other proposals was to simply create a list and ban the export of drugs. I don't need to go into too much detail on that one, as it would obviously destroy the industry in British Columbia and throughout the nation, and the several thousand jobs that rely on it.

Another concern we have with the proposals that were raised is that some of them do not appear to be within federal jurisdiction. It seems that the very first proposal would result in a regulation of the practice of medicine, which is under the exclusive purview of the provinces.

A final point I would like to make on this is that Canada is not the only country with an active and effective price control regime. Many other western developed nations have this. In fact, all of them have it except the United States. If the industry is shut down in Canada, the demand will not dissipate for the three million to four million Americans who do not have access. Effectively, all Canada will see is a transfer of jobs and wealth to providers in those countries. As Canadians, we believe that we should keep the industry here, and keep the jobs for Canadians and revenues for our provinces and federal government.

The IPABC doesn't just come here with critiques. We are offering solutions as well. Our solutions, I think, will not only ensure the drug supply for Canadians, but will also ensure that 700 direct jobs in B. C. are maintained and 3,000 more are also maintained.

The first is simply to regulate a ban on wholesale exportation, bulk exportation to the United States. The business model that we employ is a direct-to-patient prescription delivery. That's what we focus on and that's what we would like to be permitted to focus on.

I will turn over the IPABC's recommendations with respect to the activity of Canadian physicians.

Ms. Dawn Polley: Thank you.

We reiterate the recommendation that Mr. MacKay has forwarded regarding U.S. prescribers. Currently, as he mentioned, 29 U.S. states will allow Canadian pharmacists to fill U.S. doctors' prescriptions. To put that into perspective for you, my B.C. pharmacy can accept a prescription from a prescriber located in Newfoundland, yet I cannot accept a prescription from a prescriber who is located in Seattle, which is just across the border from where I live. Washington State is one of the states that will accept a prescription from a Canadian physician. If you go there with a prescription, they will fill your prescription, regardless of where you reside.

We would also support the recommendation to amend the food and drug regulations to allow Canadian pharmacists to fill U.S. doctors' prescriptions directly. We don't have any concerns about the qualifications of U.S.-trained physicians. They're all trained in the same format as our doctors are. We would feel very comfortable with that amendment.

That concludes our presentation for today. We're looking forward to and are happy to accept your questions.

Thank you.

● (1610)

The Chair: Thank you very much to all our presenters.

We'll now move to the question and answer period. We'll begin with Mr. Fletcher, of the official opposition.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Madam Chair.

First of all, I'd like to extend my apologies. I have to leave shortly to be a witness at another standing committee. I won't be here for the duration, but I'll be sure to read the transcripts.

One thing that struck me in your presentation is that you met with the minister only yesterday. Given all the media publicity and attention that this issue has garnered in the last months and years, it seems surprising to me that your first meeting was yesterday. Did you request a meeting with the minister before yesterday?

Mr. Ankur Arora: Mr. Fletcher, it was the IPABC that met with Mr. Dosanjh. We recently requested the meeting with the minister, and it was granted yesterday.

Mr. David MacKay: In terms of CIPA, we have been repeatedly requesting a meeting with the minister for over two months, and we have been repeatedly declined.

Mr. Steven Fletcher: Okay. Basically, since the change in message from the government, they have declined to see you. Have they refused? Is that it?

Mr. David MacKay: Yes, "refused" would be absolutely correct.

Mr. Steven Fletcher: Well, that's disappointing.

Let's go back to the three points that Health Canada presented on Monday. They will apparently, as you testified, shut down the Internet pharmacy industry. You just gave us a series of reasonable and thoughtful suggestions that are worth discussion. Did you raise these in your meetings with Health Canada?

Mr. David MacKay: Unfortunately, because I've not been able, as the representative of CIPA, to gain access to Health Canada employees or the minister's office, I haven't had the ability to offer those solutions, proactive or not. The only opportunity I seem to have to talk to the minister and his staff is through the media.

Mr. Steven Fletcher: Has anyone from your industry talked to Health Canada on this?

Mr. David MacKay: Not since November 1.

Mr. Steven Fletcher: So then Health Canada has not, presumably, examined the alternatives that you have presented to us.

Mr. David MacKay: I can't comment. We've tried to make very clear what we think the options are, even in presentations to members of Parliament. We hope that at some point Health Canada will duly consider these options. I can't speak for them right now, because I've never been given any feedback.

Mr. Steven Fletcher: I tend to agree. If we want to look at this in a thoughtful, thorough, and timely manner, and if we're going to have Health Canada come to make recommendations, I would expect that they would at least listen to all the stakeholders.

I would like to move on to another issue that was raised in question period about an hour and a half ago, and that was by my friend across the desk here. If I understood the question to the minister correctly, it was that Americans are getting drugs from India and using Canada as the referral or intermediary agency.

You were in question period. Would you like to respond to the question that was raised?

● (1615)

Mr. David MacKay: Sure. I didn't actually hear the question, but I understand it has been asked before.

Correct me if I'm wrong, but it was alleging that Canadian pharmacists are acquiring product from developing countries in the world and they're being transshipped into Canada for provision to American patients. Am I correct in assuming that?

Mr. Steven Fletcher: That was the suggestion. I'm not sure if it was explicitly said.

Mr. David MacKay: Well, I can categorically deny it. Certainly it's false.

We receive inspections on a regular basis, from the provincial health regulators as well as from Health Canada just recently. Our pharmacies are held to a higher standard than any other pharmacies in the world, because now we have multiple layers of regulation.

We are under the microscope, and as such, any product that is found on our shelves that does not have a DIN number, a drug identification number, would be found to be in violation of the Food and Drugs Act, which would then subsequently mean that the pharmacy would be shut down.

We wouldn't be that foolish, to bring in products from other countries. We're proud of the fact that we're selling Canadian drugs and they're market-authorized for Canada.

Mr. Randall Stephanchew: Could I just offer something?

Mr. Steven Fletcher: Sure.

Mr. Randall Stephanchew: I've worked for Health Canada and know the way the system works. The border is controlled by Health Canada, working in partnership with Canada Customs. It does not have a problem with Canada's shipment coming through. Any person who wants to import a drug must have an establishment licence to do so. Health Canada, which is even present here today, could testify to that, stating that they do not allow products to come through. Canada Customs would alert Health Canada, they would give a report of examination, and they would refuse entry.

We have no evidence to show this is occurring. I doubt it's happening. Health Canada does a great job at policing the border, and I cannot see this being true.

Mr. Steven Fletcher: I have to get through a lot of questions here, if you don't mind.

So the answer to the question is that there are no drugs going from another nation to Canada and being shipped to the States.

Mr. David MacKay: None at all.

Mr. Steven Fletcher: What about from a third nation to the States, using referrals from Canadian...? That is another implication that could be taken from the member's question.

Mr. David MacKay: Again, not true. The supply restriction schemes from seven companies over the last year and a half have forced our pharmacies to begin partnerships with licensed pharmacies in the European Union. There are times when we are faced with the situation that we cannot provide the patient with the drug, a Canadian drug. That patient will be directly referred to a foreign pharmacy that is licensed in the European Union, in developed countries only—the G-8 countries, and for the most part, the ones that are MRA. The mutual recognition agreement picks countries, and obviously the more modern and developed European countries.

I'm talking about Britain, Germany, France, and Belgium. The western European countries are where our partnerships are established.

Mr. Randall Stephanchew: The member pharmacies within CIPA tend to look for those partnered countries that Health Canada has done their due diligence on. So again it's those mutual recognition agreement countries. It's the European Union. It's the EFTA countries—Switzerland, Australia, New Zealand. Again, these are what the recommendations are, with systems that have been examined, assessed, and seem to be equivalent to Canada's. They're not exactly the same, but they lead to the same results.

It's surprising that the USFDA has never entered into any MRAs with Canada. They have a memorandum of understanding, but they like to do everything themselves. But Canada is at the forefront of global harmonization.

Mr. Steven Fletcher: In your presentation you suggested that the industry is perhaps in contraction, and Health Canada suggested that it certainly has plateaued. This is an industry that of course has grown under a Liberal government. I find it interesting that just when it's at the point that it's contracting or going offshore, they're looking at closing it down.

I guess that's more of a statement than anything else. I'm running out of time.

Regarding the issue of provincial jurisdiction, I notice that Health Canada presented a fact sheet in May 2003 that says:

> A number of pharmacies in Canada have legitimate Web sites that offer a limited range of products and services, including information for consumers, and shopping for certain items. The practice of pharmacy in Canada is regulated by the provinces, and any licensed pharmacy that offers Internet services must meet the standards of practice within its own province.

That supports your suggestion of provincial jurisdiction. I wonder if you have any legal advice or interpretation to support the position that it is provincial jurisdiction, and if the federal government even has the right to be involved. I'll ask that question.

I'll also ask one last question. I'm very intrigued about the opportunities Internet pharmacy can provide for our aboriginal communities. I would be very interested in hearing your comments there. I think by the time you've answered that I will have run out of time.

● (1620)

The Chair: I think you're going to have to be very succinct answering that. There's one minute left.

Mr. David MacKay: On the legal side of things, obviously we have analyzed our legal options with regards to the constitutionality of the regulation of pharmacy. I don't think this would be the venue to discuss those types of matters. Suffice to say that it would be our opinion that the practice of pharmacy is constitutionally under the jurisdiction of the provinces. But of course we're here to accept open discussions with the federal government as well.

Mr. Ankur Arora: I would just like to add that the provincial regulator in British Columbia has developed specific written guidelines for the practice of international pharmacy. We continue to work with them to expand on those written guidelines.

The Chair: Thank you very much.

Thank you, Mr. Fletcher.

We'll now go to Madam Demers.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): Thank you, Madam Chairman.

Good afternoon, ladies and gentlemen. Thank you for coming along today.

I have to admit that I have numerous concerns about your line of business, and that what you have said today has done nothing to levy ??? these concerns. I was late, and I apologize for that, but what I have heard and read here has not relieved me of my concerns. You claim that only seniors suffering from chronic diseases use your services. However, unless I am mistaken, seniors are not the only people to suffer from chronic diseases.

You also stated that you only provide service to people who require medication on a regular basis, because, for other requirements, the postal service takes too long. Correct me if I am wrong, but I believe that UPS and FedEx provide excellent service; therefore, if people really need your drugs, delivery time cannot constitute a real barrier.

It seems to me that you are quoting your company's image with a little... I do not know exactly how to put it, but I do not like the way in which you present your company as simply responding to the needs of seniors suffering from chronic illness.

What is more, as seniors often have a multitude of health problems and often take too much medication, they risk suffering adverse effects if they take the wrong medication, even if it is not contra-indicated or incompatible with their other medication. It is well documented that people can suffer all sorts of behaviour changes, becoming aggressive, for example. The fact that there is no one on hand to check medication that the client receives leaves me wondering how you operate.

I imagine that your business must be lucrative, given that you decided to set it up. You said that you currently provide 700 jobs in British Columbia, and I imagine that you aim to create a lot more. However, you also said that the market has ??? at around 3 million clients. If the market has indeed ??? at 3 million clients, then I am left wondering as to why you are making such a fuss about the restrictions that we wish to introduce. Personnally, I think the number is a lot higher. I think that you are hiding things from us, and I am not too happy about that. I would like to hear what you have to say on this subject.

[*English*]

Ms. Dawn Polley: I would like to address your question of pharmacy practice. I'm not sure if you heard my review of the process.

We provide a complete and thorough evaluation of a patient's medication profile, including the list of all the medications the patient is taking. We review that, and if there are problems, just as we would with any patient, we contact the physician directly and resolve it with them. We handle our patients exactly the same way as we would any patient. We review their chart; we review the list of medications. We're there to solve medication-related problems and deal directly with the physician and the patient on them.

Mr. David MacKay: If I may, in a more simplistic analysis of how many professionals are actually involved in the therapy for an American patient, I'll just quickly walk you through. You have the American physician, who sees the patient and obviously follows up with diagnosis, and that prescription is written. We don't change that relationship at all.

But once that decision has been made to go to Canada to acquire the medications, there are actually three pharmacists involved in analyzing the prescription for accuracy. We double-check with the patient, as Dawn has pointed out, to make sure that the prescription itself is accurate. The pharmacist will actually talk to the patient. The doctor who we have review the file is the second doctor in the process, so there's a double-check with another medical professional. There are times when that medical professional may actually see a drug interaction, sub-therapeutic dosing, or an inappropriate dose and will contact the American physician to alert them to something they find that might be a problem.

Therefore, there are a total of five professionals involved, versus two if they were to go to a regular pharmacist and physician. Five checks versus two. If it were my mother, I would want five professional checks in the system instead of two.

I would say that this process is by far safer than the current standard today, and it might be the new standard for health care. Five versus two. Unquestionably, we have a better bird's-eye view of the patient's medical profile than, in some cases, most physicians in the United States do. Because of the litigious nature of their society, there are many doctors involved. We hub all that information from a patient-based database of their information and are often able to see interactions that their original doctor would not have caught.

● (1625)

Mr. Ankur Arora: I'd like to address the second part of your question with respect to the 700 jobs in British Columbia. I believe the gist of it was, if 700 jobs have peaked in British Columbia, why are we here standing up for them?

Madam, I come from a province where the livelihoods of thousands of Canadians have been decimated in the forestry industry due to unfair U.S. trade practices, and I have a hard time understanding why we should eliminate 700 jobs—good jobs for people we know, people we work with—when this is generating a massive amount of revenue for our province. It's difficult for me to understand why any Canadian would want to do that.

The Chair: Mr. Boudria.

Hon. Don Boudria (Glengarry—Prescott—Russell, Lib.): I want to welcome our witnesses as well.

I was listening to the testimony provided earlier. If none of this threatens good medicine in Canada, I wonder if our witnesses would have any idea why the Canadian Medical Association, the Federation of Medical Regulatory Authorities, the College of Physicians and Surgeons of Nova Scotia, le Collège des médecins du Québec, the College of Physicians and Surgeons of Manitoba, the College of Physicians and Surgeons of B.C., the Canadian Pharmacists Association, the College of Physicians and Surgeons of Ontario, the College of Physicians and Surgeons of Saskatchewan, the College of Physicians and Surgeons of Alberta, the Alberta Medical Association, AIDS advocacy groups....

I have a list here that must have 50 names of various organizations, such as CARP, the Canadian Association of Retired Persons...and it goes on and on, each one of them expressing grave concerns about this. If it's helpful, I can read the names of the other organizations. All the consumer groups—the hepatitis network, Best Medicines Coalition, B.C. Persons with AIDS.... Anyway, I think you get the drift.

Why would they all be so concerned if there's nothing to worry about?

Mr. David MacKay: I haven't actually heard the specific concern that they're relating. Is it with regard to the Canadian doctors' involvement, or is it the industry as a whole?

Hon. Don Boudria: Well, it depends on which one. The position statement on cross-border Internet pharmacy, for instance, is on the fact that there is such a thing as cross-border Internet pharmacies. I could again read a list of eight of them on that particular side of it.

Mr. David MacKay: Mr. Boudria, I can save you the effort of doing so. As a matter of fact, I'd be happy to meet with you and literally go through the list. Every single one of the associations you just named either has a financial stake in this matter against this pharmacy practice or has been heavily lobbied by the pharmaceutical industry.

In the case of the Ontario Medical Association, I have evidence from as recently as yesterday that they actually condone practices whereby a physician examination is not required. This is with regard to a new website created by e-Salveo. I have a press release I'm going to prepare for this committee, which they will have tomorrow—hopefully translated. It will give evidence of the fact that there is a disconnect and a double standard whereby the Ontario Medical Association seems to feel it's okay—and I would agree with them in this case—that patients can acquire, through e-mail, refill prescriptions for their birth control pills or chronic maintenance medications.

It's very interesting that we can do it in northern communities or remote locations, and now we're about to consider the next wave of e-health and e-commerce, that of electronic refill prescriptions, where doctors have greater convenience, and so do the patients, in acquiring medications. Very clearly, that's the next wave. The Ontario Medical Association is on record as endorsing it in yesterday's press release, and so is the CMA. Obviously there is an endorsement of that practice and therefore, in my opinion, a double standard. In a way, it's “back at you”, as it were.

● (1630)

Hon. Don Boudria: So are you saying then that all of these groups that have identified this are wrong or have some sort of vested interest in doing so?

Mr. Ankur Arora: Mr. Boudria, I think Dawn Polley could address some of your concerns.

Ms. Dawn Polley: I think that is the opinion of some stakeholder groups. There are many other groups who don't share that view, including many physicians.

We don't believe it's an issue, because there is a direct relationship with the U.S. patient. The face-to-face requirement being outlined by some medical profession representatives doesn't reflect modern medical practice. It's a restricted policy that will make it very difficult to develop new health models, particularly for our northern and aboriginal communities.

Mr. Ankur Arora: I want to underscore that the U.S. patient has a face-to-face relationship with a U.S. doctor who is eminently qualified to treat that patient.

Hon. Don Boudria: Okay, let's assume that everybody I just mentioned is wrong in their assessment.

Australia just signed a free trade agreement with the United States on July 14, 2004, which prevents the export of pharmaceutical drugs from Australia to the U.S. In 2000, New Zealand imposed a general ban on the export of prescription drugs to the U.S., and I have a copy of the Spanish legislation that does the same. Are all these countries equally needlessly concerned as the Canadian medical groups that I described earlier?

Mr. David MacKay: Mr. Boudria, on the other hand, you've got 25 European countries who agree that parallel trade should be performed and who have legalized it as a result of the European Court of Justice. Are they wrong?

New Zealand and Australia are unique because they have been directly involved in a negotiation with the USTR, the Office of United States Trade Representative, with extraordinary pressure from the pharmaceutical industry in the negotiation of the free trade agreement with Australia. If you read it, it doesn't jeopardize access for Australians.

I don't understand the words “free trade”. If you call it a free trade agreement but you embargo the ability of that country to trade with another, how is that a free trade agreement? It seems like an oxymoron to me.

I would suggest that what you've got is a lockdown in Australia by the pharmaceutical industry—and we all know that the U.S. administration, the Bush administration, heavily backs that sector.

The Chair: Thank you, Mr. Boudria.

We'll now move on to Mr. Martin—the other Mr. Martin, Mr. Tony Martin.

Mr. Tony Martin (Sault Ste. Marie, NDP): Thank you.

I'd like you to comment on the fact that some large drug wholesalers and manufacturers have blacklisted Internet pharmacies. Have any of the generic drug companies blacklisted Internet pharmacies? How much of your business do generic drugs fill? Do you have any idea how many of those generic drugs are manufactured in Canada?

Mr. David MacKay: Let's do a quick overview.

I polled my members and, no, none of the generic manufacturers restricts supplies. They are quite happy to provide us with medications. By sales alone, I would say that approximately 20% of our sales are generic products from Canada that are manufactured in Canada. But because they're lower priced, generic sales versus brand would be approximately 12% of sales by dollar.

Mr. Ankur Arora: Speaking to the issue of blacklisting, given the fact that many of the major drug companies, as you have aptly put it, have blacklisted the Canadian mail-order pharmacies, I think the percentage of Canadian generics being sold is actually increasing. It's forming a larger component. But I also think that speaks to the supply issue for Canadians. A very good portion of the branded pharmaceuticals are virtually inaccessible to the Canadian pharmacies, which I think speaks to the supply issue for Canadians.

Mr. Tony Martin: Could you comment on the fact that 29 U.S. states recognize prescriptions written by Canadian doctors? Is the reverse—

● (1635)

Mr. David MacKay: Unfortunately, sir, no, it's not. Twenty-nine U.S. states. This research was performed by Mr. Robert Fraser, pharmacist with CanadaDrugs. Over a period of a year he directly contacted the state boards of pharmacy for all states in the United States and came up with a list of 29—I would be happy to provide the committee with this list—where it was unrestricted for access. They would directly fill a Canadian prescription as presented to them.

Unfortunately, no, we don't have that reciprocation. I think we would do well to recognize the authority of the licence and the verification of the licence of an American physician. I think it's the next step, and I would ask Canadians how many believe they have to have two Canadians sign off on their prescriptions, two Canadian physicians. When you go to the drugstore and you've seen your physician already, do you feel the need to see another physician to get a chronic maintenance medication you've been taking for 10 years? Why don't we accept an acceptable prescriber in the form of a U.S.-licensed physician?

Mr. Tony Martin: That brings me to the real question I want to ask, which is what's at the nub of this? What, in your honest opinion, is at the heart of this?

Mr. Ankur Arora: Mr. Martin, it's very difficult for us to say. We can't speculate, but what I can tell you is that there are more than 4,000 direct jobs across this nation and $1 billion in revenue being created by this industry, so I'm as perplexed as you are as to why anyone would want to eliminate a vibrant and active industry based in western Canada. I don't understand it myself.

Mr. Randall Stephanchew: I would like to offer something. It's also inconsistent with Health Canada policy, because everything is based on a risk management process. There has been no risk. There has been nothing identified as a safety concern. Patient safety is not at risk here. We are very confused by the recent actions of Health Canada, and we're not certain exactly why the about face, but right now it's inconsistent.

You heard Health Canada speak the other day. There was no evidence to support the safety concerns that are being brought up here, and again these are licensed pharmacies providing service with a moral and ethical obligation to serve patients who come before them to have their prescriptions filled. When I took pharmacy school, geography was never part of the curriculum, so I'm confused right now on why, when somebody presents to the pharmacy....

We talked about all these people opposed or voicing their concern about the practice. Again, when those pharmacies have people present to them in need, we're generally talking about 70-year-old people wanting prescriptions who otherwise couldn't afford them, because a drug that's neither available nor affordable is neither safe nor effective. I would like to ask the pharmaceutical industry what they feel on that topic itself, because you have to get drugs to people who need them.

The Chair: Fifteen seconds. Thank you, Mr. Martin.

We'll move to Mr. Savage.

Mr. Michael Savage (Dartmouth—Cole Harbour, Lib.): Thank you, Madam Chair. I welcome the witnesses today. I didn't know much about Internet pharmacies that long ago. Like other members of the committee, I've tried to understand it better and I've enjoyed the opportunity to meet with representatives of CIPA.

I want to ask you a question that goes to the issue of the potential threat to drug supply. I want to ask about what you refer to as the mail-order market cap and the natural limitation. I want to understand that a little bit better, the drug sales into the United States. Ninety-four per cent of patients prefer to purchase meds at a community pharmacy. Presumably, it was 100% some years ago. So there has been a change. Is that a trend? Should we not be concerned that more Americans would want to buy drugs from Canada and then hamper our drug supply? Is that not a number that could go up dramatically? The 6% I mean, could go up dramatically?

Mr. David MacKay: We don't believe so, because it has stabilized over the last five years. I used to wonder myself, as the director of business development, when I would go through Florida or New York, why everyone wouldn't order from Canada. I quickly found out, as I met with not only patients but physicians and seniors organizations, that as soon as a patient has any degree of insurance, they cannot integrate a Canadian purchase into that insurance program. The majority of Americans do have some form of insurance, maybe not the best form, and they do pay a high co-pay. But once they have that insurance through an HMO, a PPO, or an insurance company, they cannot integrate a Canadian purchase into that. So that immediately takes them out of the market.

In terms of it getting any higher, we ourselves wondered at some point why they wouldn't be more interested. We've discovered, of course, that not all of them are taking chronic maintenance medications. Also, there seems to be a natural limitation, and this might just be the perception of the patient. We actually studied this. We found that some people felt it was unpatriotic to come to Canada, and some might have succumbed to the FDA smear campaigns about safety and felt it was unsafe. We know that to be untrue, but nevertheless it could be a perceived deterrent for some patients. Some might have perceived it as being illegal and therefore wanted to be law-abiding. So a host of limitations naturally exist to deter patients in this regard.

● (1640)

Mr. Ankur Arora: Mr. Savage, I'd also like to reiterate that drugs are not a natural resource. They are made in pill-producing factories, and increasing output can meet increasing demand.

I also want to underscore again that Canadian mail-order pharmacies have been blacklisted from purchasing most of the best-selling branded drugs here in Canada.

Mr. Michael Savage: Where are they getting them?

Mr. Ankur Arora: As CIPA duly noted, patients are often referred to European Union pharmacies, which are filling them directly and shipping them to Americans.

Mr. David MacKay: Primarily, we purchase the medications from wholesalers in Canada. If the products cannot be acquired from wholesalers in Canada, we will offer the American patient the option, with their signed consent, to be referred to a pharmacy in a foreign country.

Mr. Michael Savage: What percent would that have to get to in order to threaten our drug supply in Canada, in your view?

Mr. David MacKay: Let's come up with a number in terms of how many millions of patients.

Mr. Ankur Arora: Again, it's not a natural resource. It can be reproduced en masse. I don't think there is such a number, sir.

Mr. Randall Stephanchew: Maybe I can offer something. We're getting into speculation right now.

When I was with Health Canada working on the mutual recognition agreement, I was in multinational facilities over in Europe assessing them. I know that a lot of these companies will produce drugs for all markets. Again, we're talking about different rooms for U.S. production, U.S. physician samples, Canadian drugs, and Canadian physician samples. They allot them: 40%, say, would go to the U.S. and 6% to Canada, Germany, France, wherever. It just comes down to redistribution from those multinational drug companies. They always forecast. They have the capacity at any time to produce as much as they want.

A recent case in point, which I'm sure you're all aware of, is Vioxx being removed from the market. It had $2.5 billion in annual sales. Our industry is $1 billion, just to put it in perspective. Within a week of being pulled from the market, the largest competitor of Vioxx, Pfizer, said, “We have more than enough of our drug Celebrex to meet the needs of all these customers”. How does that happen?

We're talking about supply. There is no supply issue.

Mr. David MacKay: Mr. Savage, there's no such thing as a finite Canadian drug supply; for example, a warehouse of Canadian drugs, and once you've depleted them, we're done. That's not the case.

Mr. Michael Savage: Do I have time for another question?

The Chair: No, you are over your time. We will come back to you.

Mr. Michael Savage: Thank you.

The Chair: On the second round, I'll be asking people to be very brief.

Mr. Merrifield hasn't had a turn yet, or Mr. Thibault.

Mr. Merrifield.

Mr. Rob Merrifield (Yellowhead, CPC): Yes, I'm going to pick it up a little bit from where it's at. Let's just lay our cards on the table here a bit, on this whole industry.

I don't believe for a minute there's a problem with safety. I believe a doctor in the United States is as good as a doctor in Canada. That argument—albeit we can say it's ethical, or lacks ethic—just rings hollow in my mind.

As for when it comes to why we say we have a shortage in Canada, we don't have a shortage of drugs, but in reality, why should we be allowed to send a product that's a made-in-Canada deal for our price review board, which has given us lower prices—up to 40% less in price for these brand-name pharmaceuticals—from Canada to an international country? That's the rub. If we're laying our cards on the table, that's why we're having a problem with this. A billion dollars is not a lot, yes, but where could it go? That's why we asked the department, when they were at this committee the last time, how we can lasso this industry so it doesn't get totally out of control.

You're saying, okay, you've met your threshold, because you can't claim it from products that are not insured from the United States—fair enough—and you're only using those products that are maintenance products. How do we know that's not going to expand? If this becomes a comfort zone for Americans, we cannot become the supplier at the drugstore of the Americans? In so doing, is there going to be a shortage of drugs in Canada? No. But why would the pharmaceuticals play this game with Canadians? And if they walk away from the game in Canada as far as research and development is concerned and as far as supplying the product to Canadians is concerned, why would they do that?

I think we have to just be honest and lay our cards on the table about where the problem really lies if we're going to try to get to some solution and move ahead.

● (1645)

Mr. David MacKay: You don't have to worry about speculation about where it can go, because one solution takes care of everything; it is to ban wholesale. You would actually limit it to status quo levels, and you wouldn't have to worry about where it could go.

Mr. Rob Merrifield: You can ban the wholesale products, and that's the real rub. I think the minister is saying two bills are going through Congress in the United States, but in reality there's a law against this industry—the importation of medications from another country—right now in the United States; they're just not exercising it. But there isn't a politician in the United States who has the guts to stand up and tell grandma she has to pay twice as much for her drugs. That's just laying our cards on the table.

Mr. Ankur Arora: Mr. Merrifield, of course, there are two parts to your question. As for the pricing scheme in Canada, it is for the benefit of medications sold from and within Canada. For Canadian entrepreneurs to take advantage of that and create jobs is international trade, and that's why we should be permitted to do it. But—

Mr. Rob Merrifield: Yes, it's international trade if it's a level playing field, but it's not regulated in the United States, and it is here. It's regulated here for Canadians, not for Americans. Those are the facts.

Mr. Ankur Arora: With all due respect, it's actually regulated throughout the world, except in the United States, so there is a level playing field that other countries will gladly—

Mr. Rob Merrifield: Fair enough. So do you sell into those other countries, or just the United States?

Mr. Ankur Arora: We're currently selling primarily to the United States, but those other countries will engage in international trade if Canada chooses not to. It's an active global market.

As to the second point, I can't speculate about the pharmaceutical companies and the games you mentioned, but I can say I don't think any reasonable person would want to put their extended patent protections at risk. They were a quid pro quo for the pricing scheme that we have. Remember, the pricing scheme we have here was not a gift to Canadians; it was a deal. I can't imagine that anyone would want to risk those patent protections.

Mr. David MacKay: If, to give us some guidance, you look elsewhere in the world as to where this has occurred and what their outcomes were, you can look to the parallel trade situation in Europe. Did prices go up uncontrollably as the result of legalized parallel trade? Did supplies come under restriction, and into crisis, as a result of parallel trade? The answer is emphatically no. That's why I really want to get into your hands this statement by the secretary general of the EAEPC—my counterpart in Europe for parallel trade, essentially—who will verify that it hasn't occurred.

Mr. Rob Merrifield: That's what's happening in Europe, isn't it? That's what you're saying, that the Internet pharmacy has happened there and it's just added competition. That's fair enough, but we're beside a market that is the largest market for pharmaceuticals in the world and has supply and demand and no price review.

Mr. David MacKay: No, the European Union is twice the size of the U.S. market.

Mr. Rob Merrifield: Okay, maybe—

Mr. Randall Stephanchew: And they had the disparities in pricing. That's why parallel trade started, with the challenge from Pharma back 15 to 20 years. Again it's gone on. Canada is a moderate place for the price of pharmaceuticals. There are cheaper places in the world: the European Union tends to be lower, and it's a huge market. Parallel trade has gone through this—

Mr. Rob Merrifield: It's the balance of the seven nations.

Mr. Randall Stephanchew: —and it hasn't collapsed their pricing scheme.

The other thing that plays into the U.S. market is that while they don't have price controls, they have direct consumer advertising. That is costing them huge dollars on the price of their drugs. No other place in the world has that. I believe one other country did, and they removed it.

Again, the question of disparities comes down to the question, is direct consumer advertising needed? No. That's an issue this government has looked at before, and Health Canada has advised us we're not going to go down that road.

Mr. Rob Merrifield: Do you advertise in the States too?

Mr. David MacKay: No, as a matter of fact, we don't. Word of mouth is our most powerful marketing tool.

The Chair: Thank you, Mr. Merrifield.

We'll now go to Mr. Thibault.

● (1650)

[*Translation*]

Hon. Robert Thibault (West Nova, Lib.): Thank you, madam Chairwoman.

[*English*]

I thank you all for appearing, for being here and helping to enlighten us on this subject. I know it's a very passionate and important subject for you, as you represent a lot of jobs. Let me tell you that I'm listening to learn from everybody who will be appearing here. I have no wish to make anybody in Canada lose their jobs, or to lose job growth if at all possible, in any industry that's safe and ethical.

These are the questions that are of concern here: the ethical administration of the drug system, of the pharmaceutical industry, of the medical industry; the safety of our drug supply; the pricing of our drug supply. Those are the questions we want to know about. How do we protect that? Is there a way we can do that and foster the development, growth, and maintenance of your industry?

I thank you for coming here, but there are fears with Canadians, and we have to ask the difficult questions and get to understand this. I've had the benefit of a presentation by Mr. MacKay in my office and I understand a bit about your industry. When we see things Mr. Boudria had presented in the House before—an ad asking, are you interested in making $100,000 to $135,000 U.S. a year with the following licence? You paid Canadian and European currently licensed retired or semi-retired doctors to sign prescriptions to patients they had not met.

I don't know if this is a member of your organization of not—I take it not—but it raises anxiety. I see that this is, I believe, an American.

I just want to raise a few points and give you time to answer. I recognize that we're short of time and you might not have time to cover them all, but I encourage you to write to the committee on any of these points.

There are questions such as the acceptance, which you raise as one the solutions, of U.S. physicians' prescriptions in Canada and acceptance by 29 of their states of ours. As a Canadian and as an individual, I see on the ethics side and on the practice side and on the safety-of-the-system side a big difference between my travelling to New York with my prescription for penicillin and having it refilled for the second time by a physician, and my mailing, faxing, or phoning regularly for a prescription for some drugs to a pharmacist who has never seen me and doesn't know my doctor and who continues doing this.

It's a completely different question. The quid pro quo would be a little different if they were doing Internet pharmacy on their side and we were doing it on ours. The best practices I encourage.

On the patent protection question, I agree that's what protects our law now, but it may change with time. Parliament may want to change the way patent protection works. It can't be held up to us that it's the only thing that keeps our system safe, that we can't change it because we have another problem of cross-border sales of drugs that might have an effect. That's something that has to be taken into consideration.

The Chair: Unfortunately, Mr. Thibault, you're using up all your time.

Hon. Robert Thibault: Well, yes, I want to raise these points and I've encouraged them to reply in writing. I think it's important to get these on the record, because we will be considering these facts and these elements at this committee.

The other question—it was raised by Mr. Arora, and it's important—is this. You suggested that this works in the free trade environment. But then in the solutions I heard that we would limit our ability to enter into agreements with cities and states. I find that difficult to reconcile. If we're doing trade on a free trade basis, then it's open. We can't regulate; we can't red-circle the number of pharmacies we have, the size of the customer base we have. Free trade is free trade.

So with the time remaining, I would invite you to comment on those.

Mr. David MacKay: Thank you, Mr. Thibault. Some of your points are well taken.

I would point out that some of the proposed changes by the minister would fall into this exact category you've just described in terms of the elimination of free trade. We're asking for verification of citizenship. Isn't that the same thing? We're now talking about not allowing certain nationalities to acquire something. Isn't that the very antithesis of what free trade should be?

Hon. Robert Thibault: This is cross-border trade in controlled substances. There can be within a free trade agreement some limits to cross-border trade of controlled substances.

Mr. Ankur Arora: Sir, since the question was posed to me, I will answer it. You didn't pose a question on your other two points, so it's difficult for me to address them.

Free trade is somewhat of a misnomer in this instance. This is a regulated industry in the United States and in Canada. It's regulated in the United States by a government-granted monopoly—the greatest form of intervention in the marketplace—to the drug companies. So there's no free trade to speak of in terms of a grant of a monopoly.

What we are trying to preserve is the freest trade possible, while addressing the concerns of the government in a positive and effective way, the freest trade of pharmaceuticals possible that is best for Canadians, Canadian jobs, and Canadian revenues. That's what we are proposing.

● (1655)

Mr. David MacKay: If I could just address, Mr. Thibault, your first point, which was your going to New York with your prescription versus the difference in the practice in Canada, I would submit to you that the only difference is the presence of the pharmacist.

Let's analyze that. You'd walk up to a pharmacist in New York and present your prescription. The fact is that the pharmacist would not receive your prescription, a technician would. The pharmacist would be counting pills. If we were to do a little field trip here with the entire health committee, took you all out to a bunch of pharmacies and timed how much time you spent with the pharmacist as your prescriptions were filled, I think most of you would average under two minutes with a pharmacist, if at all. The technician does the majority of the work.

However, if you call the toll-free number of the pharmacies that exist in CIPA membership, you can spend up to half an hour with a pharmacist on the phone, toll-free, and get an amazing amount of information. You don't have to be eyeball to eyeball. There are a lot of pharmacists who believe it's the information they exchange, not what they stare at, that is most important.

Of course, we also provide a lot of literature for our patients as well, guidance on the website, guidance in mailings. We perform our pharmacy practice in the same stringent way a pharmacist would on an average walk-up visit, if not more stringently.

Again, I would assert that you'll get equal, if not better, care from a mail order pharmacy because you have greater access.

Mr. Ankur Arora: Let me also mention that the College of Pharmacists of British Columbia has specific guidelines for this accepted practice. There is an understanding that with mass communication systems the world has changed, international trade has changed, and patient health care models have changed. Our College of Pharmacists, to their credit, has specifically addressed this issue. It believes that it's safe and effective and can be done in a positive way.

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

We'll now move to Mr. Carrie.

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

First I'd like to thank our guests for the reasonable recommendations they've put forward. I didn't know a lot about this and I've been trying to learn as much as possible, like upside-downside, about what's happening with this industry. I reviewed your presentation in the office.

I had a conversation with a former pharmaceutical rep who actually happens to be against your industry. I asked what the downside was for Canada. I think the issues are safety and supply for Canadians. He said that there might be issues related to repercussions for Canada if we allow you to just go along as you are. We might be short-shipped by pharmaceutical companies on certain drugs—you mentioned the blacklist. We might be forced to use generics. He mentioned as well that we might not get the best new drugs in Canada. That's a criticism I think you've had before.

That concerns me. Do you have an answer? Is this something that could happen to Canada? Would they do that?

Mr. David MacKay: Let me just get to your first point. You have several layers there, Mr. Carrie.

The blacklisting is only a selective embargo against the mail order pharmacies themselves, not against regular community pharmacies. So if Canadians want to get their Lipitor from Shoppers Drug Mart or London Drugs, or any other regular community pharmacy, they will have no supply issue.

It's critical that we understand there's not an embargo against all of Canada by the drug companies. There are approximately fewer than a hundred mail order pharmacies that conduct this trade to any degree in Canada. It's seven companies only, not all 35 of them. It's the products only to the mail order pharmacies through the wholesaler that are being embargoed or restricted. That's important to know.

You were talking about the potential for a drug company to withhold a launch of a drug. Is that what you were referring to as another concern of yours?

Mr. Colin Carrie: Yes, he mentioned to me that there might be brand new drugs, and bottom line, if they're not making as much profit in Canada as they could, why would they do this?

Mr. David MacKay: What's interesting is, they are profitable in Canada. As a matter of fact, a study by the Boston University School of Public Health reveals that the sales in Canada are actually incrementally profitable for the pharmaceutical industry, because if the sale had not occurred in the United States because it wasn't affordable, it never would have been realized. That's a big goose egg on the column for sales and profits. However, if the sale were in Canada, it would actually be profitable. I could tell you that if a pharmaceutical company were to hold a product hostage, there would be a very solid case for granting a compulsory licence by the patent—

Mr. Colin Carrie: That's my concern, when he mentioned these.

Mr. Ankur Arora: I would like to also address the fact that these drugs are sold internationally under patent in every other western jurisdiction under patent price-regulated protection. So it doesn't seem reasonable to me, in a far-fetched scenario, that Pharma would in fact have to withhold the launch of a drug in any single one of these countries because they are already shipping their drugs to the United States. In fact, they would have to withhold the launch of that drug worldwide, except the United States. I know that in patent protection, the time clock starts ticking at the date of filing, so they file worldwide on similar timelines. What they would do is reduce the time for their exclusive patent protection for the sale of their international market, which is equal or greater to, the United States.

● (1700)

Mr. Colin Carrie: So this claim that your industry would impede the introduction of new medicines is pretty much unfounded?

Mr. Ankur Arora: Absolutely.

Mr. Randall Stephanchew: Could I make one more comment on that? If the pharmaceutical manufacturers were to do that again.... It's totally irresponsible; that's the main statement for that. If they did do that, Health Canada has a special access program for drugs that aren't available in Canada and that are available elsewhere. People can still access those drugs. So to me, they would be irresponsible, they would have to defend why they wouldn't. Drugs start on day one at the average price for those G-7 countries, and I really don't think it's going to limit launching new drugs. Pharma would have to defend that.

Mr. David MacKay: In addition to that, they have made commitments to guarantee supply for Canadians with each of the provinces and the federal government.

Mr. Colin Carrie: Thank you very much.

I had another question. Do I have time?

The Chair: Another minute.

Mr. Colin Carrie: Canada is facing a doctor shortage and a pharmacist shortage, and one of the concerns against industry is that you are utilizing Canadian doctors and Canadian pharmacists who could be utilized elsewhere for Canadians. You did mention the reciprocity thing. Would that handle this concern, do you think? What's the likelihood of having that happen here in Canada?

Ms. Dawn Polley: We don't comment on the shortage of health professionals. This is a problem that Canada has faced for probably the last ten years, long before our industry existed. It's due to a number of factors, which I won't go into. Suffice it to say that our industry has not created or contributed to that problem. We employ less than 1% of the entire population of pharmacists across Canada. We feel that the introduction of some of our distance-based medical models in fact will relieve the pressure on health care professionals and allow us to do more by using technology, so that we can reach our patients and deal with the shortage problems that will carry on over the next decade.

Mr. Ankur Arora: Mr. Carrie, your suggestion about accepting a U.S. prescriber's prescription here in Canada also does address the point. It's a point well taken.

Mr. David MacKay: Physicians are not trading off their daily routines as professionals to do this. If they choose to engage in this practice, it's in their own off hours and evening time that they will conduct this. As such, they're not jeopardizing their current daily practices.

Mr. Randall Stephanchew: The other thing is that chain drug stores, big box stores, and grocery chains have put up pharmacies. Sometimes you can see four of them competing all on one block. Again, I would like to see them set up in northern communities, which they will not do. Again, it comes down to their business decision. I don't think we're taxing pharmacists; I think some of the 24-hour stores that are all competing within a one-block radius are doing more damage than what's going on here.

The Chair: Thank you, Mr. Carrie.

We are now actually past the hour when we were supposed to end this portion of the meeting, but I have three names: Mr. Boudria, Mr. Merrifield, and Mr. Savage. I'd ask you for a succinct question, and I'd ask the witnesses to give us a succinct answer. Madam Demers also wants to be on.

Mr. Boudria.

Hon. Don Boudria: I want to ask, how many pharmacists does your industry employ? Second, you said that you buy your brand-name products not from the pharmaceutical companies, or at least not in large measure, but from what you to refer to as wholesalers. Who are these people and where did they get the product? If you can't buy it from a company, how come they can?

Mr. David MacKay: I think we have a miscommunication on the wholesale. Let's deal with that one first.

The wholesalers acquire the product from the pharmaceutical companies, and we purchase from the wholesalers. So we get a market-authorized drug from Canada from the wholesaler. However, in the case of seven companies, they have restricted supply at the wholesale level to our pharmacies only, not to regular Canadian pharmacies. So they would submit a list of their drugs and, of course, a list of the pharmacies that they have blacklisted, or deemed to be engaging in Canadian mail-order practice, and prohibit the wholesaler from selling their products to these blacklisted pharmacies.

Was there any miscommunication about that?

Hon. Don Boudria: I think I understand a little bit more.

Anyway, how many pharmacists does your industry employ, and how many of them are in Manitoba versus B.C.?

● (1705)

Mr. David MacKay: I can only give you general numbers here, because there's no one source from which you can acquire this information. At best, we estimate.

Again, it varies, but in Manitoba, I understand the statistics from the Manitoba Pharmaceutical Association—and keep in mind that this is the greatest hub of pharmacists in this practice, because 60% of the trade occurs in Manitoba—are that of 1,155 pharmacists registered to practise, 13% are actually employed with mail-order pharmacies. That would be the highest number in Canada. I think, as Dawn pointed out, it's much lower across Canada, but a lot of those pharmacists will share shifts with community pharmacies, as well, that are not engaged in the practice.

Hon. Don Boudria: And you're saying that a 13% drain on pharmacists has not contributed—and those are words that Ms. Polley used, “has not contributed”—to a shortage of medical practitioners.

Mr. David MacKay: You're talking about apples and oranges here. Are we talking about pharmacists, or are we talking about physicians?

Hon. Don Boudria: No, she referred to both in her answer. I'll check the record tomorrow, but I'm convinced that's what was said.

Ms. Dawn Polley: Our industry in B.C. employs approximately 70 pharmacists. We probably have 2,500 registered pharmacists in our province, and in fact one hospital, Vancouver General, employs 80 pharmacists. So we represent a minute number of pharmacists in our province.

Mr. Ankur Arora: And Mr. Boudria, I would like to respectfully address the point that I think you're getting to.

There has been a pharmacist shortage in this country dating back more than a decade, before this industry ever existed, but approximately 15 to 20 years ago the practice of pharmacy changed. The pharmacist has changed from your local druggist, independent, open from 9 a.m. to 5 p.m. Now there are big-box chain stores, grocery stores, mass merchandisers, with pharmacies on every street corner, and they now represent more than 25% of the pharmacy market, and that did not exist before.

Every pharmacy must have a licensed pharmacist. More pharmacies by the chains and the mass merchandisers means they are draining pharmacists.

Hon. Don Boudria: But they sell to Canadians.

The Chair: Can we go on, Mr. Boudria, to the next person?

Hon. Don Boudria: Yes.

The Chair: I would ask the responders not to all answer the same question. We're trying to keep each person to three minutes, and if everybody wants to answer every question, I can't do it and the members can't get their questions out.

Mr. Merrifield.

Mr. Rob Merrifield: Well, yes, and I'm pleased that we're going a little bit over. I think it's very important that we air as much as we possibly can here.

What percentage of your Internet pharmacy is actually national—to the north, to Canadians? It would be a very small percentage.

Mr. David MacKay: Very small.

Ms. Dawn Polley: A very small percentage.

Mr. Rob Merrifield: Minuscule, you might say.

Mr. David MacKay: We're only in the initial stages of analyzing that.

Mr. Rob Merrifield: Okay.

The generic drugs, you say, are at about 20%.

Mr. David MacKay: By volume. By dollar, it's 12%.

Mr. Rob Merrifield: By dollar, 12%; by volume, 20%.

You get these from Canadian-produced generic firms—

Mr. David MacKay: Correct.

Mr. Rob Merrifield: —from which you buy in bulk, get a wholesale price, and then you send them south.

Mr. David MacKay: Yes.

Mr. Rob Merrifield: It's a very competitive market on the generic side between our two countries.

Mr. David MacKay: That's right.

Mr. Rob Merrifield: In fact, I would say we're behind the United States as far as price on generics is concerned.

Mr. David MacKay: Generally.

Mr. Rob Merrifield: We're higher priced in generics in Canada than in the United States.

Mr. David MacKay: Generally speaking, not for all products.

Mr. Rob Merrifield: That's right.

So the only way you can compete in that market is to get a wholesale value from the generics. Is that a fair statement?

Mr. Ankur Arora: Actually, Mr. Merrifield, I think there's a bit of clarification required.

In many instances, the wholesale acquisition cost for U.S. pharmacies for U.S.-made generics can be cheaper, but whether that savings is passed on to the U.S. customer is actually quite questionable, whereas I think a lot of the savings from Canadian generics, when purchased through a Canadian mail-order pharmacy, are actually passed on to the consumer.

Mr. Rob Merrifield: So their markup may be higher—

Mr. Ankur Arora: Considerably.

Mr. Rob Merrifield: —and therefore, it allows you to compete. Fair enough. I'm just trying to get a handle on the percentage.

I believe Ms. Polley answered a question, saying that for an individual who has a prescription from Seattle, you can't fill it, but from Newfoundland, you could.

Ms. Dawn Polley: No, it was that I can fill a prescription from a prescriber in Newfoundland, yet I cannot fill one for a prescriber in Seattle.

Mr. Rob Merrifield: That's right.

I'm wondering about that, because the department was in here the other day suggesting.... My understanding is that a physician who is, say, working in British Columbia has a licence to practise in British Columbia but is not licensed in Alberta or any of the other provinces, and therefore the prescription cannot be filled. Is that wrong?

Ms. Dawn Polley: Each province regulates its own college of pharmacists, and in B.C., our college has defined a prescriber as anyone who's licensed to practise medicine in Canada.

● (1710)

Mr. Rob Merrifield: Okay, so right across Canada, it doesn't where we're you are, you can have your prescription filled by a pharmacist. Is that fair?

Mr. Ankur Arora: In B.C.

Mr. Rob Merrifield: Oh, just in B.C. Is it different in other provinces?

Ms. Dawn Polley: It is a provincial regulation. I can't speak for other provinces.

Mr. Randall Stephanchew: In Manitoba, as well.

Mr. Rob Merrifield: Okay, we'll get into that with the department. I was just curious about the testimony, because I didn't understand it quite the way it came out. I'm just trying to get a handle on how it's done.

On the whole idea of shortages, one of your recommendations would be to say that you don't need another doctor to just sign off on this, because you have a medical practitioner in the United States. It may not meet the requirements for Canadians, really; it's Americans who are taking the risk, and its their doctor-patient relationship at that point.

That's why that argument rings hollow to me, from that side of it, but if we followed that recommendation, it would actually alleviate some of the doctor pressure, you might say, in Canada.

Mr. Ankur Arora: Yes.

Mr. Rob Merrifield: Nonetheless, I'm not sure that in my last round I challenged you to say how you're going to actually lasso this, because that is ultimately where it has to go. It's the price in Canada that is a balance through the price review board, which sets our prices for brand name pharmaceuticals for Canadians.

You said it's because of the bulk buying, or that bulk buying would solve that problem. I would challenge you on that and say, I'm not sure that would do it on its own.

I know my time is gone, but—

The Chair: Your time is over, and I will not be able to allow an answer to that.

Mr. Rob Merrifield: Well, maybe you could—

The Chair: However, you've had the challenge from Mr. Merrifield to prove that the ban on bulk buying would actually limit this to within the range of business we have now, as opposed to a big increase. You can write him your answer.

I think Mr. Thibault is next.

Hon. Robert Thibault: I have one question for you.

You raised the point that you had plateaued to a certain level, and one of the things that limited your ability to grow was primarily your sales being to the U.S. and the U.S. not allowing insured drug purchases to be from you, which would be the people on their MSI—I'm trying to think of the name that the U.S. uses for their insured services.

What if they were to remove that? What if tomorrow the U.S. said all insured citizens can get their drugs wherever they choose, through the international pharmacies? What would happen to your industry? What would the reaction be? Would that remove the plateau? Would there be unlimited growth?

Mr. Ankur Arora: Actually, I think that has been addressed by the proposals put forth here, because in order to bill an insurance company directly for the purchase of a medication, you would have to have a commercial contract, and as Mr. MacKay has proposed, we support a ban on those commercial contracts as well.

Hon. Robert Thibault: But in light of the other point you were making, that it's in a free trade society, I don't know that we could. If we're saying it's free trade, if we're saying it's legal to sell, if they're saying it's legal to import....

Now, I understand their law says it's illegal, but they're not enforcing it, and we'd have control. If all controls came off, if the Americans took their controls off and said you could bring it in and anybody could make contracts, could we limit it? Would we have that authority? If not, if we don't, if it's free trade, what would happen then?

Mr. David MacKay: I think there's a little bit of circular logic going on here right now. We have not been able to establish whether we can't do that yet, whether we can't look at a ban of a commercial contract. I don't think that discussion has been fleshed out enough for us to conclusively say. That's still speculation. We believe that opportunity should be analyzed, along with bulk wholesale.

But I put it back again to the same thing. The proposed changes by Health Canada smack of the same type of anti-free trade. Therefore, if one offsets the other, let's just stay where we are at status quo and continue what we're doing; let the natural market forces of free trade take over, and the pharmaceutical industry can choose to lower their prices in the United States and take care of this whole situation overnight.

Mr. Randall Stephanchew: Here's one other point. In his presentation, I believe Dave gave you the number that only 6% are using mail order anyway. Some of those will choose not to use Canada as a source, regardless of whether they opened up and said they had no stipulation on where you can go. I really do not think you're going to get the flood of orders you're talking about.

Hon. Robert Thibault: But it's fair to say that the plateau question would be removed, would it?

Mr. David MacKay: It depends on whether they're looking for wholesale or mail order. Mail orders hit the natural cap, if all they ask for is mail order. I'll give an example. The Dorgan-Snow legislation right now, even if passed—and I can tell you why I don't think it's going to pass at all—for one year would only look for mail order from Canada, and not for any wholesale whatsoever. It actually is sensitive to Canadian issues when it preserves status quo.

● (1715)

The Chair: Thank you, Mr. Thibault.

Madame Demers.

[*Translation*]

Ms. Nicole Demers: Thank you, madame Chairwoman.

If I understood you correctly, you said earlier that when you are unable to fill a prescription, you ask for the individual's permission to have it filled by another country which is a member of your association.

A few days ago, we heard testimony from the deputy minister for Health, who told us that there were certain problems involving temperature sensitive medication. He said that if the medication were incorrectly packaged, it could affect its safety and effectiveness. When a drug is sent by another country—and this is perhaps the point that my colleague wish to raise this morning—, from India, for example, how can you ensure that, when it reaches the patient, the drug will still be safe, of sound quality, and effective?

[*English*]

Mr. Randall Stephanchew: That's a very good question. The simple answer to it is that temperature-sensitive products are not being shipped by CIPA-member pharmacies. It is one of our policies in place that we do not do that.

You had asked earlier the question whether you could use FedEx or not. You cannot use Federal Express or courier companies to take these packages across.

The other products we're looking at are solid oral dosage forms that have good stability as room temperature products and that are being packed up and shipped appropriately. These are the same systems that are being used within Canada from a drug manufacturer to a wholesaler, from a wholesaler to a pharmacy, going across our vast nation to where it gets to.

As to coming across the ocean and how partner pharmacies would do this, we're not in control of those partner pharmacies. If we can't fill a prescription here in Canada through what we do, we would give the opportunity to deal with someone else in another jurisdiction. It would be up to them how they deal with it. That's not a Canadian issue. That is from that country, the European Union, under recommendations from what CIPA does, to the United States directly.

With the drug products themselves, it's movement of products. I think they are being stored appropriately, and we're using the same method as Pharma does.

Mr. David MacKay: Directly referring to your question, I think you heard even in the testimony from Health Canada officials that after their inspection of 11 Canadian pharmacies—and some of them were actually shipping the biologic products, the temperature-sensitive insulins—there was 100% compliance thereafter to not engage in that practice. We're pharmacists; we have regulators. When our regulators tell us to please not do this because we haven't got assurances, we comply.

[*Translation*]

Ms. Nicole Demers: I have one last question. Would you be prepared to limit your services to only selling medication for chronic health problems which only effect seniors?

[*English*]

Mr. Randall Stephanchew: Generally, the customers who are being served by this industry right now are those who have stopped working, are off drug plans, do not have coverage. Again, principally they are elderly persons. But if they are on chronic maintenance medication and they meet the criteria...and in most of the agreements with the pharmacies they have to be of the age of majority, they are on chronic life-sustaining medicines, and those are the medicines that are being provided. It's not acute care products, because we can't get them to them quickly enough, and it's not narcotic or controlled drugs, because we don't want to deal with those and we're not licensed to be able to move those drugs across the border.

Mr. David MacKay: It's a fair question as to how difficult it might be to actually implement something that would be a filter for that, because these are patients...not in Canada or the U.S. How would we do that? The burden of doing that would be extraordinary. We think we can achieve the same thing by limiting it to something that would be a decision more inherent to Canadian law.

Mr. Ankur Arora: I don't think any of the member pharmacies support discrimination based on national origin or age. I think that's a principle we all uphold.

Mr. David MacKay: It would be a slippery slope.

The Chair: Thank you, Madame Demers.

On behalf of the committee, I would like to thank you very much for putting forward your case. Our schedule is such that, with two bills referred to us by the House of Commons, I'm not sure when we're going to get back to this topic. In any case, we will reserve the right to contact you or recall you. I think you're going to submit something to us in response to Mr. Merrifield. Thank you for coming so far, and thank you for your fulsome answers to our probing questions.

I would ask the members of the committee to stay for a minute, and I would ask those who are here to view the Internet pharmacy debate to please leave quickly and quietly, so we can continue with our business. Thank you.

Ladies and gentlemen of the committee, you have before you a chart describing the meetings for the next five weeks. Missing from it is the fact that Bill C-28 was referred to us from the House on Monday night, so there is yet another bill that has to be considered. You will see that there are a number of breaks in March, so it seems to me that our responsibilities are laid out here by the clerk on this particular thing. I just wanted to see if anybody had any questions or concerns about the way this is laid out.

Mr. Thibault.

● (1720)

Hon. Robert Thibault: I ask the question to all the members. I see there are two sessions here for the Auditor General. As these subjects have been brought to the public accounts committee, I suggested that perhaps they would want to discuss with their colleagues if they would be happy that the testimony there answered all those questions. I attended, and at that time the Auditor General advised that she was happy with the measures having been taken to respond to her concerns. I think cautious optimism would be the proper term to answer the question of the points that she raises in here. I think the committee would find it very difficult to find the discussion elements for two slots, based on the testimony that she would give; and the testimony, I presume, would be exactly the same as it had been at the public accounts committee.

I don't know if the other members had the chance to consider that.

The Chair: The researchers tell me we are picking up those aspects of the Auditor General's report that were not dealt with at public accounts. What are the two they did? They did Veterans Affairs and Health Canada. We are doing Correctional Service, the RCMP, Citizenship and Immigration, National Defence, and Veterans Affairs—everything to do with health, where the Government of Canada and Health Canada have a direct obligation to deliver.

It's interesting that you should raise this. If a lot of this has been done—not all our particular issues—I'm just wondering if we might be able to fold it into one meeting.

Hon. Robert Thibault: I would submit, Madam Chair, that the Veterans Affairs things were done at that time. If you remember, the report was saying that she was hoping Health Canada, where it administered on the question of the aboriginal community, would be as efficient as it is in the DND side and those others. So one meeting might be enough.

The Chair: Apparently the two meetings represent different witnesses, but I'm wondering if we could do the meeting scheduled for February 21 in the first hour, and the meeting scheduled for March 7 in the second hour, and just switch witnesses.

The Clerk of the Committee: That's next week. I would have to tell the departments to have their people ready then.

Mr. Rob Merrifield: Actually, I'm having a problem on February 21; I can't be here. This is one that relates specifically to some of the issues I wanted to ask her.

The Chair: I know, but the Auditor General can't come on the other date.

Mr. Rob Merrifield: She can't come on March 7?

The Chair: She can't come on March 7. She is only available on February 21.

Mr. Rob Merrifield: Then I think we have to go with February 21 and leave the March 7. We can decide after that meeting if we don't want any more.

The Chair: I don't know if that's fair, because a different set of witnesses are now preparing their presentations for March 7. If we weren't going to see them...or if we wanted to see them on February 21, the question is whether or not they could even be ready, because it's next week.

Mr. Rob Merrifield: Then I would suggest we leave it. Then let's leave it where it is.

The Chair: All right.

Hon. Robert Thibault: I don't want to disagree, but I wanted to remind the committee that we had said that we wanted to deal with the Internet pharmacies as quickly as possible and finish that report. I was hoping we could open up those two slots for what I think we've all agreed is a priority area.

Mr. Rob Merrifield: It is a priority area, and I believe the rest of discussion on this meeting is on whether you want more witnesses to come forward. I believe we do, so we can have a pretty fulsome debate on the Internet. This is a pretty serious issue that we really need to come up with—

● (1725)

The Chair: We don't have the possibility next Wednesday because it's budget day and we will be all busy. On Wednesday, March 9, we could put in a meeting on Internet pharmacies, if you like.

Mr. Boudria.

Hon. Don Boudria: Madam Chair, if and when you do, when would be a good time for me to suggest two different groups that I think we should hear from? Do you want me to do that right now?

The Chair: Could you just talk to the clerk afterwards? What we're trying do to is make sure we keep hearing a balance between the two sides.

Hon. Don Boudria: That was the idea. I'll just take 30 seconds and I'll give you the names.

The Chair: Go ahead.

Hon. Don Boudria: I think we should at least listen to the Canadian Medical Association because of the paper they published against Internet pharmacies.

The Chair: We already have them.

Hon. Don Boudria: They're there? Then there is the Best Medicines Coalition. They're an association of AIDS victims and all of this. I can give the name to our official after.

Mr. Rob Merrifield: Do we have this list?

The Clerk: Do you want me to pass them out?

The Chair: Fine, pass them out. I haven't even see that list.

Mr. Rob Merrifield: I don't know who we should bring forward if I don't know who is already coming. If we have a list of who's coming, then I think we should be given an opportunity next week maybe to bring forward a slate and make sure it's a balanced one.

Mr. Colin Carrie: Madam Chair, do we have to see Bill C-206 that soon? Do we have to start on that right away because it was referred to us, or can we put it off?

The Chair: That's the usual custom, wouldn't you say, Mr. Boudria?

Mr. Colin Carrie: So you do have to get going on it.

The Chair: It seems to me if you don't take the bills as they come to you, you could end up with a whole pile in June and not enough time to do them.

Hon. Robert Thibault: Isn't it in the rules of the bill?

The Chair: Exactly, committee chairs are asked to put it on the agenda at the first opening. It turned out that particular day was the first opening.

Are we still on television? I'm thinking maybe we should go in camera. Could somebody move?

The Clerk: We would have to stop for a minute to shut everything down. A little pause.

The Chair: I know, but the motion has to be on television.

Mr. Thibault is moving that we go in camera. All in favour?

Mr. Rob Merrifield: The reason for in camera?

The Chair: Because there are some things I want to say to you in private.

[*Proceedings continue in camera*]

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