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Chair

Mr. Bill Casey

Standing Committee on Health

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● (0850)

[*English*]

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

We welcome our guests from the Office of the Parliamentary Budget Officer.

Today we have with us Jean-Denis Fréchette, parliamentary budget officer; Mostafa Askari, assistant parliamentary budget officer; Peter Weltman, senior director, costing and program analysis, Office of the Parliamentary Budget Officer; and Carleigh Malanik, financial analyst, Office of the Parliamentary Budget Officer.

I understand that Mr. Fréchette is going to have a short introduction and then Ms. Malanik is going to have a slide show for us.

Mr. Jean-Denis Fréchette (Parliamentary Budget Officer, Library of Parliament): Thank you, Mr. Chair, vice-chairs, and members of the standing committee, for this invitation to discuss your work plan on the national pharmacare program and the support that the office of the PBO could offer.

Every time that a standing committee or a parliamentarian seeks our expertise, we really appreciate the opportunity and always collaborate to the extent allowed by our limited resources and our legislative mandate.

Thank you also for your motion. In 30 years on Parliament Hill, I have seen hundreds and hundreds of motions, and I can tell you that this one is particularly very detailed, well written, exhaustive, crisp, and clear. It is unfortunate that I cannot tap into the expertise of your members, Mr. Chair, who collaborated to put this motion together. They would be an asset for the PBO, which, by the way, has very limited expertise on this issue.

I understand that we will have the opportunity this morning to discuss your motion. There are indeed elements in the motion pertaining to the PBO's mandate that will need further clarification—for instance, the aspect of policy development.

I have to admit that I was little bit apprehensive when I read your notice of meeting entitled “Development of a National Pharmacare Program” and “Briefing Session with the Office of the Parliamentary Budget Officer”, mainly because we are not in the business of policy development. We normally cost private member's bills, legislation, and existing programs, but when there is no program per se, we don't develop a program and cost it, which I am sure you understand.

Also, the last paragraph of your motion relates to the independence of our analysis, which is specifically mentioned in the PBO's legislation.

[*Translation*]

It may be because I'm francophone, but when I see in the English version the words “will work” as in “the Parliamentary Budget Officer will work with”, the statement seems a bit normative or “prescriptive”, as you say in English. When my spouse tells me “you will do this”, it's in my interest to do it.

In short, this restrictive aspect of the motion may call into question the independence of our analyses in the future. We certainly want to clarify this point with the committee during our discussions.

[*English*]

In that context, we have a short PowerPoint presentation aimed at helping you to better understand our mandate and operating model. Our presentation was sent to your committee before we received the motion, but as you will see, it's a good link and they are quite well related to each other.

With your authorization, Mr. Chair, I would like to ask my colleague Carleigh Malanik to walk you through the presentation, after which we will be happy to answer your questions.

Thank you, Mr. Chair.

Ms. Carleigh Malanik (Financial Analyst, Office of the Parliamentary Budget Officer, Library of Parliament): I'll start with a brief overview of the PBO mandate, which Jean-Denis Fréchette has already spoken about.

Costing a national pharmacare program would fit under the last section of the PBO mandate, “upon request from a committee or parliamentarian”. As for the PBO's role and where we fit in the costing of a national pharmacare program, it would come after the proposal has been written out, once the parameters of the program have been determined. That's when we can certainly provide a cost estimate. We cannot help in designing the program.

Over the next few slides, I would like to go over a brief introduction to how one can cost something such as a national pharmacare program or other projects.

Before you start getting into detailed and rigorous cost estimations, interested parties can turn to existing information to help inform expectations of what a new program would look like. This is something that PBO also does in surveying the literature before it begins its cost estimations. Canada currently has a wealth of information on pharmaceuticals.

The next few slides provide an overview of how we would approach a costing in developing a cost estimate, and they also provide background information using publicly available data from the Canadian Institute for Health Information.

Currently, public spending on prescription drugs accounts for roughly 43% of total prescription drug spending in Canada; this is for 2015. The total spending on prescription drugs is just over $29 billion. This type of estimate can be very helpful in providing a basic cost estimation of what a pharmacare program would look like, assuming that nothing else changes.

Whereas the previous information provides a snapshot, the information on this next slide provides more of a historical look at prescription drug spending in Canada. What we can see is that it has been increasing over time. The growth seems to have slowed since 2010. The gap between public spending on prescription drugs and private spending on prescription drugs did widen in more recent years. Again, this can help inform what the cost of a national pharmacare program might look like if trends continue and, again, nothing else changes.

With this information in mind, the total national spending on pharmacare is a composite of several provincial programs as well as federal direct spending. With that in mind, each provincial plan does vary, so one needs to ask, in the development of a pharmacare program, what it will look like. Will it look like an existing program or will it be something new? This information can assist in getting a slightly more rigorous or informed cost estimate before moving into the in-depth analysis.

As more sophisticated analysis begins, one can dig deeper into the underlying factors that influence drug expenditures. We have here a brief list of examples for looking at the demand side and the supply side factors that you might want to dig into. Some of them—for example, the needs of a growing population over the needs of an aging population—the government may have no control over. Expectations and behaviours can be another factor, as can the health status of the population, and there are several other factors.

The supply side may be some factors that the government can in fact influence, such as prices, potential inflation, eligibility for who would be under the program, utilization of particular pharmaceuticals, the availability of non-drug substitutions—perhaps through research funding—and several other factors.

Related to this, then, is identifying the key cost drivers. Once you have an understanding of which factors can have an influence, you can start to focus on which have the largest influence. Again, this information is publicly available from the Canadian Institute for Health Information, and it shows the average annual growth factors for pharmaceuticals in only the public sector.

● (0855)

According to CIHI, the Canadian Institute for Health Information, population growth and aging have contributed a fairly steady share of this growth in public drug expenditures. General inflation has contributed a little more, although it seems to have fallen slightly.

After becoming informed on all of these issues, one can better anticipate the impacts in determining the effect each of the program criteria will have on the cost of a total pharmacare program.

To create the pharmacare program, several key parameters or objectives would need to be determined, such as who will have coverage, what drugs will be covered, how much of the cost will be covered, and how much each party will be willing to pay. All of these things need to be answered. Once you've looked at all these key cost drivers, you will be better informed on what each of those answers would look like. At the very end of all of this, when the parameters have been identified, is when PBO can step in.

First PBO would identify the data sources and help develop an appropriate methodology using the available data and resources. Using this information, PBO then would draft the terms of reference and provide that to the party requesting the analysis that the health committee would hear. PBO would then work with stakeholders, data holders, and experts to solidify any required assumptions. Lastly, of course, PBO would produce a rigorous cost estimate, along with a report stating all assumptions in a transparent manner. This work could also include sensitivity analysis.

That is the end of the presentation. Thank you.

The Chair: You have two seconds left. You must be the parliamentary budget office.

We're going to start with seven-minute questions from Dr. Eyolfson.

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

The kinds of things you're presenting here are exactly the questions we need answered. It sounds as if you could be a big help to us.

We talked about the different costings. There are costings in supply and demand in terms of how much this is going to cost. That's the big barrier. If it wasn't going to cost much, we wouldn't have to discuss it very much.

We talk about the estimates of how much it would cost to implement this, how much we would spend. One of the discussion items that comes up over time is the potential for cost savings and how much the costs of instituting such a program would be offset through savings in the health care system. We know there are expenses to the health care system when people are non-compliant with medications, get sick, and come into the health care system.

Through your office, would you be able to do any analysis of how much Canadians could save in hospital visits due to non-compliance or how much we would save our health care system if people could afford their medications?

● (0900)

Mr. Jean-Denis Fréchette: Thank you for the question, which is a great question.

It's part of the model. In Carleigh's presentation, when we say we will develop terms of reference, we will of course develop that with the committee. Depending on what drivers or what factors you want to have in the model, we will include those because the costing is also how much savings you can have.

The difficulty we're having right now is this. What is the model? What is the system? What is the program that you want to have? Is it a national program in scope, only financed by the federal government, and so on? What we proposed to do eventually with this committee—if it's the wish of the committee—is to develop that and include those kinds of factors.

Right now we have your motion, which is, as I said, very detailed. I would prefer to have your vision of the program and then add all the factors and parameters you want to have included in the costing project.

Mr. Doug Eyolfson: I think you've answered this question already, then. I guess it would depend on the model we put forward.

Will you be able to provide an estimate as to how much it would cost if we made sure every single Canadian was able to afford his or her medications?

Mr. Jean-Denis Fréchette: Mostafa, I'm sure you want to answer something to that.

Mr. Mostafa Askari (Assistant Parliamentary Budget Officer, Office of the Parliamentary Budget Officer, Library of Parliament): Let me first apologize for being late.

Certainly the savings from the pharmacare program have to be the main reason that you want to have a pharmacare program; otherwise, it would not make any sense economically, so one has to find a way to estimate that. I think the range of estimates that you put in the model, the final estimates from that, would be the main factor that would determine the range of savings that you're going to get from the pharmacare program. That's a very challenging part of this. One way others have done this is by looking at the savings that other countries that have a pharmacare program have seen since the introduction of a program. That may or may not be a good benchmark for Canada, because the system here is certainly different.

Another way of making that saving is by negotiating prices with the pharmaceutical companies. Right now, my understanding is that the provinces are actually already doing that, so there are some savings already being seen. Those all have to be taken into account if you do the costing for a pharmacare program, and I think, as Mr. Fréchette said, it's also important to know exactly the type of program that the committee is considering, because you can have many different structures for these programs, and the cost would certainly be different in each case.

Mr. Doug Eyolfson: Okay, thank you.

There's a paper that we have looked at. It was published in 2015 by Steven Morgan. It was called “Pharmacare 2020”. Are you familiar with the document?

Mr. Mostafa Askari: Yes.

Mr. Doug Eyolfson: In that paper there was an estimate that we could reduce total spending by $7.3 billion in a best-case scenario under a national program due to larger bulk buying, as opposed to a number of provincial bulk buys.

Would you be able to perform a costing analysis that would be able to confirm or deny whether that was the case, whether those kinds of savings might be achieved?

Mr. Mostafa Askari: Certainly our costing would be an independent costing. Whether the results we get would be close to or different from those results I cannot speculate right now, before we start doing the work.

Mr. Jean-Denis Fréchette: If I may, Mr. Chair, I said in my opening remarks that I was apprehensive about the motion. For example, at the end of the motion, it says that “the PBO will work with Canadian Institutes”, which is fine, but “and other sources to obtain”, and the PBO's report “will not rely on analysis prepared by or for a third party”.

We need some discretion here, and that's exactly why you're touching on that point. What do you mean by that statement in the motion? I would like to clarify that because, as Mostafa said, we need to review the literature. If eventually we do a costing for this committee, we will have to review the literature, including those studies, and seek to assess whether or not we can evaluate the value of those studies.

● (0905)

The Chair: Okay, thank you.

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

I want to thank the witnesses for being here. I think I'd love to have a little more time with you as well, because I think some of the things you've already said opened my eyes.

I think, Mostafa, you were saying the savings should be the main reason for doing it. We've heard already that people are making all kinds of assumptions. What I'd like to get to is whether can we get a model that we want so that we can give proper direction. Can we define what the problem is?

One of the interesting comments we had was from Neil Palmer, who is the president of PDCI. He was saying there is insufficient data on the numbers of Canadians who either lack prescription drug coverage or have insufficient drug coverage, which undermines the ability to develop policy in this area. I think what we need to do is take a snapshot of what is going on here.

He said:

> Figures of 10% to 20% with no coverage or inadequate coverage are frequently cited. However, the underlying data supporting these figures is weak and generally based on unreliable opinion surveys.

That's true.

He continued:

> That 10% to 20% could be underestimate or an overestimate. Either way, we need to know. We need to know because it's not possible to make informed policy recommendations and decisions when there is such uncertainty.

With us giving you direction, I think what we have to do is take a look at where we are right now. I think you have two slides, Carleigh, that opened my eyes. One was slide number 4, which showed $16.6 billion in private spending on drugs. The other one was slide 9, where you're talking about parameters.

Do you guys have any insight on which Canadians are have coverage now? For those without coverage, what percentage are low-income Canadians who may be having problems affording drug coverage? For those without coverage, which percentage is higher? Is it a problem not to be having some type of private insurance for these people? I'd like to see what we can do to dig down and define the problem today.

Do you guys have any idea about what the problem is we're asking you to help us solve?

Mr. Jean-Denis Fréchette: To answer your first question about the data sources, that's exactly what we do all the time when we do costing. That's why it's in one of the slides you identified.

Believe me, sometimes we have a request from parliamentarians or committees and we say we don't have the data, so it's just impossible. I don't know about this case, but if we do the costing, then we will do this type of survey.

On your other question, we do have a profile of those who are low-income and not middle class. We don't talk about middle class. We talk about low incomes and so on. That will be part of the parameters that we will use. We did other studies on that, and that will be part of the costing. Those are easier to get in terms of information and data.

The other part of your question about who is covered, and so on. There are some firms—you mentioned Brogan, for example—that we can pay and then see what quality of data they can provide.

Mr. Colin Carrie: We've had some witnesses say that if we went from a mixed system to a monopolistic system run by government, on day one we would have to come up with $16.7 billion.

What I'm challenged with as a Conservative—we're looking at government spending right now—is that the Liberal government had what they called a modest deficit of $10 billion. That's what was promised. I think the deficit is about three times that size. I think your office even said that with the spending going on, these things could be unsustainable and that we have to look at how we're going to fund any new program spending.

We're not seeing a lot of benefit from increased spending. We're getting numbers showing that unemployment is at an all-time high. Businesses are going elsewhere. If we want to implement this monopolistic type of system, then how do we pay for it?

Based on he current fiscal situation, which you are very much aware of, can our country afford a monopolistic government-run system that may be costing us $16.6 billion more per year?

● (0910)

Mr. Mostafa Askari: It depends on what the political choices are. That is not the kind of thing we provide comments on. That's a political decision. It is the parliamentarians' and the government's decision in looking at the trade-off between different policies and different issues, and then looking at the cost of that and whether the system can accept that cost. That decision is really up to you.

Mr. Colin Carrie: Given today's numbers, to add almost $17 billion.... If it is already unsustainable, how much more would that be pointing us in that direction?

Mr. Mostafa Askari: In what sense is it unsustainable? Actually, the federal government's overall fiscal situation is sustainable, based on the reports we have done on its overall sustainability. In fact, there is fiscal room.

This is a long-term assessment, not a medium-term assessment. We are talking about the long run, given the population aging in Canada. With all that taken into account, our assessment is that the fiscal situation at the federal level is sustainable. As for the provinces, that's a different issue. They do have some problems.

Certainly, if you have a program that costs a lot of money, it's going to increase the deficit. That's fair. That's a given. That's just the math of it.

Mr. Colin Carrie: Yes, $17 billion—

Mr. Mostafa Askari: Whether the system—the government and Parliament—is willing to accept that or not is something that has to be decided by you.

Mr. Colin Carrie: What I am looking for is advice on how to pay for it. Just doing my own math, it's $17 billion, and there are 35 million Canadians. That's $500 more per Canadian per year that would have to be put into the system from taxation. We would have to find the money somewhere. That's the kind of advice I would be looking for from you, to see where we would go on that.

Would it be more efficient to have one government system doing it, or just to tweak the system we have here? How are we going to solve this problem? It's huge. If we get a snapshot of the statistics we have now, it allows us to get a better idea of where we are going for policy so that we give you guys good direction, because we are relying on what you say.

Do I have more time?

The Chair: No, you don't. Was that a question?

Mr. Colin Carrie: No. It's just direction to them, because for sure we are going to be relying on what they bring back to us.

The Chair: Does anybody want to reply to that?

Mr. Mostafa Askari: There are two parts to it.

The snapshot of where we are is a matter of looking at the data that is available to see exactly where we are. That's something we can certainly look at.

Advice on how to fund the program is something that's outside of our mandate. We do not deal with policy, and there are good reasons for that. Although our mandate does not specifically mention whether we do policy work or not, the operating principle we have established since the beginning is not to get involved in policy discussion. In our belief, that is really the job of the elected officials, not the parliamentary budget office. We can look at the costs and analyze the deficit and the budget, but not provide any recommendation on how to fund this specific program.

Mr. Colin Carrie: That's exactly the answer I was looking for, so thank you for that.

The Chair: Mr. Davies, go ahead.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you for being with us today, witnesses.

I want to clear up some fundamental issues. I think it is very clear that if this committee gives you proper parameters, you can develop the costing of universal pharmacare. Is that correct?

Mr. Mostafa Askari: Yes.

Mr. Don Davies: Can you also gather—

Mr. Jean-Denis Fréchette: We can also work with the committee. It's not only a matter of providing. As I said, it is a back-and-forth discussion, as we do with other committees. We develop the terms of reference based on whatever factors, drivers, and parameters you provide, and then we discuss that. If you don't agree with our terms of reference, we will work on it. It comes from the committee.

● (0915)

Mr. Don Davies: Okay.

The other thing this committee is looking for is to gather some data from an objective source on, for instance, the number of Canadians who currently don't have access to prescription coverage and those kinds of things. Can the PBO also do that for us?

Mr. Jean-Denis Fréchette: We can do that. I can tell you it is mid-fiscal year, so it's a good time to ask us, because we can still play with our budget. It is going to cost money, as you know.

Mr. Don Davies: All right.

If I'm understanding you correctly, Mr. Fréchette, you need this committee to develop the parameters of the program that we're asking you to cost. Is that correct?

Mr. Jean-Denis Fréchette: That is correct.

Mr. Don Davies: What I'm unclear on is whether the motion that has been given to you is clear enough for you yet, or are you asking this committee to spend some more time on developing clearer parameters to give you?

Mr. Jean-Denis Fréchette: It's too clear. It's too detailed. I'm sure you worked a lot on that motion, but it's the first time we have a motion before we do terms of reference. Normally it's vice versa. We work, we have discussions with the committee, we develop terms of reference, and then your committee can have a motion on those terms of reference. The work is done.

For example, item c. of your motion asks for the estimate of the costs of creation and administration, and you have two parameters there. Then you can add whether it is national, monopolistic, financed only by the federal government, and so on. That would be the basis, and then you add to that. Then we could work with that and present you our terms of reference.

Mr. Don Davies: I know we can, but is this clear enough? Could you go away from this meeting with this motion and proceed to provide us with the costing we're asking for, or do you need this committee to sharpen any particular parameter for you? That's what I'm trying to find out.

Mr. Jean-Denis Fréchette: If we can play with the motion, if the motion is not final and adopted such that this is what we have to do, then we certainly can play with it a little bit and reorganize and have terms of reference using some of the elements of the motion.

Mr. Don Davies: Is there enough for you to take this away and do some preliminary work and come back to the committee, and then have us maybe examine the parameters and adjust the study? Is that something you'd suggest we do?

Mr. Jean-Denis Fréchette: I would suggest that. I would prefer to do that, as opposed to having a strict motion to follow without any wiggle room. I need some discretion about what I can do.

Mr. Don Davies: Of course.

Mr. Jean-Denis Fréchette: The last paragraph is the best example, as I gave you earlier.

Mostafa wants to add something.

Mr. Don Davies: Go ahead.

Mr. Mostafa Askari: I'll be very brief.

Typically if there is a request like section c. of the motion, it's broad enough. If the committee can eventually provide some more details in terms of whether you are looking at this as a federal program or as a provincial program, if it is to be fully integrated with the medical system or managed separately, those kinds of parameters are important for us in doing the final costing. If we have those, then on that basis we can develop terms of reference that we will send back for the committee's final approval. Once the terms of reference are approved, we would go away and do our work and write the report. Then we'll send the report back.

Mr. Don Davies: Would you suggest that you take this motion, look at it, and give us suggestions on what further parameters might be helpful, such as the ones you just mentioned as to whether it is integrated—

Mr. Mostafa Askari: That is certainly a possibility. If that's the wish of the committee, yes, we can certainly do that.

Mr. Don Davies: Okay. Can we also provide the PBO with several different models for you to cost?

Mr. Jean-Denis Fréchette: Can you give us a couple of years to do it?

Certainly. We had that situation with other requests in the past, but not for a topic like pharmacare. Doing just one model of pharmacare would be really time-consuming.

Mr. Don Davies: It would be big enough. Okay, you'd suggest we stick with one.

Mr. Askari, I just want to correct one or two things.

You said savings are the objective. That's not necessarily the case, sir. One of the objectives might be universal coverage for all Canadians, and we may recognize that it might cost us more money.

Second, Dr. Carrie was talking about a $17-billion deficit, but once again, not necessarily. Universal pharmacare might cost more money, but it could be funded by any number of increased revenue sources if we wanted to, so it doesn't necessarily add to a deficit. Is that not correct?

● (0920)

Mr. Mostafa Askari: That's correct. As I said, the funding all depends on the choices you make.

Mr. Don Davies: I have a final question, if I have time. What is a sensitivity analysis?

Mr. Mostafa Askari: Obviously these are estimates and not precise. Normally when we cost something, we look at the key factors—the key cost drivers, for example—and then we provide sensitivity relative to changes in the assumptions we have made in doing the costing.

For example, if you make an assumption that by providing a pharmacare program there will be a reduction in the price of prescription drugs because there is power to negotiate better, that's unknown. That's an assumption that you have to make. We can change that assumption and see how the result will change relative to the different assumptions, from high to low and through the range.

Mr. Don Davies: The bottom line—for me, anyway—is to find out how much a universal pharmacare program would cost and how much and where the savings would be from such things as streamlined administration, bulk buying, cost-related nonadherence, etc. Those are the two main things: what it would cost and where our savings would be.

That's the bottom line, I guess. Is that something the PBO could do?

Mr. Jean-Denis Fréchette: It would be part of the result of the costing, as long as we have all the parameters from this committee.

As I said before—and I will repeat myself—I don't want to develop a program for a committee and cost the program. I don't want the media to say that the PBO developed this policy. I'm not elected, as Mostafa said, and we are not in that kind of business. If you have an idea, we will present your idea. If it's your idea, fine. We will discuss it and we will most likely include all these topics.

Mr. Don Davies: I understand. Thank you.

The Chair: Mr. Kang, you're up.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Thank you very much, Mr. PBO and panel, for appearing before us. I used to read about you in the papers, but it's nice to see you personally.

I was looking at Mr. Morgan's study from 2015. That model says that it's going to save us $7.3 billion. I think there will be savings on top of that, because people who don't have the coverage now are costing health care a lot of money too. I would like you to look at that number for people who are not covered right now by health care and don't have coverage for prescriptions. How much savings would there be?

Mr. Carrie was saying that it's going to cost us about $17 billion more. Right now, somebody's paying for that. I believe that money will be going into the pharmacare pool, and I don't think that it actually will cost the government $17 billion more. Maybe we could have copayers or taxpayers or something to recoup the money that we're going to lose.

I would like to see the study.... If we were to go with Mr. Morgan's model, we would save $7.3 billion. How much money are the people who don't have that coverage now costing the system? That will be a saving for us too, in other words. I would like your thoughts on that.

Mr. Mostafa Askari: One thing I can say with some confidence is that if there is a pharmacare program, demand for prescription drugs will increase, because obviously there will be people who are not covered now, and they will be covered by that program. That cost will increase, and it will put more pressure on the budget or the cost of the program.

As to whether there will be savings, as I said, that's a critical assumption, and there's a critical issue in regard to how much savings you are going to have from a pharmacare program, both from the fact that there is a possibility of negotiating prices that are lower than the current prices and also because there will be more discipline in the way people consume prescription drugs.

Those assumptions are critical, and we cannot really say what we are going to get right now. In Steven Morgan's model, they have made certain assumptions and they came up with those results. We have to do our own kind of work and come to some kind of conclusion at the end as to exactly what that is. If it is significantly different from their estimates, then we'll have to explain exactly why that is the case, and we will do that as part of our report.

● (0925)

Mr. Darshan Singh Kang: Thank you.

In your presentation, you mentioned that each province has its own pharmaceutical plan, with some similarities between them. What are some of the fiscal levers available to the federal government to help optimize pharmacare costs across the provinces in using these similarities? Can we use those similarities?

Mr. Mostafa Askari: Well, the provincial programs, as far as I know.... One thing I should say, actually, is that it's a new area for us. We haven't really worked in this area before, so whatever I'm saying is based on the very casual read of the literature that we have done over the past few days.

What I know about the provincial programs is that they are significantly different. The Ontario program, for example, is an age-based program, so only the seniors can use the program. Alberta and British Columbia have completely different programs. British Columbia's is an income-based program, so that once your income is above a certain level, the costs you have to cover yourself go up significantly.

There are significant differences between these programs. I don't know exactly how the federal government can play a role in bringing all those together, if I understood your question correctly.

Mr. Darshan Singh Kang: We heard from previous witnesses that other countries in the OECD use the copayment model of pharmacare but that it has proven to be a fiscal failure. Does your office have the capacity to conduct comparable research on this subject for use by the committee?

Mr. Mostafa Askari: We can certainly look at other countries' programs and see exactly how they are implemented, what the costs are, and those kinds of things, if that's what you mean. Certainly that would be part of our background research to doing this kind of costing work, because we have to look at what is available out there.

Benchmarking from other jurisdictions is always an approach we take when we are doing costing. Especially if there is not enough domestic information available, then we have to benchmark from other countries, certainly.

Mr. Darshan Singh Kang: We had Professor Flood here, and she was saying that in New Zealand drugs are much cheaper than here, so can you do some comparable study on why they are negotiating cheaper prices and why we can't get cheaper prices with the pharmaceutical companies?

Mr. Mostafa Askari: That's a completely different project, actually. We can look at how pricing is done in different jurisdictions and see whether it's cheaper or not cheaper, but why that is the case is extremely difficult to ascertain, because there are many different factors with regard to how different governments negotiate with pharmaceutical companies and how pharmaceutical companies behave. That's a completely different issue.

Mr. Darshan Singh Kang: I asked that question because we are after savings, so maybe we can fit that in. That could be part of the puzzle to make an argument for pharmacare. If we do it one way, it will cost us $29 billion, while some studies say we can save $7 billion. If we took negotiation into consideration, maybe it would save us more money. That was the reason I was asking that question about whether you could fit that in there in your terms of reference or mandate.

Mr. Jean-Denis Fréchette: Certainly we'll compare, for example, New Zealand and two different federal-provincial systems. That's certainly a factor that we'll have to include in our costing model.

● (0930)

The Chair: Okay. That completes our first cycle.

Now we're going to go to five-minute questions, starting with Dr. Carrie. Welcome back.

Mr. Colin Carrie: Thank you very much. To our witnesses, thanks again.

One of the things Canadians want us to look at is why we are doing this and what the problem is. Mostafa, you were saying there are a lot of assumptions being made. We're doing this so that hopefully we can see some savings. That would be the main reason.

We're looking at the taxation system, the fiscal situation. We've just received your most recent report, and it states that after three months the federal government expenditures in 2016-17 total $62.9 billion, which is 5.7% higher than the $59.5 billion spent over the same interval in 2015-16. That's the largest increase in at least five years, so before we start spending more money, that first assumption has to be clear.

In your answer last time, Mostafa, you did state that you as a group could give us a snapshot or a benchmark of where we're at today. Is that correct?

Mr. Mostafa Askari: We have to look at the data that's available. Ideally that would be a part of the final report, but if you want from us sort of a preliminary report only on what is available just to date on this and some preliminary analysis of it, it would be a separate report that we can provide.

One thing on which we'd like to be clear is the way that our work is done. We can provide a report. First of all, anything we produce will have to go on our website, so if the committee wants us to do a preliminary report on what is available, then we can certainly do that. We'll go look at it and provide a report back to the committee and put it on our website, and then we'll go to the second stage, which will include more detail and will actually cost the pharmacare program.

Mr. Colin Carrie: I think that would be helpful to us, because as you were saying before, you don't give advice on the policy side of things, but if we could have a snapshot....

I was wondering if we could amend Mr. Kang's notice of motion to put something in that says, “that the PBO first declare if current statistics available allow for thorough and comprehensive analysis, as has been requested below, and as soon as possible report to the committee the viability of accurately completing the request below”.

If we put something in front of the motion as a friendly amendment, it would allow you to give us that snapshot ahead of time before we pick one route. It's as though we're being asked to make a policy decision without knowing where we stand today. That's all I'm saying. Would that be helpful?

Mr. Jean-Denis Fréchette: When you mention the snapshot, are you talking about the current situation?

Mr. Colin Carrie: In Canada.

Mr. Jean-Denis Fréchette: Yes. As you know, we appear twice a year before the Standing Committee on Finance with the economic fiscal outlook. We update the outlook twice a year. It's going to be in October. We're scheduled to appear the third week of October with our EFO. That will provide you with some kind of a snapshot of the situation.

Mr. Colin Carrie: That's the fiscal side of things, but what I was talking about is a snapshot—and I believe Mostafa said you could get this—for Canada to help define what the problem is. What would things look like moving forward? Who would have coverage now in Canada, and where are the gaps? Are those without coverage low-income Canadians for whom this is a problem? Is it more some higher-income Canadians, so it may not be as much of a problem to have access? How big of a problem is it for people who don't have insurance?

I see from many witnesses that we need to target in on the people who don't have any coverage and who can't afford the coverage. As my colleague here was saying earlier, we would like to see all Canadians have the necessary coverage they need. Defining the issue now would give us a better idea on moving forward and directing you on policy and on information that would help us develop policy. That's all I'm asking.

Mr. Jean-Denis Fréchette: Okay, I'm sorry; I thought the snapshot was of the economic situation, but you're talking about the situation of pharmacare—

Mr. Colin Carrie: Yes, the situation we have now.

Mr. Jean-Denis Fréchette: —and the coverage situation. It would certainly be part of a study, but I'm not sure we can have a snapshot that quickly. It would depend on the availability of the data.

● (0935)

Mr. Colin Carrie: My question is, could you do it? Maybe I should ask Mostafa about that, because I thought in his last answer he said that you could do it.

Mr. Mostafa Askari: Let me clarify. If it would the wish of the committee for us to do two separate reports, the first one will be the status—

Mr. Colin Carrie: What we have today.

Mr. Mostafa Askari: —today. If that's the request from the committee, then we'll have to go and look at the data and see what we can do in that area. That will be our first report. Then the committee can, on that basis, give us instructions as to whatever they want us to study around a pharmacare model, and then we'll go and do the second report.

Mr. Colin Carrie: I think it would be irresponsible to jump into something that could be this huge without getting a good idea of the snapshot for today, how we define the problem, and what the best ways are to go about fixing it, so I would definitely appreciate that.

The Chair: Thank you, Mr. Carrie.

Mr. Oliver is next.

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

I want to be clear on what I've heard from you, because it has been helpful to have you come back and give us some feedback.

We've heard three potential models here. There's the comprehensive pharmacare program across Canada from the Morgan group. There is another extreme, which is simply that the government provides coverage to uninsured Canadians and the system stays the same otherwise, with all the inefficiencies and cost issues that are locked into it. The third one is more the government providing insurance, but then there's a managed competition model that's layered in to try to improve the efficiency of the system.

What I've heard from you is that you want us as a committee to give you one direction. You want to cost one, or else you'll be costing for the rest of your days, and I'm sure you have other important things to be doing.

Is that a yes? Would you like us to come forward with one model?

Mr. Jean-Denis Fréchette: Yes. We need direction from this committee saying you want this model.

Mr. John Oliver: Okay.

Mr. Jean-Denis Fréchette: We'll develop terms of reference, we'll come back to your committee, and then we can establish a working plan.

Mr. John Oliver: For the private sector spin, the graphs were interesting. You can see that when the pan-Canadian pharmaceutical negotiations started, on the public sector side the expenditure begins ro drop or slow down, whereas the private sector expenditure continues to grow. I think the understanding of how the negotiation of pricing happens in Canada, and how we are situated...I think we're second right now in the G7 for the cost of drugs.

You could look at the G7 costing and move us more to the median or average pricing. Are there similar models you could use to arrive at a target cost of a national pharmaceutical program?

Mr. Mostafa Askari: That's a very good question, but as I said, we have to go back and do some work and look at these things and see what is available out there and what we can say about them. Again, this is quite a new area for us, so we have to educate ourselves a bit on what's on the line with all these things, and then we can provide some assistance.

Mr. John Oliver: You'd look at our initial motion and then come back with questions of clarification and look for direction and suggestions to help narrow down the study and be more focused.

In response to Mr. Carrie's comments, people are paying for those drugs right now on the private sector side. They're paying through employer-based plans or they're paying through their own private insurance that they're purchasing. If we move to a national formulary without increasing costs to private employers or increasing costs to the people who are currently buying private insurance, we would be able to transfer some of that spending to offset the cost of this program to government. Is that spend something you can estimate and collect data on?

We wouldn't increase costs to employers, but at the same time we recognize that they're already paying something here that can be captured and used to sponsor a national program.

Mr. Mostafa Askari: Well....

Mr. John Oliver: A quick example would be a hospital in the MUSH sector. There are already transfers going in to cover the costs of benefits, so governments would be able to recover that.

Mr. Mostafa Askari: I'm not 100% sure exactly what the question is, but again all these have to be part—

Mr. John Oliver: I'm addressing the question of the $16 billion in the private sector, which doesn't necessarily transfer across to the government to sponsor it, because there are already payments being made, so without increasing costs on the private sector, we could recover some of that spend and use it to make this a more affordable program.

Mr. Mostafa Askari: Certainly that would be the case. There will still be a private sector payment for prescription drugs even after pharmacare, because pharmacare obviously is not going to cover everything. There will be a division between the costs in terms of what the public sector is paying and what the private sector is paying. Whether there will be some kind of savings here in that process that can be used by the federal government is a question that has to be asked.

● (0940)

Mr. John Oliver: But the necessary drugs and those in the second tier would be transferable spends, however the government manages it, to help cover the pharmacare program.

Mr. Peter Weltman (Senior Director, Costing and Program Analysis, Office of the Parliamentary Budget Officer, Library of Parliament): I think I'd just like to back it up, if I have a minute to respond.

What we would be most comfortable providing is, as Mostafa stated earlier, a comparison of examples. We can show different countries that are paying different prices, and we leave it there. I don't think it's within our ability or mandate to suggest areas of savings. We would just leave the opportunity out there in the report, showing what these people are paying, what those people are paying, and what these other people are paying.

I don't think we'd go as far as to say we could save money if we tried this or we tried that. I think that would be better coming back after policy-makers say that they have decided on an approach that they want to take to manage this program and ask us to come back to them with an updated cost estimate.

Mr. John Oliver: We heard from the Pharmacists Association. They're quite concerned that we as a nation would lose the full service that a pharmacist provides in terms of not just filling the prescription but also providing advice on drugs and complications and co-issues. Is it possible to make sure, if we were looking at a national pharmacare program, that there would be full coverage and full compensation models built into that for the people who administer the prescriptions along the route?

Mr. Peter Weltman: Again, I see that as policy direction. If you come back to us and say we want a program managed on this basis, exactly the way it's delivered today, with this change and this change, and ask us to come back to you and cost it, we could do that, but we wouldn't come to you and say, “Well, if you did this, we could do this, or if you did this, we could do that.”

Mr. John Oliver: Thank you.

The Chair: Go ahead, Dr. Carrie.

Mr. Colin Carrie: I have so many questions today, Mr. Chair. Thank you very much.

This is excellent, because I think in the scenario that I'm looking at, it appears we're being asked to perform surgery on a very important program in Canada without first coming up with a diagnosis. There's more than one way to get the solution that we would like. I think, Mostafa, you said there still will be private care because the public health care system won't cover everything.

My impression from some of the witnesses is that they don't want a private system. They do want a monopolistic type of system, one system, in which perhaps bureaucrats or different groups of individuals would decide which drugs would be covered. That's one of my concerns.

The decisions we make, first of all, are going to be expensive one way or another, but we do want to make sure at the end of the day that we're actually solving the problem that's out there, and we don't really have up-to-date statistics on it. Do you agree that it's important to gather sufficient data on the number of Canadians who either lack prescription drug coverage or have insufficient drug coverage, in order to properly estimate the cost implications of a universal public national pharmacare program?

Mr. Mostafa Askari: As I mentioned earlier, part of the modelling we are going to have to do is to look at that and see exactly what the potential is for the demand for prescription drugs, and then what would be the cost.

Mr. Colin Carrie: Yes. I'm concerned that we're jumping in before we have some of the data. I will state that there are a lot of assumptions being made. I believe Mr. Kang said he doesn't think it would cost $17 billion more. We assume there are some savings to be had, but we don't know, and before we make the decision, I'd like to see you come back.

I'm trying to find the best way forward. Again, just to clarify, do you think the best way forward for you guys to give us the information would be if we made an amendment to this motion and we got the two reports to get a snapshot of today? There's going to be more than one way and more than one opinion on how to move forward. I want to get the diagnosis before we perform the surgery.

● (0945)

Mr. Jean-Denis Fréchette: I cannot make a decision for the committee. You're asking me a difficult question. This committee is master of its own destiny. You decide, but we will work with whatever is the committee's will. I think you know the limits. We mentioned the limits, or what we would like to see, but I cannot comment.

Will it be helpful? If you do it, we will work with whatever motion you will have.

Mr. Colin Carrie: Mr. Weltman, I believe you had a comment.

Mr. Peter Weltman: I think what would be helpful when we talk about defining the problem is knowing that it's not within our purview to do so. If the committee is presented with the problem statement and we are asked to provide an estimate as to the cost of that problem, then we can do that, but to define the problem is beyond our mandate.

Mr. Colin Carrie: You know, I appreciate that. Perhaps a better way to ask for what I'd like to get from you would be to ask you for the data to analyze what's out there today. I think that would be a good way of moving forward, and if, as Mostafa said, you could do two reports, then it would give us that information. You guys can look at it that way before we make a policy decision. Mr. Oliver did say he would be looking at a monopolistic system and a one-payer type of system, and if we are going to go down that route, I want to see what we're getting into before we make those decisions.

Mr. Jean-Denis Fréchette: If I may...maybe I'll put myself in trouble and maybe I should switch to French, because I'm less in trouble when I do that.

An hon. member: You go ahead.

Mr. Jean-Denis Fréchette: Mr. Chair, here is what we could do, and I'm not suggesting anything; I'm just saying here's a potential scenario.

We took notes of all the discussion from both sides, and remember that we are non-partisan. We are independent of the government and we're non-partisan as well.

We took notes of what was discussed this morning from both sides, and what we could do is come back with our terms of reference. We have the motion that is there. I think we can manoeuvre around that. We took notes of other good suggestions from both sides for models, and also your last suggestion. We will come back with our terms of reference, whether or not we're going to have two reports, three reports, three models, or one model. Those terms of reference will belong to this committee to decide the direction you want the PBO to take. I think it's going to be easier for this committee to go forward on that basis as well, or to amend the terms of reference. It's going to be easier for the committee to decide which direction you want to take.

We'll be honest with you after that. If we say we cannot do that, then it's for whatever reason. If it's helpful, that's the way we can go.

Mr. Colin Carrie: Thank you for that.

Do I have any time? No?

The Chair: You're done. Ms. Sidhu is next.

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

Thank you all for being with us.

What types of challenges are involved in using international comparisons in a costing analysis?

Mr. Peter Weltman: The challenge is getting appropriate data. That's the challenge we always face in any cost estimate. The process is bringing ourselves up to speed on the situation. This is a new area for us, so we've been busily reading background materials. Then we would reach out to our network that we built up over the years to understand what data exists, and sometimes the data is not very good. We look at how that compares to our particular situation. There's a bit of judgment and experience involved in making sure the data that we are using to benchmark with is relevant to the study that we're doing. The biggest challenge is finding it and then making sure it's comparable.

Mr. Jean-Denis Fréchette: If I may add something, it's the cost of the data. You remember I mentioned that we have limited resources. It's not only in terms of people; It's also in terms of budget. In terms of buying data, we do have a budget for that, but international data is costly, as you know.

Ms. Sonia Sidhu: In the PBO's upcoming research, is there any way to point to what the most expensive diseases are that are lacking prescription drug compliance? As we heard, 23% of people are not getting medication because of the cost.

● (0950)

Mr. Mostafa Askari: We would have to go and look to see whether the data is available for something like that. That's an extremely difficult thing to get—exactly how people use prescription drugs, whether they use them properly or not, and whether they actually use the right thing or not. That's extremely difficult.

There may be some survey data, but I'm not sure whether it is very reliable. Anyway, these are things that we have to go and examine.

Ms. Sonia Sidhu: In other reports related to health costs that the PBO has done, were there any barriers you faced in fully examining the cost that the committee can help you with?

Mr. Mostafa Askari: The work we have done in the past, in terms of health care costs, has been at a very high level, such as total provincial health care costs. Those all used available data from CIHI and other macroeconomic data that was available. There weren't really any issues there.

If we need some help from the committee to get information that we cannot get easily ourselves, then certainly the committee would be helpful in that case.

Ms. Sonia Sidhu: Can the PBO please talk a bit more about how their office analyzes a hypothetical system like this one, where the price is such an unknown and specifications differ province by province?

Mr. Peter Weltman: In the past, we have studiously avoided studying hypothetical situations. In the start-up phase, because of our limited resources, we've tended to look only at bills that were presented, private members' bills, because we wanted clarity. For example, we were asked early on to look at the cost of poverty. There were a lot of different assumptions that needed to be made, and we respectfully excused ourselves from doing that.

That's the simple answer. That is why we keep coming back and saying we need some precision around what the program looks like. With a private member's bill, there is usually a fair bit of precision in the bill. In this case, we are looking at a policy proposal, so we would not do any hypothetical study.

Ms. Sonia Sidhu: Thanks.

The Chair: Mr. Davies, go ahead.

Mr. Don Davies: Thanks, Mr. Chair.

If we asked you to determine the cost of adding pharmaceuticals to the Canada Health Act as an extension of insured services, could you do that?

Mr. Mostafa Askari: Well, that would be one model, one sort of structure, and that structure means that there has to be a formulary that would cover certain prescription drugs that all the provinces have to include in their program. Certainly, that's one structure.

If that's the case, sure, we can focus on that.

Mr. Don Davies: Suppose we asked you to estimate the cost savings from a series of discrete, itemized factors. For instance, the federal government could engage in bulk buying of essential drugs in a formulary. I assume that we would give you a formulary of, say, the 150 most commonly prescribed drugs and we could ask you to estimate the potential savings from bulk buying. We could have exclusive licensing agreements with respect to certain drugs, as some countries are doing, and streamline the processing of claims. There is cost-related non-adherence, as Dr. Eyolfson has mentioned; that's the term for how much we would save from people getting access to their drugs as opposed to waiting and getting sicker without them. We could have an evidence-based formulary and increased use of generics.

If we itemized those as A, B, C, D, E, do you think you could give us rough estimates on what the cost savings from each of those elements might be?

Mr. Mostafa Askari: These are all good questions. To know whether it is possible or feasible for us to do that, we would have to go back, look at the question, look at the data availability, and see whether we can put a model around it and come up with a reasonable estimate.

Some of these things may require strong assumptions that may reduce the credibility of the results, because if you make too many assumptions, then the results are not very credible. These are the kinds of questions, unfortunately, we cannot answer right now until we go back and do our homework and get a better sense of the information that is available and the experience of other countries and other models. Then we can put together some terms of reference and come back to the committee and say what we can do within a reasonable timeframe.

● (0955)

Mr. Don Davies: The reason I ask is that witnesses at this committee have said that if we were to have a universal pharmacare system in this country that was an extension of the Canada Health Act, then they estimate that there would be an additional cost because you're covering more people, but that it would be offset by savings from these different areas.

I think the committee's interested in having some objective analysis of whether that may be the case, so that's why I'm asking.

Mr. Mostafa Askari: Those are big assumptions, and that may be true, depending on how you do it.

The Chair: That completes our testimony and our questions. I want to thank the PBO for your comments and your agreement to take this on, because we haven't given you a model to analyze.

We're lucky to have your agreement on that, but what exactly is the way forward now? What's going to happen next?

Mr. Jean-Denis Fréchette: The first issue is that we did not talk about any timeline.

Here is the way forward. We took note of all the comments from all sides. We will come back with the terms of reference or some kind of a work plan, according to what we heard, with some options.

We would like you to then decide which one you want. It will be your model. It will not be the PBO's model, so let's be clear on that. It's going to your choice. I'm sure people in the department are listening right now in meeting rooms, and maybe they do have a model. Maybe they have something in mind. We will ask them if they have a model. Then we can cost that. That's going to be the model they may have. They probably don't appreciate what I just said, but we will ask the department. There is a policy shop, a policy section in departments, so that's certainly a discussion we will have. That's the first thing.

The second thing is that we will present the terms of reference with some kind of timeline. In two weeks, roughly, we should be able to come back with the terms of reference based on the discussions that we had this morning, with some options for you to decide which one you want.

From there we'll discuss the timeline and what we will do. Then we can report on a regular basis to the committee, as we do with other committees, on the difficulties that we have with accessing data or developing our own analysis of it. I want to be clear that if you provide me with some kind of margin to manoeuvre within the motion that you have there.... As I said, I'm not sure where the motion stands right now. If I have to respect the motion, it's a little difficult, but if we can play a little with the motion, then that would be easier for us to develop the terms of reference. In two weeks we should come back with what I said.

The Chair: In two weeks you'll notify us. Can we schedule that now, or should we wait until you contact us?

Mr. Jean-Denis Fréchette: We will contact the chair's office. The process is always that we contact the chair's office.

The Chair: When we choose the model, do you have any idea how long it will take to get to get a final report? We're not in a hurry. I think I can say we're not in a panic.

Mr. Jean-Denis Fréchette: I would like to give you an answer. When Senator Kirby's report was done, I was at the Library of Parliament monitoring some of that research. I can tell you that maybe it will take...well, I won't say that long, but we will see after we have further discussions with this committee about the terms of reference.

I don't know if you have a steering committee. Do you want to deal with the terms of reference in the steering committee? I don't know; it's up to you.

● (1000)

The Chair: Mr. Davies, did you have a question?

Mr. Don Davies: Yes. I'm just wondering if it would be better to do the reverse. We, as a committee, could take the information we've received from the PBO and hone our motion, given the information you have—by the way, the motion is not passed yet—to provide you with the model and the parameters. It almost seems backwards to me to ask the PBO to provide us with the model and the parameters.

The Chair: Does the PBO have enough to work with now to analyze the models and come back with models? Do you have enough to do that?

Mr. Mostafa Askari: We can certainly look at the availability of data and put together preliminary terms of reference, which we can then share with the committee. Further discussion could clarify different parts of that, and then we'll go over the final terms of reference at that stage. That's a possibility.

As I said earlier, the idea of having a pharmacare program in general is by itself a costing project. Then we need further details in terms of what the committee thinks would be a reasonable kind of structure for that program—whether it is a federal program or a provincial-based program, those kinds of details. Then we can develop better terms of reference on that basis, finalize that with the committee, and start the work.

The Chair: So we have enough to go ahead.

Mr. Mostafa Askari: That's right. We can provide the terms of reference. As I said, it won't be the final terms of reference, but we can provide preliminary terms of reference for what kinds of things we can look at.

The Chair: Mr. Oliver, go ahead on procedure.

Mr. John Oliver: I just want to follow up on Mr. Davies' suggestion. I think it's worthwhile for us to take a look.

I think we did pass the motion preliminarily but agreed that we would look at it again at the end of this session, following this discussion. Maybe we could go back, address some of the questions and concerns that have been raised here, be a bit more specific in certain areas, and pass it over, but I still think we should have an iterative process with the PBO. We'll pass a motion to give them a more concrete direction of where we as a committee would like to see the study go, but then be receptive to a report back in two weeks from the PBO on what works, what doesn't work, and what advice they would give us to fine-tune it. I think that would be a bit more of an iterative process than to simply punt and wait for that to come back.

The Chair: Ms. Harder is next. We are breaking all the rules here. I hope it's all right with everybody.

Ms. Rachael Harder (Lethbridge, CPC): I agree with Mr. Oliver. I think it would be in our best interest to reconvene as a committee and talk about the motion that we are putting forward, in terms of the direction that is being delivered to the PBO, because it feels a little convoluted right now.

The other thing I would recommend to the committee is that once our motion or direction goes forward to the PBO, perhaps we could ask them for an outline of their report before they get going so that we would be able to see exactly where they are able to take it, because there are going to be some points that perhaps they can't expand upon and others that they can. Perhaps we could get a detailed outline from them and sign off on that before they put the time and energy into it.

The Chair: Mr. Kang, go ahead.

Mr. Darshan Singh Kang: I agree with Ms. Harder and Mr. Oliver. I think we have some amendments on the floor. I think we should deal with the motion first and maybe amend it; then we send it to the PBO, and the PBO comes back with the amended motion. They can get a better direction from there.

The Chair: We'll do committee business after the PBO, and we'll discuss that.

Dr. Carrie, go ahead.

Mr. Colin Carrie: Thank you very much, Mr. Chair.

I agree with everything that was said, but perhaps it would help us out a little to ask the PBO to inform us of what challenges and obstacles they have, perhaps in getting some of the information. You mentioned international data. It may cost a little, but whether we are going to be spending $17 billion or whether there is $7 billion of savings in there and it's $10 billion, it is still a large amount of money. Maybe it would be worthwhile, before we spend $10 billion, to get some good snapshots and ideas of what's going on. They could come back and just give us advice on what their obstacles are in terms of gathering this information for us.

● (1005)

The Chair: All right.

Are there any other comments?

Mr. Kang, go ahead.

Mr. Darshan Singh Kang: Mr. Chair, let's not put the cart before the horse. Let's deal with the motion and send it to the PBO, and then those things will come afterward.

The Chair: Also, we can communicate with the PBO as things unfold here at the committee and provide them with information as it comes forward.

Is that it for everybody? All right.

Thank you very much for coming, and thank you for not just saying, “No, we won't do this.”

The meeting is adjourned.