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Chair

Mr. Bill Casey

Standing Committee on Health

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● (0845)

[*English*]

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

I'd like to welcome our guests this morning. We're continuing our study on a possible national pharmacare program.

I want to start with Dr. Thomas Perry, because he has a technical display. We have the technician here for a short time. We want to make sure that everything works.

Before we start the presentation, he's provided us with a brief for each one of us, but it's only in English. I need unanimous consent to distribute these only in English. Do I have unanimous consent?

Some hon. members: Agreed.

The Chair: Okay. The clerk will distribute them.

Just give us a second, Dr. Perry, and we'll continue with your presentation.

Dr. Perry is from the University of British Columbia Therapeutics Initiative, and he is chair of the education working group.

Dr. Perry, you have 10 minutes to start off, and we look forward to your remarks.

Dr. Thomas Perry (Chair, Education Working Group, University of British Columbia Therapeutics Initiative): Mr. Casey and the committee, thank you very much for inviting me.

Much of what I'm going to say you have heard in different forms from a number of your witnesses, so I'll try to be as fast as I can and give you time for questions.

I'm presenting on behalf of our group, which is an independent group at the University of British Columbia. We have a grant through the provincial ministry of health. I don't want to sound immodest, but we have an international reputation for the quality of our work, and we have no conflicts of interest. That was a policy established when we were founded in 1994—absolutely, strictly no conflict. My colleagues said, “Don't disclose your own conflicts because none of us have conflicts related to the drug industry or this topic.”

I want to show you some of the lessons from our experience over the last 22 years, why we also feel that a national pharmacare program must be based on the best evidence if we want to get the best results, and why evaluation of drugs has to be independent of the pharmaceutical industry. This is a lot harder than it looks, but it's the only possible way to protect the public interest, not only in health but in taxpayers' dollars.

In British Columbia, PharmaCare started in 1973. This was an innovation of the government that was elected in 1972. It was popular policy, but there was no formulary, and any new drug was automatically covered. By 1989, the costs were compounding at 16% per year, which was doubling effectively every four or four and a half years. It was completely out of control, and it was irrational to say that the benefits were doubling every four and a half years. I know some politicians will say, “We will double your benefits every four and a half years”, but everyone knows this is impossible.

In 1994, because of this pressure and a very large provincial budget deficit at the time, the Ministry of Health realized it needed unconflicted advice on whether it should pay for new drugs. It established our group with a very strict conflict of interest policy: no pharmaceutical stock holdings, no money from drug companies, no going to drug dinners, and no contact. This was to protect us and isolate us, not from the intellectual issues but from the possibility of being compromised.

Then the Ministry of Health developed the courage to actually make funding decisions based on the results of this process, which was the real innovation in British Columbia.

The critical elements are to clarify the scientific evidence, free it from conflict and bias, start with an open mind, be rigorous about assessing the evidence, come up with a summary of the evidence, and turn that over to the Government of British Columbia, which then made its funding decisions.

It must be evidence, not opinion. If I say as a doctor that I find, for example, that opioids seem to work nicely for some of my patients with chronic pain, that's not adequate evidence for a policy decision. It might be in clinical practice, but not for government policy decisions. We need randomized clinical trials to have that kind of knowledge.

The results are that by 2007—I'm taking this point of time because we have the *Canadian Rx Atlas* that Professor Steve Morgan compiled that shows us this—the per capita drug costs were sufficiently lower in British Columbia that had we been at the Canadian average, we would have been spending $701 million more every year as of 2007. That would be much higher now.

We felt that $208 million of that savings came from choosing lower-cost drugs, which is partly referenced-based pricing. Another part of the saving was that PharmaCare did not cover many expensive drugs reimbursed by other provinces. I've chosen two examples to make this point to you. Drugs for Alzheimer's disease are the first example, and the other drugs are the so-called COX-2 inhibitors that were competitors for ibuprofen and naproxen, introduced starting in 1999 for use mostly with osteoarthritis and rheumatoid arthritis.

We found that there was not evidence that these drugs were effective or better. PharmaCare in British Columbia declined to pay for them. Subsequent academic studies demonstrated that this led to no harm, but almost certainly must have saved potentially hundreds of lives in British Columbia alone, and that it saved a bundle of money for the taxpayer.

● (0850)

This became the precedent for the common drug review that you heard about in some of your earlier meetings.

I'll give you an example. The so-called COX-2 inhibitors, first licenced by Health Canada in 1999, were promoted as much safer, and some of you will remember the ads for Celebrex or Vioxx. However, within a few years both the brand name Vioxx, rofecoxib, and valdecoxib were removed from the market almost immediately, so most of you won't have even heard of them. Then lumiracoxib, which caused liver toxicity, was later removed, so you may not have heard of that drug either, but they were all licensed in Canada.

We looked clearly at the evidence and found that it clearly showed that these drugs were not superior to other drugs. We were vilified at that time as an academic group, including by our senior academic leadership. I know what it feels like to have the department head say, “Well, you're with the Therapeutics Initiative, but you may still come to our dinner”, and yet we were right.

The reason we were right is that we read the experimental evidence, such as was available, carefully. PharmaCare, on that basis, did not pay for them. The results were that our consumption was much lower than Ontario's, for which there is comparison. We didn't see the large rise in prescriptions that Ontario did. We had fewer hospitalizations per capita for gastrointestinal hemorrhage. We had much lower costs. The reason we achieved this was that the British Columbia government listened to the scientific evidence in a way that other governments did not.

A second example is donepezil, rivastigmine, and galantamine. Anyone who's had a relative with Alzheimer's disease or dementia will be in some way familiar with the names of these drugs. They were alleged to offer hope for people who have no other hope. They were very heavily promoted and aggressively advertised. The real evidence showed, and still shows, that they were basically not effective. Even an article by André Picard in today's *Globe and Mail* refers to this. They were dangerous for some patients. They would have almost certainly caused falls, collapse, fainting spells, diarrhea, urinary incontinence, etc.

PharmaCare did not pay for them. Again, both the government and the independent agency that provided the scientific review were vilified because these drugs were so heavily promoted as useful. I don't think there's anyone serious in the world now who feels that these drugs really are beneficial, possibly with rare clinical exceptions. The results were that we used fewer of these drugs in B.C. than in other provinces. I think there's universal consensus around the world that British Columbians didn't miss anything.

We know from certain other studies about the reference pricing initiative that PharmaCare saved very substantial amounts of money. The initiative was a decision that we would pay for the lowest-priced drug of a class where the drugs appeared to all have similar effects. This would include drugs such as ACE-inhibitor drugs for blood pressure, statins—as done in New Zealand—and calcium channel antagonists. Studies done partly by our group and partly by people at Harvard University demonstrated that there were no harmful consequences.

Then why are we here? I put this in to remind you that this is not the goal. The goal is not to have many more drugs. From some of his questions that I read from previous testimony, I think that Dr. Eyolfson is well aware that doctors, increasingly, are relatively poorly informed about drugs. Dr. Anne Holbrook also made this point to you. We don't want a student, like the one in this picture, facing a crazy desk full of drugs and trying to make rational decisions with drugs paid for either by somebody's out-of-pocket private money or by public money—certainly not public money.

Nor do we want what is shown in the next photo.. This one is from September, two months ago. It is a women who is overly sedated with three different sedative antidepressant drugs and is using four antidiabetic drugs. One of those antidiabetic drugs, the long insulin pen there, is a new version of a long-acting insulin that has no possible, conceivable advantage. It was reviewed by the common drug review, which recommended it not be listed. It's not paid for by the taxpayer; it's paid for out of her pocket. This is a women who, as a foster mother, raised a lot of children with fetal alcohol syndrome, as well as children born to mothers with heroin addiction. She needs money, and she's throwing her money away on these drugs. This is not the point of national pharmacare. The point of national pharmacare should be to help avoid that, if possible.

This speaks to what we really need, and Dr. Monica Dutt made this point to you when she raised the case of a young boy with type 1 diabetes. Without insulin, he dies. His mother was apparently begging her, if I understood her testimony correctly, for samples of some insulin, because she literally could not afford it.

● (0855)

That's what pharmacare should be about, in the same way that the purpose of medicare in Canada was to deliver useful treatments to people who really needed them, whether you cite Tommy Douglas or Emmett Hall or whomever as the father or the mother of medicare.

The logical expectation, then, should be—and here I echo many other witnesses—first that we should improve the health of Canadians, should not increase the harms, and should reduce drug costs and be proud of doing it, so that we can be sustainable and can fund the other determinants of health, such as clean water, proper nutrition, education, housing, and physical fitness, which are all suffering now in my province. We're spending so much money on health care, including drugs, that we no longer have music programs in our schools, for example. Also, as you know, we have many reserves all over the country without clean water.

The technical requirements to do this are that we need to base the policy on the best evidence, and it must be derived by people who are not conflicted. This point has been made in the United States for guidelines. We're lagging behind in Canada, but we're getting there.

Also, the independent group requires real expertise. I read again Anne Holbrook's testimony to you this morning and saw that she pointed out that there are very few clinical pharmacologists left in Canada. We need educators and independent expertise to do this.

I'm going to wrap up there. You have in your handout, I think, the list of other members of our academic group who contributed to the Therapeutics Initiative.

[*Translation*]

Thank you very much.

[*English*]

The Chair: Thank you very much for the presentation and explanation.

Now we're going to go to the Arthritis Society, with Janet Yale, president and chief executive officer.

You have 10 minutes.

Ms. Janet Yale (President and Chief Executive Officer, Arthritis Society): Good morning.

[*Translation*]

I am happy to appear before the committee.

[*English*]

It's really a pleasure to be here this morning. Let me begin by thanking the standing committee for inviting me to appear today.

I'd like to start with a couple of facts. First, arthritis is a disease. I say that because many people don't see it that way, but that's exactly what it is: it's a disease, not an inevitable aspect of aging. It responds to treatment, to therapy, and as we're here to talk about today, it responds to medicine.

Second, arthritis is a chronic disease, and that's vitally important. A lot of the focus around medicine has been dedicated to those with acute conditions, and that's of course totally understandable, but we have to also address those who live with chronic disease and chronic pain and whose quality of life depends on affordable access to the right medicines.

How many Canadians are we talking about? It is 4.6 million, and that number is growing. Current trends suggest that by 2030 that number will double to nearly 10 million Canadians. Not only in health-care terms, but in economic terms, the toll is enormous. Arthritis is the second-leading cause of disability. It takes people off the job and out of the workforce, costing, according to our estimates, $33 billion a year, and two-thirds of that is lost productivity. By 2040, we'll be looking at an annual economic impact of double that. We call that the “arthritis tax”.

I'm not even touching on the intangible but very real human costs of arthritis, such as the young child with juvenile arthritis can't play outside with his friends, a young mother whose disease is so advanced that she can't pick up her children and hold them, grandparents who finds it so painful that they don't travel to visit their family.

Those are the intangible but very real human costs of arthritis. I raise that because I want to underscore the enormous good that can be achieved with fuller, more affordable, and more equitable access to medicines.

Let me offer the first of two core recommendations to you today by saying, yes, the Arthritis Society strongly favours universal pharmacare, a program that will plug the loopholes, the gaping holes in coverage that people with chronic disease face today, an approach that will expand access to medicines, boost productivity, and combat pain.

Let me assure you that based on those I talk to regularly, the need is great. As we all know, in hospitals the cost of those medicines is covered, but those living with arthritis typically aren't in hospitals, and coverage is inconsistent. In 2013 we surveyed more than 1,000 Canadians with arthritis and found that only 63% reported they had workplace insurance plans. That's nearly four in 10 who aren't covered, resulting in large numbers who end up having to leave the workforce, retire early, because their treatments don't allow them to remain productive. For those with private plans, we're seeing an increasing litany of challenges with some drugs covered, others not, copayments rising, and benefit caps becoming more common. Most concerning of all for us, choice can be limited, with newer therapies having restricted access.

That takes me to my second really important recommendation. Yes, we want to see a national pharmacare program, but it can't be built solely around the idea of lowering costs. It also has to have a substantial commitment to choice. Let me explain.

I know that for many, one of the benefits of a national pharmacare program is the idea of reducing the prices for more expensive drugs. By establishing a larger or even national formulary, our collective bargaining power can drive prices down, allowing us to buy in bulk and potentially save large amounts of money. We applaud that idea, but we can't risk establishing a formulary that is too restricted in terms of the range of medicines that are available, because the reality is that people living with arthritis each respond to different drugs differently.

A range of choice is therefore important, and that applies particularly to some of the more expensive new drugs called "biologics". That new category of drugs includes living organisms. They're biologic, not chemical, compounds. Because of that, they interact differently with different individuals, according to that person's biological makeup. They can be a miraculous life-changer.

● (0900)

I'm going to tell you one story. A young man named Matthew was on his way to being a star athlete when he was diagnosed with rheumatoid arthritis and was completely incapacitated. He dropped out of school, had no ability to function, and was in constant pain. Now, thanks to biologics, he has been able to turn his life around. His pain has reduced dramatically. He's able to finish university and start looking at a career. That's not beyond his grasp, even though being an athlete is not going to happen for him.

However, the problem is the cost. His drugs cost between $20,000 and $25,000 a year, and since he's out of school, he's no longer on his father's plan. The family is looking at funding that and, effectively, looking at financial ruin because they want to make sure their son gets the life-changing treatments he needs.

We need universal pharmacare. That would make sure that people like Matthew were covered. However, it won't work if we're too narrow in our approach, because as I said, biologics affect different people differently, so if we restricted access to one biologic in the class for people with arthritis, many people like Matthew would not be well served. Similarly, if we force people to switch treatments to cheaper alternatives such as biosimilars, which are now emerging, it could also result in reduced therapeutic benefits.

From our perspective, it is the patient at the centre of the decision, in consultation with their health care provider, who should determine the treatment and medicine that is most appropriate for them. I know that's not a simple choice. Expanding that choice and leaving choice available would offset some of the savings that might otherwise be achieved through national pharmacare, but we think a balance is required to establish a system that truly serves the needs of Canadians, especially those with chronic diseases like arthritis.

Universal pharmacare is needed. With 4.6 million people living with arthritis and struggling to pay for their medicines, that is clear. I urge the committee to establish two guiding imperatives, not one. Lower cost and wider choice will be the recipe for real progress.

On that, I'll conclude my remarks. I look forward to answering your questions.

● (0905)

The Chair: Thank you very much.

Now we move to the Canadian Federation of Nurses Unions with Linda Silas, President, and Anil Naidoo, Government Relations Officer, and our most loyal witness.

Ms. Linda Silas (President, Canadian Federation of Nurses Unions): Thank you very much, Mr. Casey and committee members.

You have copies of both our submission and my speaking notes, and I'll try to stick to them.

First of all, *merci*, and a big thank you to your team, Monsieur Gagnon and company. My first scheduled appearance was May 17, and we've been juggling dates because it's been so important for us to appear in front of you.

As stated, I am national president for the nurses unions. We represent close to 200,000 working nurses across the country, including nursing students, and we are one of the strongest advocates for a national pharmacare program.

We commend the committee for your mandate, which is the development of a national pharmacare program. It's not another study; it's the to-do list on what we're going to see.

We've lobbied the Council of the Federation, and I'll talk about it. We've directly lobbied federal and provincial health ministers and gained lots of support there, and of course we've lobbied in federal election campaigns and provincial ones.

We've also published research material from Dr. Marc-André Gagnon of Carleton University, "A Roadmap to Rational Pharmacare Policy in Canada". You would have had copies of it in the past.

Some may be asking why nurses are the strongest advocates for a national pharmacare program. It's simple: on every shift, every night and day, we see either the impact that not taking their prescribed medication has on patients or we see the impact of the provinces and territories having to struggle with their health care budgets and having to cut, because $30 billion of the health expenditure in this country is spent on prescription drugs. That is four times what was spent 20 years ago—and yes, 20 years ago I was a nurse.

We are about to publish a new paper on the cost of drugs, but it's going to have a different economic twist. It's going to be about the billions that this country is wasting. That will come out in early December, and I'm sure you will all get a copy, probably laminated with pictures to make sure you all read it.

We have heard that many Canadians pay some of the highest prices in the world for prescription drugs, and these costs are predicted to increase further in the future as we pay for more complex drug therapies, an aging population, and expanding patent protection regimes.

We know that the provinces and territories, through the Council of the Federation, have moved to lower drug costs through bulk purchasing. We also know that there are limits to what they can accomplish compared to a national prescription drug program with scope and efficiency. Not properly controlling drug costs directly hits provincial and territorial budgets and leads to cuts in health care budgets as a knee-jerk reaction.

It is frustrating for the nurses of this country to see governments spending far more than necessary on prescription drugs and then choosing to cut health services, leaving patients with poorer health care and more vulnerability. Based on the evidence your committee has already heard, it seems that there is only one answer, and it is clear.

To your committee and all elected representatives, on behalf of the front-line nurses I represent, I say that now is the time for action. The evidence is strong and the evidence is clear. What we need, and the challenge that we have, is to muster the political will to take action. We need to be asking not if but how we can implement the structure of a national prescription drug program for Canada.

To do this we must include the best practices from around the world and design a system that will fit within our Canadian context. It certainly can be done, and anyone who says it can't be done doesn't know the history of our country in achieving solid public policies that benefit all Canadians.

Yesterday I met with Minister Philpott. One of her team members said, in a little snarky remark, “Well, Linda, you just want the New Zealand model.” My reply was simple: we need a Canadian model, a made-in-Canada model based on all the evidence from around the world. What we're doing now is inefficient and too costly and, honestly, not too smart.

To be clear, we need a reform of our health care that will meet the needs of all patients. It could save billions of dollars. These billions of dollars need to be reinvested into first nations health priorities, a safe senior strategy, and health human resources, mental health, long-term care, and home care, just to name a few.

● (0910)

The Liberals promised $3 billion in home care. Studies have said that a national pharmacare program would cost between $1 billion and $4 billion, with savings of between $7 billion and $11 billion. In my quick calculation, that's a pretty good rate of return, and that could pay for home care, mental health demands, and everything else we've been hearing about on health care.

Of course, implementing a national pharmacare program should be done with clear steps, and this is what we're hoping this committee will be able to give the federal government: clear steps to implement a national pharmacare program. It will require governments across the country and health care professionals to work together.

It will also look at the covered workplace benefits. Moving to pharmacare will limit the open formulary currently used by insurance companies. As a union leader and negotiator, I know that and I support it, but just as they've done in the past, insurance will adapt and offer different products. I am not worried about the insurance companies at all.

Private insurance will continue to have a part in our health care system in some form, but having 60% of drug coverage for Canadians managed by private interests at a very high cost and without universal coverage is not in our national interest. Let's remember that government exists to ensure the needs of citizens are protected, and corporations have long adapted to shifts in public policies.

Our members favour national pharmacare based on the evidence and on an evidence-based formulary, and it will not result in workers rebelling. This is fiction. Many unions, including mine, have passed many resolutions promoting a national pharmacare program, and we continue. It is time that we applied a health lens to all government policy, and the best place to start is with prescription drugs.

I was there when the provinces and territories struck their first deal, co-operating on bulk purchasing. This saved about $490 million annually, and it will increase, but this is peanuts. We have to remember that we're a very small country in population. We're the same size as the state of California, and we need to do more than bulk purchasing. We have to change the way we do things with our prescription drugs, period.

I was also there during the last negotiation of the health accord. We don't want the same repetition. We don't need another committee to study national pharmaceutical products. That was my message to Minister Philpott yesterday. We need actions and we need them now. The provinces and territories cannot wait for another study on what to do with the health accord or what to do with pharmacare.

Let me conclude on a personal note. Many years ago I was a young nurse activist stomping my little feet and making noise because health care had been cut in my own beautiful province of New Brunswick. Some of you might remember. We had Premier McKenna, a full house of Liberals, and no opposition at all. Premier McKenna said, “Linda, stop complaining. Find solutions. I have no more money.”

Premier Gallant, Premier Notley, Premier Wynne—I can name the 13 of them—are all saying the same thing now: “We have no more money for health care.” We have to find a solution. We know the solution is about stopping the waste of billions of dollars in over-inflated costs of inappropriately prescribed prescription drugs. We have to start now with a national pharmacare program, reinvesting in the health of our communities and finally doing our job—or your job, as MPs.

Finally, we have to talk about trade, and I only have 10 minutes, so I'm finishing it right there. You have to exclude health care and any new programs when you negotiate trade with any other countries around the world.

Thank you very much.

● (0915)

The Chair: Thank you for your very clear message.

I'm moving right along now to Dr. Doug Coyle, Professor and Interim Director at the University of Ottawa in Public Health and Preventive Medicine.

Dr. Coyle, you have 10 minutes.

Dr. Doug Coyle (Professor and Interim Director, University of Ottawa, School of Epidemiology, Public Health and Preventive Medicine, As an Individual): Thank you, and I'd like to add thanks to my fellow speakers.

My name is Dr. Doug Coyle. I am currently a Professor and Interim Director at the School of Eepidemiology at the University of Ottawa. I am a health economist and have worked in this research area for the past 26 years. As with Dr. Perry, I have no conflicts of interest to report.

I am a member of the Ontario Ministry of Health's committee to evaluate drugs, where I help make recommendations on the funding of new pharmaceuticals. I was previously a member of the Canadian expert drug advisory committee, which gives similar advice at the pan-Canadian level, and also the Ontario health technology advisory committee, which makes recommendations in the funding of new technologies to hospitals.

Thank you very much for giving me the opportunity to present my views today. At the University of Ottawa, I teach graduate students in the methods to appraise new technologies in terms of their costs and benefits, and whether or not they represent the best use of our scarce health care resources. I've conducted a number of studies in this area on drugs, devices, vaccinations, screening programs, and exercise programs.

I have a passionate belief in the necessity of a publicly funded health care system. This is based, first, on the fundamental belief that equality in access to health care should be a right, and second—and we should never forget this—that the nature of health care as a commodity is such that provision through a market-based system is inefficient.

I've been asked today to present my views regarding a national pharmacare strategy. Before proceeding with my views, I'd like to remind you that when I moved to Canada in 1995, the issue of a national pharmacare strategy was a hot topic, but little progress, if any, has been made in the 21 years since then.

The common drug review and the pan-Canadian oncology drug review have been established to help provincial ministries review the evidence related to the costs and benefits of newly available pharmaceuticals. However, though both agencies have a process whereby recommendations related to funding are made, they do not have the ability to make these reimbursement decisions.

Recently the pan-Canadian Pharmaceutical Alliance, or pCPA, was established across provinces to assist them in discussing with industry possible solutions to allow the coverage of new pharmaceuticals through agreements in price. The federal government has recently joined pCPA. I am going to talk about some of the issues related to that for the rest of my talk.

I believe that a fair, equitable, and transparent Canada-wide process for making the complex and difficult decisions with respect to reimbursement for health care interventions is a necessity to ensure the sustainability of our health care system. Although the developments that have taken place appear valuable, today I wish to highlight concerns with the current situation with respect to pharmaceutical funding.

These concerns relate to three fundamental principles by which a national pharmacare strategy needs to be organized: the need for fairness, the need for transparency, and the need for consistency in decision-making across all health care interventions.

Fairness should be at the heart of all decision-making with respect to health care. Thus, difficult decisions on what should and should not be covered need to be made through a process that recognizes the need to treat people equally. However, not all new technologies represent value for money. Despite industry claims, most, if not all, new technologies are unlikely to save money in the long term. The downstream costs that are averted through their adoption are not sufficient to cover the upstream costs of their purchase.

We need to assess whether prices given for new technology are justified, given their potential benefits. Ultimately, given that we work within a system with a constrained budget, the cost of providing one technology should not be measured in dollars and cents but in terms of the potential health benefits that can be realized by the funding of one technology rather than other technologies that we can no longer fund. For too long in Canada, reimbursement decisions with respect to pharmaceuticals have not recognized this basic tenet of decision-making.

With respect to the issue, there are clear problems with pCPA. Once negotiations begin with pCPA, it rarely fails to make an agreement with a company on a specific drug. We all know that if we walk in and tell a car dealer that we are going to make a deal, we won't get the best deal that's available to us.

Second, and more importantly for future decision-making, pCPA does not appear to have criteria by which it defines a bottom line in decision-making. For pCPA to be of any use in facilitating a national pharmacare strategy, it must develop a framework that allows identification of what is and what is not a good deal and be willing to walk away from the table when no reasonable deal is on offer.

● (0920)

Thankfully, there are research techniques that can assist in making such difficult decisions, and pCPA needs to adopt these.

I'd like to give you today the example of Soliris. Soliris, you've probably heard, is a drug for the treatment of a disease called paroxysmal nocturnal hemoglobinuria. Thankfully, we can call it PNH—I can't even pronounce those words—which makes it a lot easier for us to follow.

PNH is rare blood disorder. Soliris is effective. It reduces the incidence of thromboembolism, the major cause of mortality in this disease, and it reduces the need for blood transfusions, the major management cost of the disease.

However, Soliris costs $500,000 per patient per year. That's probably why you've heard of Soliris. An independent analysis conducted relating to Soliris found that it would be worth funding on the basis of equity, if a price reduction of 98.5% were achieved.

The funding of Soliris at its listed price would cost almost $25 million per annum, even if only 20% of those eligible to receive it would receive treatment. With that $25 million, we could provide many other health care services to Canadians that would provide much greater health benefits.

The pCPA did reach an agreement with the manufacturer of Soliris for the treatment of PNH. Given the necessary price reduction, it is highly unlikely that this agreement represents a fair and reasonable decision.

We should support innovation by ensuring that funding is given to those technologies that represent value for money, including those that are not commercially sponsored. By guaranteeing funding to new technologies, we are not helping industries. Industries that become too reliant on government subsidies and preferred supply arrangements stagnate and decline. This, I feel, is the current fate of the pharmaceutical industry.

If you were to proceed with a national pharmacare strategy, I would argue that we need to make transparency a fundamental principle. We need a much more transparent process in making decisions, as well as in transparency agreements between manufacturers and health care payers.

A major component of the pCPA is facilitating such agreements between ministries and manufacturers. These agreements are typically confidential, and thus no one can assess whether such agreements are in the best interests of Canadians. Openness encourages innovation and ensures fairness for all Canadians.

The final point I'd like to raise is the one I really want you to take home: the need for a more comprehensive approach to the funding of all health care interventions for all Canadians.

The focus today is on pharmaceuticals. This is in line with a typical focus on the funding of new technologies that have a commercial interest. This leads us to funding decisions that typically favour such technologies over alternative health care interventions, where profit is not a driving factor for those advocating for their coverage.

However, we need to consider all the technologies that are out there. Many existing technologies are underfunded, yet have evidence to support their effectiveness and cost-effectiveness. Many of these do not have commercial sponsors.

Given the changing demographics of our country and the increased long-term need for home care and long-term care, the continued focus on pharmaceutical coverage is, in many ways, missing the major potential problem facing our health and social care system. Care through hospices, home care services, and nursing homes suffer from a lack of commercial interest in promoting them and are often overlooked by those societies advocating for health care. There is a lack of funding for conducting research to highlight their benefits, and there is limited lobbying because of the lack of a commercial sponsor.

To summarize, I'd like to reiterate the following points.

For a publicly funded health care system to be sustainable, we must have decision-makers who are willing to make the difficult decisions not to fund specific new technologies. By failing to make such decisions in a consistent and fair manner, decision-makers are currently not doing their job. This is detrimental to Canadians as a whole. Fairness should be a key principle. Funding technologies that deny the availability of other technologies that provide more benefit is not fair. This is frequently the case with respect to funding for pharmaceuticals.

Transparency is key. The degree to which decisions on health care funding, especially for pharmaceuticals, are made behind closed doors through confidential agreements is scandalous and needs to be addressed.

● (0925)

Finally, although the focus today is on a national pharmacare strategy, I want to emphasize that sensible and rational decisions made on a consistent basis are required in the funding of all health care interventions, not just those with commercial interests promoting them. Thus a national health care strategy will be a longer-term benefit to Canadians and may ensure the sustainability of the health care system we all so passionately support.

I thank you all for your time.

The Chair: Thank you all for sharing your experience and knowledge with us. It's a big help to us in our study.

We're going to start our first round of questions now. They're seven-minute questions and answers, and we're going to start with Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you very much for your testimony. Just to show my colours, I'm a strong champion of the need for a national pharmacare program.

Linda and Janet, thank you very much for echoing and giving us additional testimony as to the need for that.

The focus of my questioning is more on construction, on how we would achieve it, and the optimal ways to make it work. My first question is more for Thomas and Doug.

It would appear from the advice we've been given that expanding the Canada Health Act to include out-of-hospital prescription drugs would be the most direct and easiest way to achieve that, versus establishing a brand new federal-provincial entity that would oversee a national plan. There would be an expansion of the Health Act. Do you have any comment on that and on how best to construct a plan?

Dr. Doug Coyle: I would probably fundamentally disagree with you. I'm sorry. I think we currently have a very bad approach to decision-making about funding of technologies at the provincial level. Allowing provinces or mandating provinces to provide pharmaceuticals on a wider basis to all Canadians as part of the Canada Health Act will in some way ensure what I think is inequitable coverage of individuals and will not address the fundamental issue, which is that we're prescribing too many expensive drugs that are unnecessary and that are causing a lack of health benefit to be accumulated by Canadians when there could have been more sensible and rational decision-making regarding what to fund and what not to fund across the whole health care system.

Dr. Thomas Perry: I think I agree with that. I don't purport to have expertise in this, but I was a provincial cabinet minister at one point in my life and I'm familiar with some of the difficulties.

I think the problem now is that the industry plays provinces off each other. I'm sure you're aware of that from your own health care background. If we're going to have a sufficiently efficient system through which we can also address the issues that Janet Yale raised, obviously when there's a very effective drug for someone with a devastating disease, all of us would like to see that drug being affordable for that person. The treatment with an effective drug may be more important than the visits to the doctor. In fact, undoubtedly they are, but the drug has to be affordable. Professor Coyle made this point nicely with the example of Soliris, which is an extreme one. I would strongly recommend that you review Kelly Crowe's report on CBC television. You should review it at least twice, because the report points out that the real cost of developing that drug was virtually nothing, possibly less than 1% of its present sales price.

● (0930)

Mr. John Oliver: Mr. Perry, the common drug review that CADTH operates was based largely on a British Columbia model. Do you have any thoughts? It's led us with very high drug costs. I think we are the secondest-highest jurisdiction. Do you have thoughts on how to improve this situation, and what works and what doesn't work in that model?

Dr. Thomas Perry: Thank you for the question.

Remember that pricing is partly under the control of the Patented Medicine Prices Review Board, which has been a pussycat throughout its history. To the best of my knowledge, it has never exerted any serious attempt to control drug prices in Canada.

CADTH, so far as I know, was modelled originally on our process in British Columbia; however, it repeated one of the mistakes the British Columbia government made in 1994-95, which was to guarantee secrecy to the pharmaceutical industry sponsors on the grounds of protecting commercial or trade secrets. A detailed report that I produced, for example, on donepezil—the brand name is Aricept—was never released to the public because the British Columbia ministry had agreed with Pfizer not to release it.

On the common drug review, I'd like to give you an example. I was invited to participate in the review of two drugs, but I'm not allowed to tell you which, so I'm not going to. However, the drugs reviewed were pregabalin—brand name Lyrica—for pain, and a form of fentanyl that can be taken under the tongue or in the mouth.

As a condition of that work I was paid $10,000, through a contract with UBC; I was obliged to sign a confidentiality agreement that I would not disclose anything I learned to anybody, including the people of Canada; and I was approved by UBC and its ethics committee, which is an outrage, I think. I'm very impressed that a meeting like this is available to all the people of Canada in both languages.

What I learned as part of that procedure that I'm not telling you is that pregabalin was less effective than an old drug, amitriptyline, for neuropathic pain, pain in the feet of people with diabetes, and barely better than a placebo. To its credit, the common drug review did not recommend that this drug be listed on provincial formularies. Who paid, however, for all of the work that went into that honest academic assessment of the drug? Why did the studies that the company did not publish remain secret? That's what needs to be fixed with the common drug review.

Mr. John Oliver: Okay. Thanks very much.

So then, Doug and Thomas, we have the Patented Medicine Prices Review Board and we have the pCPA. If we were to move, to one common priced-out formulary, to whom would you give ownership of that?

Dr. Doug Coyle: I would start again. The pCPA doesn't have the expertise to review the effectiveness and cost-effectiveness of therapies, and the PMPRB doesn't have that expertise either. I think we need to have a national body not unlike the NICE in the U.K., which has a comprehensive independent approach to the evaluation of new technologies—not just drugs—and allows an assessment of their value for money.

NICE has criteria. NICE looks at how much they spend on health care—

Mr. John Oliver: I'm sorry; what does NICE stand for?

Dr. Doug Coyle: It used to be the National Institute for Health and Clinical Excellence, but I'm pretty sure it has changed its name again.

Dr. Thomas Perry: It's the National Institute of Clinical Excellence.

Dr. Doug Coyle: That's what its old name was—that's why it was NICE—but it changes its name on a frequent basis. It has changed it again.

Mr. John Oliver: So you recommend that we look at that?

Dr. Doug Coyle: Yes, very much. What they actually have is a bottom line. They've looked at how they spend health care dollars—well, health care pounds—and they look at the benefits that obtained, and they work out how much they would lose by funding one technology over another. They've come up with what the value of a health technology should be, and technologies not funded unless they make that value.

That's my concern about pCPA: there is no bottom line. They go into a room thinking, “Any deal will do; let's hope we get 25% off this time. Maybe we'll get 30%, if we're lucky.” There's not actually a comprehensive approach that says, “If we fund this drug and it doesn't reach the threshold, it's going to be bad for Canadians.” That's the approach that NICE takes.

● (0935)

The Chair: The time is up.

Dr. Carrie, you have seven minutes.

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

I want to thank the witnesses for being here for this very important meeting. Before I start with my questions, though, I do want to ask for unanimous consent, Mr. Chair, for this motion that I have. As we're looking at the opioid crisis and we really did a lot of work on that interim report, I'd like to ask for unanimous consent for a motion that I think is extremely timely.

I move that pursuant to Standing Order 108(2), the committee call upon the Minister of Health to immediately appear as a witness to discuss the opioid summit and the next steps in dealing with this serious crisis.

I didn't put forth this motion before as we were dealing with that Alzheimer's bill, but I must first thank the committee members for working together on a report on this extremely serious crisis, the challenge being a timely one. I believe in the last 24 hours seven or eight Canadians have died of opioid overdose. Since the minister has just completed her summit, I think it would be a very timely opportunity now to get her to come here and give her testimony so we can actually add her very important testimony to our report. This is something that I think is not going to be going away. It is a crisis. Everybody recognizes it as that.

I want to thank the committee members who went on the unofficial tour of that clinic. It really hit me to talk to someone who is addicted to these opioids and to know that there is hope and help out there. I think the minister has great insight on that, since the summit has just been completed. Before we let this go too far, it would be great if we could have her come as soon as possible to committee so that we can complete our very important report.

Therefore, I'm asking for unanimous consent. I think it's pretty obvious.

The Chair: Go ahead, Mr. Ayoub.

[*Translation*]

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

With all due respect to my colleague and especially to the witnesses, and despite the important issue he is raising, I want to point out that we have spent a lot of time studying the opioid crisis. It does not seem appropriate to discuss it now and to ask for unanimous consent for a motion, while we have witnesses who are waiting for questions.

I strongly suggest that we get back to this later, specifically, so that we can really take the time we need to discuss the issue. I am feeling somewhat stymied as to how to continue our discussions. This seems like an important aspect that requires our study. However, I have a great deal of respect for the people who came here. I have questions for them and certain other colleagues surely have some as well. As we know, our time is limited and goes by quickly.

[*English*]

The Chair: Go ahead, Mr. Oliver.

Mr. John Oliver: I move that we suspend debate on this topic.

The Chair: We have to have a vote on the motion to suspend debate. There's no debate on that motion. The motion to suspend debate is votable right now, and there's no discussion.

(Motion agreed to)

The Chair: We're suspending that motion. I'm not saying it's going to go away, but right now it's—

Mr. Colin Carrie: It's extremely important, and I thought we could get unanimous consent quite quickly.

The Chair: I don't know how that will go, but I thought certainly the visit that we had to Dr. Ujjainwalla's facility was impressive.

We're going to resume your questioning.

Mr. Colin Carrie: Thank you very much.

My first question is to Doug. You brought up an extremely challenging ethical question.

Mr. Don Davies (Vancouver Kingsway, NDP): Mr. Chairman, I have a point of order.

I'm sorry. With great respect to Dr. Carrie, are you counting the time that was used in that point of order in terms of his questioning?

The Chair: Yes, that's his time.

Mr. Don Davies: Thanks.

Mr. Colin Carrie: Thank you very much.

You brought up an extremely important challenge and ethical dilemma when you're looking at a pan-Canadian pharmaceutical-type program. You mentioned value for money. Of course, you brought up Soliris, the big one in the room.

My question to you would be this. If Canada implements this type of program, however it lands, who would decide on which drugs are covered? It's an extremely difficult question, because if you're one of the patients who would really benefit from a drug that's out there and you'd really want to have access to that drug but you have a system that won't allow you access, how would you suggest to this committee that a program could get around that problem?

● (0940)

Dr. Doug Coyle: We do the same for technologies right across the health care system. We decide what's covered and what's not.

I have a chronic hip problem. My physiotherapy is not covered under the Ontario Health Insurance Plan. We've decided that's not something that is beneficial to cover. The only reason that we seem sensitive to pharmaceuticals is there's a pharmaceutical industry lobbying for the coverage of their products.

We need to make consistent decision-making. That is the job of decision-makers. If a product is not worthwhile—don't think about it in terms of dollars and cents, but think about it as funding this technology—you are denying someone else a health care intervention that will provide more benefit to them. If you cannot make those decisions as a decision-maker, you need to get a new job.

Mr. Colin Carrie: You brought up an example of physiotherapy. I don't think anybody around the room here would argue that physiotherapy is not a very scientifically evaluated form of therapy, but we've had decision-makers say that it's not covered in Ontario. I myself am a chiropractor, and chiropractors face the same issue.

Canadians have the option as well of buying private health insurance, so you may have private health insurance that would cover physiotherapy, chiropractic, vision, or audiology, these things that historically have not been covered, but for pharmaceuticals, some witnesses have suggested that we don't have that private insurance system. We just have one monopoly type of thing. If we do put something forward, would your recommendation be that Canadians should maintain the option of getting a private type of insurance?

Dr. Doug Coyle: I think that's not really part of the issue here today. I think the issue here today is how we are going to make decisions at a national level over what is covered through the publicly funded health care system. The decision about whether or not people have access to other health care through a private insurance is a separate decision.

We have to remember that the Canadian health care system is really a historical accident. We have coverage for physicians in hospitals mainly emanating from early decisions made in Saskatchewan about trying to ensure they have adequate availability of physicians. We have a health care system that has arrived just through accident, based on those events in the early 1920s.

To be honest, if you want to make a system that is sustainable, that is beneficial to all Canadians, we have to consider all health care interventions that are on the table as potential, valuable interventions to fund, and we should stop advocating just for those for which there's a commercial sponsor who's willing to make a profit from them.

Mr. Colin Carrie: I'm sorry; I may have misspoken. My question is whether Canadians should be allowed to buy private insurance for pharmaceuticals too, with the proper—

Dr. Doug Coyle: I think I answered that question.

The Chair: That's it. Your time is up. Thanks very much.

We have Mr. Davies for seven minutes.

Mr. Len Webber (Calgary Confederation, CPC): Excuse me. On a point of order, Mr. Chair, with regard to Dr. Carrie's time, it was brought up that you were going to take away some of his time for his motion. Does that include also the response that came from our Liberal counterparts? Is that included in his time allotment?

The Chair: That's a good question. It's all included in Dr. Carrie's time on that issue, and I gave him—

Mr. Len Webber: I find it rather unfair, to tell you the truth, that they went on, likely knowing that they were using up his time. I don't know, but I think he should have more time to ask his questions, as a lot of the time was taken up by—

The Chair: We're just following the rules, and we're taking up time now. I appreciate the point, but we're following the rules.

Mr. Len Webber: We're taking up time from whom right now, Mr. Chair?

The Chair: Actually, it's stopped.

Mr. Len Webber: Okay. It should have stopped here as well. That's my point.

The Chair: Okay.

Go ahead, Mr. Davies.

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

Thank you to all the witnesses for some very powerful and very trenchant testimony.

Ms. Silas and Mr. Naidoo, I want to start with you. In your view, should we develop a national pharmacare program? Do you believe it should be created as a separate stand-alone program managed collaboratively by the federal, provincial, and territorial governments, or, alternatively, should existing provincial and territorial public health insurance plans instead be expanded to cover out-of-hospital prescription drugs as a requirement under the Canada Health Act?

● (0945)

Ms. Linda Silas: I think you heard from Professor Perry that it has to be based on the evidence, the evidence, the evidence. It is clear that in our country, because of its size and population, that we need one system to work in collaboration with the federal government, the provinces, and the territories. Right now we have 13 little kingdoms or queendoms around the country deciding on which medication is going to be on a formulary. We need to bring that expertise into one house and save money, but we also have to push the expertise up to make sure that we have the best system in the world.

Mr. Don Davies: Would it be your suggestion that we create one national formulary, albeit with input from the provinces, territories, and independent experts?

Ms. Linda Silas: It is, and it's also to take it out of the hands of politicians.

I'll go further than Professor Coyle. In January we had a meeting with the provincial and territorial health ministers. They were all there. The most support we got was when we said we needed an independent committee to accept what was on the formulary.

Take it out of the hands of the politicians. Regardless of their education status, they don't want it to be a political or a commercial decision. It has to be based on the evidence, and we have to make sure it's the experts. It's not the Linda Silases of the world or the Minister Philpotts of the world; it's the experts.

Mr. Anil Naidoo (Government Relations Officer, Canadian Federation of Nurses Unions): There's also one aspect of this that goes even further and is even more damaging. We have benefits managers in corporations who are asking, "Why am I managing drug programs?" Part of the absurdity of the system we have right now is that a large chunk of it is managed by corporations that have no expertise, and we're price-takers, and beyond that even, it's whatever drug is approved that gets onto the formularies. These are open formularies. They are very damaging financially and also as health benefits.

Mr. Don Davies: I have one other question to you, Ms. Silas. You mentioned the need to develop a Canadian model based on best practices. You pointed out in your brief that Canada is the only country in the world with a national hospital and physician care system that does not have some form of pharmacare, so we're not reinventing the wheel here.

What specific practices do you think should underpin a Canadian model?

Ms. Linda Silas: It should be universal for sure, and then it should be based on the evidence. I think if we stick with those two, we will save the money we need to get reinvested in our health care system.

Universality is what our health care system is. Dr. Carrie talked about physiotherapists or chiropractors; those will still exist. We will still have an insurance company system out there in our health care system, but the base of what we need to get better has to be covered under a universal program, and that's where prescription drugs should be.

Mr. Anil Naidoo: I would just add—

Mr. Don Davies: I'm sorry, Mr. Naidoo. I have a couple of other questions. I only have seven minutes.

Dr. Perry, I need to ask you a question. In fact all witnesses, but you in particular, have highlighted the critical need for independent evidence-based pharmaceutical prescribing and formulary development. If we created a national universal pharmacare system with a national formulary, what specific suggestions would you give us to create that? How do we create that national formulary with independence?

Dr. Thomas Perry: We've learned a lot in British Columbia about the value of independence, and we learned that someone who has no stake, who has no conflicts, and is not allowed to hold conflicts will inevitably make a different judgment over the facts than someone who has been compromised.

The Americans have learned this. The National Academy of Medicine recommended five years ago that guidelines we can trust be developed by people who are not allowed to have conflicts of interest.

Professor Gord Guyatt at McMaster University, an internationally famous Canadian scientist, has been emphasizing the need to revise any Canadian medical guidelines under the same principles so that you have to say to a cardiologist, "You're a wonderful doctor and we know you have a lot of clinical experience, but because you have been a key opinion leader for a pharmaceutical company, you're not going to be allowed on the guideline committee."

I think Dr. David Juurlink probably explained—he certainly did at the opioid summit—that with an opioid guideline now, people with any possible conflict of interest are being excluded from the guideline. It's somewhat like the best of our court system. It's the only possible way to make the best judgment.

I think the other important answer is we need more evidence. For example, someone amongst us oldsters in this room almost certainly has atrial fibrillation, and if there isn't anyone here yet, there will be one of us within the next five or 10 years. When that happens, we don't know what the best anticoagulant treatment is. There are now five possible oral drug choices in Canada. No one can possibly tell you what the best treatment is—no cardiologist, no matter how expert—and the opinion of the Canadian Cardiovascular Society is that we won't ever know because no one will ever do an experiment to find out.

No, of course, they won't. The drug companies who make product A will not run it against products B and C in an honest trial to find out, but if we wanted to know as Canadians—I am likely to face this, given my family background—what the best treatment is, we need a publicly funded trial on the model of the U.S. veterans administration or the U.S. National Institutes of Health or the British Medical Research Council. Even in Canada we used to have some Medical Research Council trials in the old days. We could find that out, and that would be a critical element of the evidence-gathering for a rational program.

● (0950)

Mr. Don Davies: Dr. Perry, I want to quickly get a question in on transparency and sunshine laws, because you seem to be highlighting this.

Do you have any suggestions? Maybe you and Dr. Coyle as well could tell us how we can shed more light on this.

Dr. Thomas Perry: Yes. Thank you for the question.

We have a desperate need. I was showing one of my medical students an obviously conflicted opinion on opioids from the *Mayo Clinic Proceedings* journal in 2009, which sounds like a very prestigious journal. It's an article obviously ghostwritten, not written by the professor whose name was on it but written by a medical communications company and paid for by one of the opioid manufacturers. I asked my fourth-year medical student two weeks ago to try to find out how much this man was paid. Within minutes he was back to me by email saying it was $500,000 U.S. during 2015.

The U.S. has cms.gov, the Centers for Medicare & Medicaid Services' sunshine law. We have no ability to know anything in Canada—that is, anything about payments to physicians or to other health care providers, maybe nurses or social workers. With one stroke, if the Parliament of Canada passed a sunshine law, we would suddenly know who the key opinion leaders are and how much they have been paid to give the kind of messages that led, in large part, to the opioid crisis.

The Chair: As fascinating as this is, your time is up.

Go ahead, Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub: Thank you, Mr. Chair.

I thank all of the witnesses for being here with us today.

We are going to continue the discussion. My questions are about conflicts of interest.

This seems interesting to me, because the notion of conflicts of interest was present in this regard a few years ago and could continue to be present in the future, but with different parameters, points of view and ways of evaluating these aspects.

I paid close attention to Ms. Silas' testimony concerning the independence of the decisions of a committee or an independent group, in connection with their accountability.

In my opinion, that committee needs to be completely independent, free to act and to make choices. However, the fact remains that there are choices to be made and that a government is always ultimately accountable, either at the provincial or federal level. Governments provide the funding.

Regarding conflicts of interest and accountability, how do you see the relationship between those two concepts? Ms. Silas could answer first, and then I will give the floor to Dr. Coyle and Dr. Perry.

Ms. Linda Silas: Thank you for the question.

When we talk about conclusive evidence, we are talking about all of the evidence. It is not just a matter of the medical impact the medicines can have, but also their cost.

As politicians, when recommendations are submitted to you, as is being done today, you try to find a balance. Firm recommendations will be made. Of course, the cost aspect must also be included in any decisions.

However, the conflict of interest issue must be of prime importance in how the evidence is collected for those who will ultimately make the decisions.

● (0955)

Mr. Ramez Ayoub: I believe I understood that you want us to exclude the political aspect from our decision making.

Ms. Linda Silas: Yes, and that is what the majority of Health ministers would like to see happen. Currently, neither the medical evidence nor the evidence related to costs is preeminent. Political lobbying seems to have precedence, and I acknowledge that reality. I also do lobbying, but in favour of a general system.

As for politicians who must determine what is most effective, only scientific medical proof and the cost aspect should be considered. In this way, politicians would be in a position to make a decision.

Mr. Ramez Ayoub: Thank you.

[*English*]

Dr. Doug Coyle: Thank you very much for your question.

I'll answer in English, because French with a Scottish accent is an experience you don't want to hear.

I think the idea of independence is crucial, but transparency is equally crucial. We need a system put in place that the policy-makers and politicians have agreed on, that represents Canadian values, that is transparent, and that represents what's best for society in general. Then you leave independent people to make the individual decisions about what interventions are covered and what are not covered. You appoint another body, an overseer body, to make sure the independent body is adhering to the principles that Parliament or decision-makers have agreed to. That works well. It creates a system that the legislative decision-makers have bought into and have created.

You find the experts who have no conflict of interest to take part in that. Don't believe the argument from the pharmaceutical industry that those who have pharmaceutical money are therefore obviously the experts. The pharmaceutical industry creates experts and creates key opinion leaders. There's a great German saying, “Whose bread I eat, their song I sing.” That is very common across the physician world these days. We need to keep independence, but transparency is the key.

At the end of the day, it comes up to the decision-makers to develop the process that represents Canadian values and then let those independent people run with it.

[*Translation*]

Mr. Ramez Ayoub: Thank you.

I am going to continue on the issue of ethics and conflicts of interest, but more specifically as concerns professional ethics.

The topic is not new. We have already heard physicians and pharmacists tell us that pharmaceutical companies exert daily pressure on them. I would even add that some of them are given training by these companies. It is a fact where surgeons are concerned, and we have examples. Some pharmacists are solicited regularly to promote certain medications, or asked to offer replacement medications rather than filling physicians' prescriptions.

It's useful to have a committee that recommends a list of available medications that may be reimbursed by insurance companies, but afterwards you have to make sure you choose the right medications among thousands of possible options, while being subjected to influence and pressure by the pharmaceutical industry.

How do you see this situation?

[*English*]

Dr. Doug Coyle: That's an excellent question. As I said, I sit on the Ontario Committee to Evaluate Drugs and make funding recommendations. We're supposed to have the leverage to ask for physician education as part of our decisions. There is no funding available for independent physician education relating to pharmaceuticals.

We can make a decision to fund a drug that might cost an extra $8 million or $10 million a year to the Ontario public drug plan. It would not take a fraction of that to be able to put out some documentation to do some insight in terms of training of physicians to know what the implications of these new drugs are.

If we're to go ahead with a national pharmacare strategy, the decision has to be that physician education is a key component to that as we allow new pharmaceuticals to go into the formulary.

The Chair: Dr. Perry wants to make a comment.

[*Translation*]

Dr. Thomas Perry: I appreciate the question, but it might be better if I answered in English.

[*English*]

I'm a recovering politician, as Mike Harcourt would say, so I've been on both sides of this issue, and I'm proud to be a good specialist physician. Doctors are trained and socialized, as nurses will know only too well, to think that we are special and we are better human beings than other people. Nurses have an element of that as well. It's very difficult for us as a species to come up with the idea that we might be bought or conflicted or influenced by conflict.

A voice: All around.

Mr. Thomas Perry: It's all around, yes, and having been an elected person and dealing with the first very strict conflict-of-interest law in British Columbia, which arose because of obvious corruption, I got used to it. When I came back to the university, I realized that my former colleagues aren't used to the idea of declaring conflicts.

Here's a recent issue of the Canadian Medical Association Journal. With the permission of the committee, I'd happily pass it around. It is partly in French. I brought this along to read on the airplane. The lead article is about the increasing crazy prevalence of diabetes among indigenous people, but I realized that on the cover it says “Happy Januversary”, which is an advertisement for brand name Januvia, or sitagliptin, a drug promoted for the treatment of diabetes.

I'm going to be not overly specific, but someone in a very prominent position of power over me in my university has been sending out surveys about the coverage of this drug in British Columbia on Merck stationery. Is that appropriate for a doctor who is in a prominent position in a university? His predecessor with the university years ago sent out similar surveys on Merck stationery for cholesterol-lowering drugs.

This is a description of.... It's not a bad person. This is an excellent physician, but I'm saying it's an example of how pervasive the failure to recognize conflict is, and the only solution around that is really absolute independence and government, whether it be federal, provincial or territorial, insisting that we can't allow that, any more than you would allow it in Parliament here.

● (1000)

The Chair: The time is up, Mr. Perry.

What's the name of that journal?

Dr. Thomas Perry: This is the Canadian Medical Association Journal for November 1, 2016. I'm happy to circulate it, but I'd love to have it back because I still haven't read the article.

The Chair: You can't do it officially.

Dr. Thomas Perry: Can I do it unofficially?

The Chair: That's up to you.

All right. Our second round is five minutes, and we're going to start with Mr. Webber.

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

I'm going to focus a number of my questions on Linda Silas, if you don't mind.

I understand that you represent 200,000 nurses. Five of them are in the family that I married into, and all I can say is that Christmas dinners aren't very happy, because four of them are Liberal and one is an NDP. Anyway, I do get my turkey, so I'm happy.

A voice: Cold turkey and hot—

Mr. Len Webber: Cold turkey, yes.

First of all, I wanted to question you on this research material that is going to be published that you are going to give to us, laminated, in December. I can't wait until December, Ms. Silas. I need to know now if anywhere in this report there is any information on what a national pharmacare program would cost Canadians.

You talked about the wasted billions. What about how much it's going to cost for a national pharmacare program here in Canada? Has the nurses union done any research on that?

Ms. Linda Silas: The nurses union hasn't done any that. We have focused on the waste. However, the CMAJ did research just two years ago on the cost, and that's where it was between $1 billion and $4 billion. There will be more, and we'll focus there.

To keep your nurses happy, I'll make sure that you get a little bag of nurses union swag for Christmas.

Mr. Len Webber: Fantastic. I don't have to go shopping now. Thank you.

Mr. Davies alluded to this. He asked you if there should be one national formulary in this country, and you agreed. In fact, I did some research. I have people to do my research for me, nurses in particular, and I understand that the BC Nurses' Union opted out of the B.C. public drug formulary after initially opting in.

Do you have any comment on how unions in general, and nurses unions specifically, would respond to a national pharmacare program, including accepting a national formulary that is more restrictive than their members' access under existing private insurance coverage?

● (1005)

Ms. Linda Silas: I started this job 13 years ago, and I have to say that negotiators then weren't as much in favour of a national formulary as they are today. With health and dental, if I look at all benefits, it's about 6% of payroll.

When we look at it as negotiators, that 6% that goes towards providing health and dental and other allied services could be put somewhere else. As I said in my introductory comments, we will negotiate whatever plans. My personal plan is very poor compared to others in what I can get for chiropractic and physio. It's limited to $500 a year, compared to others that have $2,000. You negotiate what you have.

BCNU's came about with negotiations, and they changed their negotiations. They decided that instead of a wage increase, they'd put their money toward a better plan. That's their decision, as well as other unions. If I look at Unifor, the largest private sector union in this country, they associate a national pharmacare savings of $1 to $2 per hour for workers, if we would have it, because medicare is about $5 to $6 per hour.

Mr. Len Webber: Interesting.

I want to get into a bit of the jurisdictional issues across the province here. I understand that through the provincial nurses' unions, you have a lot of contact with the different provinces and territories and the governments there.

From your experience, where do you understand that provincial and territories governments are with regard to pharmacare?

Ms. Linda Silas: They need help. There's not one province, one territory, that doesn't need help in health care. They're as frustrated as we are when they see that they have to handle this on their own. When 40% of your provincial budget is health care and more than 30% of that health care budget goes towards prescription drugs, there's a problem.

Two years ago, we were paying more for prescription drugs than we were paying for doctors in this country. That's a problem. They need help, but they know they can't do it by themselves. They need federal leadership on this, and we're hoping that the to-do list of next steps will be done by this committee.

The Chair: Dr. Eyolfson, you have five minutes.

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

Thank you to everyone for coming.

Dr. Perry, I loved your description of yourself as a recovering politician. I've been referring to myself as a "recovering ER doc". It was my experience, the things that we couldn't help in the department, that pretty much got me thinking of doing this.

Like Ms. Silas, I am acutely aware of the effects of what happens when people can't afford their medications. Most of my career was in an inner-city hospital, with lots of poverty. People were coming in life-threateningly ill because they couldn't afford their insulin. Some were ending up on dialysis because they chronically couldn't afford their insulin. It was these sorts of things.

I know there is a good opportunity for improved outcomes and increased health care savings. We talk a lot about savings to the health care system. Someone pointed out that we shouldn't be talking about how much we save but about how it's the right thing to do. I am the first to agree with that. However, we do have a publicly funded system that has only so much money. We have to make a case that it is cost-effective, and from the testimony I heard today, it sounds as though it is, in fact. It sounds like the savings to the health care system would to a great extent offset the cost of putting this in.

I just wanted to confirm what you said, Ms. Yale, about how patients should have the choice of what works best. On the choice of medication, would you agree that if it's a more expensive medication, there should be evidence that this more expensive drug is more effective, has fewer or comparable side effects, and there should be good scientific evidence to support that?

Ms. Janet Yale: Absolutely. A lot of the comments that have been made have been about how you create that evidence base through an independent assessment as to which ones are more effective than others. My point was simply that some of the new biologic therapies are not perfect substitutes for each other. They're biologic formulations. The issue is that what works for one person may not work for another. Even when someone gets on an effective treatment regime, it may stop working for them after a number of years, so the issue isn't that they're perfect substitutes, in which case you could do, as you say, that evidence-based assessment. The question then becomes how we ensure, through that evidence base, that we understand the indications for which some drugs are appropriate, rather than simply listing one drug in a class. That was my fundamental point. Absolutely, it should be evidence-based in all cases.

What's making it more complicated now is that as with chemical compounds, we came up with generic substitutes. With biologic formulations, what are called "biosimilars" are coming to market, which are generally speaking much less expensive than the originator drug. For Remicade, which has been in existence for some time, there's a new drug called Inflectra that has now come to market. The big questions are, one, does the less expensive drug become the drug of choice when prescribing for new patients, and two, do people who are on a good treatment regime with the originator drug get forced to switch?

In the absence of evidence, and to your point, our position is that people shouldn't be forced to switch, but we do need better evidence as to the relative efficacy of these alternative treatment regimes.

I hope that's helpful.

● (1010)

Mr. Doug Eyolfson: Thank you. Yes.

This is borderline off topic, Dr. Coyle, but I appreciated your comment about medical technology in general. In my obstetrical training I've known what most obstetricians would agree with me on today—namely, that routine ultrasounds in pregnancy have never been shown to make any difference in outcomes in pregnancy.

People think about that. I get raised eyebrows. I sometimes get people angry when I say that, but in fact they've never been shown to improve outcomes in pregnancy. We have to make a case in terms of the evidence. Think of the potential money saved to the health care system if we stopped doing something that isn't helping. I think we need to consider that with all our drugs, with all our more expensive drugs.

Dr. Perry and Dr. Coyle, I don't know if you're aware, but there is some evidence coming up on the medication class that seems to be the number one money-maker for industry right now, and that is statins. There appears to be some evidence that this entire class of drugs may not in fact improve outcomes.

The Chair: He just needs a short answer.

Mr. Doug Eyolfson: Yes, I just need a short answer.

Do you think we should start reviewing the evidence on these medications that are taking up a huge part of our spending?

Dr. Thomas Perry: Well, it's a good example of an area where conflict of interest gets in the way of a real understanding and science. Our academic group still feels that statins in secondary prevention for people who already have had heart disease or stroke probably have—

Mr. Doug Eyolfson: Absolutely, yes. I was talking about primary prevention. That was my mistake.

Dr. Thomas Perry: In primary prevention, for someone like me, for example, who has relatively high cholesterol but is otherwise fit, we think that the overall harms may well exceed the benefits.

There's no question. I'm sure you've seen this as well, as has Dr. Carrie, probably. Anyone who has been in clinical practice with their eyes open, including the nurses here, will know that statins frequently cause very severe muscle damage, weakness, and pain.

The official experts, even in Britain at Oxford University, still insist this is exceptionally rare. They're completely out to lunch on that. The reason they are out to lunch turns out to be the way they define muscle disease, or myopathy, with a crazy elevation of the CK. If you or I have statin myopathy but don't have a CK at least 10 times the upper limit of normal, according to them we don't have anything wrong with our muscles, even if I can't walk back to my hotel today.

Mr. Doug Eyolfson: Thank you very much.

The Chair: Thank you.

Ms. Harder, you have five minutes.

Ms. Rachael Harder (Lethbridge, CPC): My first question here goes to Ms. Silas. You said that right now we are paying more for pharmaceuticals than for doctors. Wouldn't that just be exacerbated with a national pharmacare program? Wouldn't we be paying even more for pharmaceuticals than we are for doctors?

● (1015)

Ms. Linda Silas: The CIHI report of two years ago said that we were paying more for prescription drugs than for doctors. Now, the cost of physicians is a little bit more, but we're still talking about 30% and 32%.

No, we wouldn't be paying more for pharmaceuticals than for doctors, because we would base our national pharmacare program on efficiency, science-based evidence, and prescription habits. That, plus the bulk buying, is how we would reduce costs. You would have more than one prong here, and it would reduce your costs.

The goal is to have efficient prescribing habits, cover all Canadians, and reduce the costs. To do that, you have to have more than one prong.

As I mentioned in my notes, the costs in the last 20 years have gone up from $5 billion to $25 billion in drugs.

Ms. Rachael Harder: In your estimation, would you say that a national pharmacare program would give patients a greater choice in drugs? Would it make more available to patients?

Ms. Linda Silas: As Ms. Yale said, the patients have to be at the centre, but they have to be given the right choice. It would still be based on what your physician or nurse practitioner prescribes and advises you to take. It would be based on the formulary if you want it to be universally accessible under. You may not need a one-a-day pill, but if you can afford a one-a-day pill, go ahead and get your one-a-day pill. What we actually need is the specific medication to get better, and that should be covered. That is not a choice.

I agree with Dr. Perry that if my cholesterol is a little bit high and I don't want to take medication for it, that is my choice. It depends what your definition of choice is.

Ms. Rachael Harder: My other question is for you as well, Ms. Silas. No one at the table has been able to give a clear answer, and you haven't been asked yet, so I'm hoping that maybe you can bring some clarification. How do we work with all the provinces and territories to bring about a national pharmacare program?

Actually, I'll ask my preceding question before that. Is Quebec included under the body that you represent?

Ms. Linda Silas: No. We work with them. It's like any other national agreement. There's a little *astérisque* excluding Quebec.

I did say at a conference where Quebec was very well represented that we believe, because the numbers are clear, that Quebec would have to be included. They do not have a perfect system for covering medication in Quebec. Neither does British Columbia. The costs are skyrocketing. They will have to have a place at the table. It's called negotiation. If we can't negotiate among 13 or 14 parties, including the federal government, we're in big caca here.

Ms. Rachael Harder: In your estimation, what is the best way to go about doing that? There is sovereignty that has been granted to provinces, and they do have jurisdictional powers, so it seems wrong for us to just run roughshod over that. We do have to be respectful.

In your estimation, how do you go about forming a positive relationship when implementing a national pharmacare program?

Ms. Linda Silas: Let's look at the Canada Health Act. We have one Canada Health Act for the 13 provinces and territories and the federal government, so all are there. What the provinces and territories have is the delivery of care. That is very specific. There's not one federal health minister that I've met over the years that wants to get their hands into the delivery of care.

For how it's funded and how the major programs are covered, look at all the discussions we're having on mental health now. Everyone agrees we have to do something about mental health. We will have to do something on mental health together. Everyone agrees that we have to do something about indigenous health. We will have to do something on it together. Quebec is included in that.

Ms. Rachael Harder: Okay. Thank you very much, Ms. Silas.

The Chair: Dr. Perry, you're champing at the bit there to make a comment.

Dr. Thomas Perry: I just thought they're such important questions that Ms. Harder and her colleagues were asking. I think the real goal in the interests of the people of Canada is that a national program provides better outcomes, with adequate and possibly better choices in some environments, and it saves money.

Sometimes too much choice is a bad thing. I don't know if you've ever tried to buy a sofa, but my wife and I have been trying to buy a little one for several years. We go to try them out and we can never make up our minds. When I was a medical student in Mr. Tootoo's riding, there was one shirt in the Hudson's Bay store in Pond Inlet, so I bought it, and a jean jacket as well. It was a great blessing to have only one choice.

That's an extreme counter-example, but to Ms. Silas's point about mental health, you could look at the number of antidepressants licensed in Canada. If you want to see an example of how Health Canada fails us, look at the summary basis of decision for licensing a drug called vortioxetine, which is the newest antidepressant in Canada. If you look a little further, you can see that Health Canada licenced it because in one experiment it was better than a placebo, even though in all the other experiments it wasn't better than a placebo, and it was worse when compared against other depressants. Nobody really needs that choice, and certainly we should not be paying for it out of public funds. If somebody wants to pay out of their own pocket, it's legal, but as a taxpayer, I'm a very fiscally conservative NDPer. It may surprise you, but I don't want to be wasting my money as a taxpayer. I want to be using it on patients like the one Ms. Yale referred to, who really needs a treatment that has saved his life.

● (1020)

Mr. Anil Naidoo: There's just one thing I would say to Ms. Harder. The provinces have actually asked for an intervention on pharmacare. They've asked for the federal government to be involved in this, if you go back to the last negotiations in 2004. The represents them, trying to coordinate without federal leadership. It's not something that's being imposed on them.

The Chair: Thanks very much. Those are interesting comments.

Ms. Sidhu is next.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Chair. Thank you to all the witnesses for the valuable information.

We have all heard that 20% of Canadians cannot fill their prescriptions. As a diabetes educator, I saw the impact of past untreated diabetes, which leads to serious complications.

My question is for Mrs. Yale. There are 4.6 million Canadians living with arthritis. You mentioned in your testimony a lower cost and a wider choice. As well, can you expand more on your view about rare drugs, or orphan drugs for rare diseases?

Ms. Janet Yale: Sure. Thank you for that question.

The interesting thing in arthritis is that of the 4.6 million Canadians with arthritis, about one million have inflammatory arthritis, for whom the biologic therapies I was referring to are relevant. Most Canadians have osteoarthritis, which is the progressive deterioration of the joints, for which right now the only treatment is a joint replacement, other than pain management and, as you were pointing out, non-pharmacological options. We shouldn't ever lose sight of the need for non-medicine options, whether it's physiotherapy, exercise, diet, nutrition, and so on, to prevent the progression of disease.

Generally speaking, people with arthritis are not necessarily well served by the medications that are available today, and yet there are huge numbers of people.... We're not talking about orphan diseases with small populations who need very expensive designer drugs, but about millions of Canadians who have progressive osteoarthritis and wait in the queue for years until their disease progresses to a point where a joint replacement may or may not be appropriate. We think there's a lot more need for more new treatments than exist today to alleviate their disease and their pain without having to go through surgeries—which in turn cost the health care system money—because we have no other treatment to prevent disease progression.

As far as orphan diseases are concerned, it wouldn't be my expertise to comment on whether or not we make those drugs available or on what basis we might provide catastrophic drug treatments for orphan diseases.

I'm sure you would, Doug.

Dr. Doug Coyle: Yes. I've done quite a lot of work in the area of drugs for rare disease and I'd recommend, if you get a chance, to go on a website called Million Dollar Meds that I've been working on with colleagues at UBC.

It's interesting that rarity comes up as a factor in discussions like this all the time. We have done surveys of Canadians and surveys have been done worldwide about what people value and what they would expect to place at a premium. It comes back time and time again that people want the health care dollars to be spent on maximizing overall outcomes for all Canadians and that rarity is not a factor that people think deserves a premium.

The reason we keep coming back to rarity is that rarity is the area now where pharmaceutical manufacturers are making their profits. That's why rarity has become a big issue in the last few years. If you look at the actual values and preferences of society, people do not think that rare diseases should be treated as a special case over and above the overall health outcomes for all Canadians.

● (1025)

Ms. Sonia Sidhu: Thank you.

Dr. Coyle, what additional steps could be taken to support prescribers in reducing the potential for prescription drug abuse among their patients?

Dr. Doug Coyle: I think that might be a better question for Dr. Perry than for me.

Ms. Sonia Sidhu: Dr. Perry or anyone can answer.

Dr. Thomas Perry: It's a very good question.

I think part of the answer goes back to remarks I read in a transcript of an earlier hearing, I think by Dr. Eyolfson, that the level of education about drugs of Canadian medical students and doctors has declined drastically in the last 20 or 30 years. Dr. Anne Holbrook also made this point to your committee. I was very glad to see that, because it's something that those of us in clinical pharmacology—my training is similar to Dr. Holbrook's or Dr. Juurlink's—have been lamenting for years. We've been absolutely impotent to change the trend of curriculum change. I do not think this is a conspiracy of the pharmaceutical industry. I think we did the damage to ourselves in the medical schools.

Before coming here, I asked some of my current fourth-year medical students if they had anything to say to the committee. Their advice was that they need much better education about the use of drugs, that they need it back in the curriculum, and that they need non-conflicted teachers. We cannot have our teachers decline to show their conflicts and clearly giving a sales pitch for a drug company, like the ad that I passed around. This should be elementary in any modern university in 2016, but it is not yet, for reasons that I alluded to earlier.

I had the opportunity to make that point directly, face to face, as close as I am to Ms. Silas, with the dean of our medical school 10 years ago, and I think he thought I was out of my mind, nuts. Please, I'm not. Talk to the students or come to some of the lectures. Just as drug therapy has become much more complicated, as Ms. Yale has referred to, knowledge has gone down. This is something that will require enormous efforts to undo, and it requires public education too.

Another step that would help it is if Health Canada were more transparent and the common drug reviews were more transparent and better promoted so that an intelligent layperson, such as you, not trained in medicine, could read for yourself and draw your own conclusions. There's no reason an intelligent, reasonably educated person with a high school degree in this country should not be able to understand whether a drug really benefits someone or not.

The Chair: Thanks very much.

You have three minutes, Mr. Davies.

Mr. Don Davies: Thank you.

We started off with a motion to discuss national pharmacare. I think what we're finding out is the ugly underbelly of the current system in Canada. Something that's come up that we're hearing is that a lot of public money is currently spent on drugs that are dispensed but never used, perhaps drugs that should never have been dispensed at all. There seems to be waste in the system. I'm wondering if anybody has any suggestions on how we can tighten that up.

I'm not saying I believe in this, but what about the concept of having some form of patient copayment for drugs, to give them a bit of skin in the game? Is that a good idea, a bad idea?

Dr. Doug Coyle: I think we have to be really clear. There are a large number of Canadians who live in a fairly poverty-stricken environment. Any type of copayment really affects their ability to access health care. I think the fact that we now charge people to take an ambulance to emergency is scandalous. The idea that you have someone debating about whether or not they call when some loved one is in crisis because they're going to be charged a hundred bucks to get a ride to a hospital is just dreadful. The idea that we have a comprehensive health care system in Canada is just not true. I can understand the idea of copayments, the idea of trying to discourage waste, but I think we have to come up with more sensible ways of dealing with that. Maybe it's shorter prescription periods for the first prescription to see if the patient is going to be compliant, and then carry on.

I fundamentally don't like the idea of copayments.

● (1030)

Mr. Don Davies: Ms. Yale, would you comment?

Ms. Janet Yale: I have to agree wholeheartedly.

I think, as you've heard, that many of the issues relate to education on the part of the prescribing physician. I think the stories we hear are much more about people doing without other things in order to be able to afford their medicines.

I don't think people want to overmedicate; I think people, particularly those with chronic disease, want to be able to live pain-free. With the current preoccupation with the opioid crisis and fentanyl, which is absolutely legitimate, the concern we would have is that undiagnosed and untreated chronic pain is under-treated because people fear getting onto pharmacological therapies that risk addiction. I think most people are very averse to that, and I think that copayment is not the answer.

Mr. Anil Naidoo: Copayment has been tried in Canada with medicare before—in Manitoba, I think in the seventies—and it just changed the nature of who was actually accessing the system. Poor people used it less, and wealthy people used it more. The system still was used cumulatively.

Dr. Thomas Perry: I don't have an ideological view on this, but I'll give you a specific example of what the problem has been with one drug.

Gabapentin is a drug brand-named Neurontin that was promoted for chronic “neuropathic pain”. It became a $3-billion-a-year blockbuster in the U.S. in about 2000 to 2004. Pfizer was successfully sued and convicted of racketeering fraud in United States federal court for its promotion, because there was virtually no evidence that it was effective and lots of evidence that it was not.

They were able to hide that by recruiting key opinion leaders in medicine who gave the message that you need to start with a small amount and then gradually increase the dose and keep taking more and more and for a long time, none of which was true. There was no clear dose response; the drug generally did not work at all. One could tell within hours, and certainly within a day or two, whether it was going to work or not for your own pain, and yet they managed to make a $3-billion-a-year empire out of that drug.

The legacy of that is that, as Dr. Eyolfson will undoubtedly be able to confirm for you, is that people feel they need to take gabapentin for a year or two years. As a doctor, you ask, “Why do you keep paying for this even out of your own pocket?”—or for Lyrica, which is not covered in most provinces—and the reply is, “Well, the doctor told me to keep taking it and it would work eventually.”

It sounds ludicrous, and yet as an experienced physician I could weep enough tears to fill this room over the times I've seen that situation and seen an individual's money, which could have been used for a better purpose, wasted, or public money wasted.

Mr. Don Davies: Mr. Naidoo, I want to finish by giving you the last word. You've been sitting here throughout listening, as Mr. Chair said, to all the testimony. I want to give you the last word.

What is the most important thing that you want to say to this committee about national pharmacare?

Mr. Anil Naidoo: I think the work of this committee is historic. I hope you recognize that what you produce will be something that provides the foundation for what we do in the future, because there has not been, I don't believe, as in-depth a study as is possible.

Now, whether you're able to produce that report.... I look at the people around the table and I'm hoping that you will.

I'm saddened that you weren't able to travel to ask the question, “What kind of system can we use?” The one benefit of being last in this, and Canada is the outlier, is that an abundance of countries have implemented different types of systems, and we have massive amounts of opportunity to do the right thing here in Canada. It just requires political will.

We met with the health minister yesterday and we have met with other politicians, and I'm not sure there is that political will. I think it has to start in this room, in a way. A cogent report will provide the foundation for the future, but our window is very short. With trade agreements that restrict us, with increasing costs, with a fragmented system, with all the entrenched interests, it is going to be difficult, but we are looking to you to provide some clarity.

● (1035)

[*Translation*]

Dr. Thomas Perry: I invite you to come to British Columbia. You are always welcome there.

[*English*]

The Chair: Thank you very much. I certainly want to thank the witnesses. At every meeting we have, we walk in and we don't know what we're going to hear, but you're all so committed and you're all so passionate about health in Canada and Canada's health. We appreciate it very much. We've learned a lot, and I'm sure that some of you will be back for further clarification from time to time.

I'd like you to stay, because I want to say goodbye to you, but first of all we have a little bit of business to do.

I'm going to invite Dr. Carrie to move again the motion that he moved earlier.

Mr. Colin Carrie: It is that pursuant to Standing Order 108(2), the committee call upon the Minister of Health to immediately appear as a witness to discuss the opioid summit and the next steps in dealing with this serious crisis.

The Chair: Is there any debate?

(Motion agreed to)

The Chair: That was passed with unanimous consent. Thanks very much.

This concludes our meeting. Thank you very much, everybody.

The meeting is adjourned.