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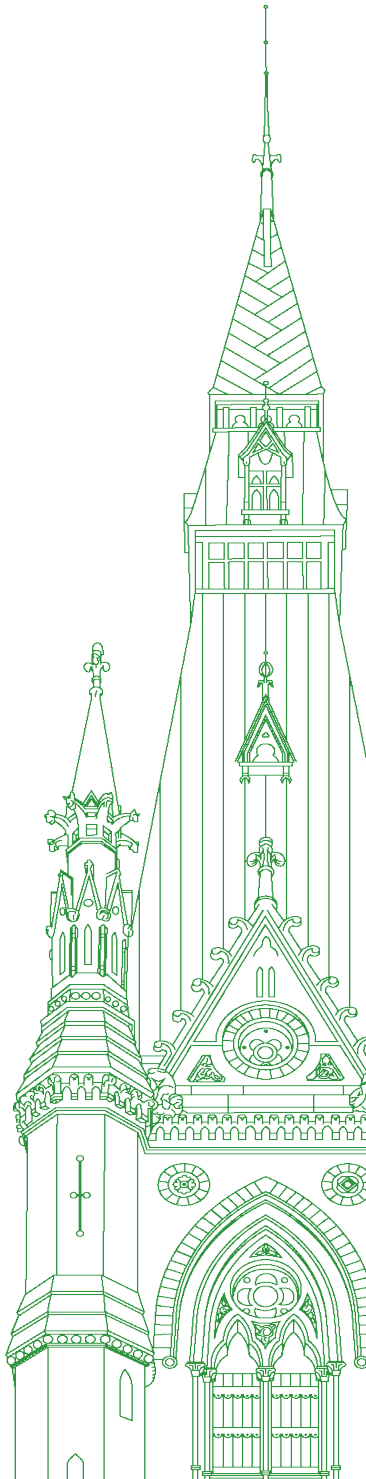

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, December 4, 2023

● (1105)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 93 of the House of Commons Standing Committee on Health.

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders. I understand that we have one witness and one member participating virtually, so in accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

For the one witness we have by video conference, you're probably already aware of this, but you have translation available at the bottom of your screen. You have a choice of floor, English or French. Close the mic when you're not speaking, and avoid taking screenshots of the screen, please.

Today, from 11 a.m. to 1 p.m., we have a panel on the opioid epidemic and the toxic drug crisis. Pursuant to Standing Order 108(2) and the motion adopted on November 8, we're going to begin that study today.

Before we begin, I'd like to introduce the officials we have with us.

From the Canadian Institutes of Health Research, we have Dr. Samuel Weiss, scientific director of the Institute of Neurosciences, Mental Health and Addiction. Dr. Weiss is the gentleman who is participating by video conference. The other witnesses are here in person.

From the Department of Health, we have Jennifer Saxe, associate assistant deputy minister, controlled substances and cannabis branch; Carol Anne Chénard, acting director general, office of controlled substances; and Kelly Robinson, director general, marketed health products directorate.

From the Department of Indigenous Services, we welcome Jennifer Novak, director general, mental wellness, first nations and Inuit health branch. From the Department of Public Safety and Emergency Preparedness, we have Marie-Hélène Lévesque, director general, law enforcement policy directorate. From the Public Health Agency of Canada, we have Shannon Hurley, associate director general, centre for mental health and well-being.

Thank you all for taking the time to appear today.

Before I hand the floor over to Ms. Saxe, I understand that there is a possibility of bells before we complete this panel. If and when that happens, I'll be asking for unanimous consent to continue.

Also, we have heard from the Minister of Mental Health and Addictions, who has indicated her willingness to come before the committee on this study, probably in the new year.

With that, I'm going to turn the floor over to Jennifer Saxe from the Department of Health for her five-minute opening statement.

Ms. Jennifer Saxe (Associate Assistant Deputy Minister, Controlled Substances and Cannabis Branch, Department of Health): Thank you very much.

[*Translation*]

Good afternoon.

Thank you for providing my colleagues and I with the opportunity to address this crucial issue.

In my comments today, I would like to share some information about what we know about the crisis, based on the data we collect at the federal level, and to outline some of the measures we have been advancing to reduce harm, prevent overdoses and related deaths, and to expand access to treatment and support recovery and wellbeing.

The overdose crisis we face today is a profound public health emergency, reaching into the lives of individuals across diverse demographics. This public health crisis is having a tragic impact on people who use substances, their families, and communities across the country, and is shaped by a wide range of factors.

[*English*]

Based on the latest available data, there have been 38,514 opioid overdose deaths since January 2016. While 90% of these deaths in Canada occurred in British Columbia, Alberta and Ontario, it is important to note that elevated rates have also been observed in other areas with smaller population sizes, including Saskatchewan and Yukon.

Most apparent opioid toxicity deaths are among young to middle-aged males. In fact, males accounted for 73% of accidental apparent opioid toxicity deaths.

Indigenous peoples are disproportionately impacted. For example, while first nations make up 3% of British Columbia's total population, 16% of those who died of an overdose identified as first nations. Also, according to data from the Alberta First Nations Information Governance Centre, the rate of opioid poisoning deaths is seven times higher for first nations people compared to non-first nations people in the province.

The data also confirmed that very high rates of overdose deaths are the direct result of increasing street drug toxicity. Of all reported overdose deaths, 81% involved fentanyl. Multi-drug toxicity is a contributing factor to the crisis. Increasingly, people are using a mix of drugs, which is significantly increasing risk.

[*Translation*]

This crisis is widespread and pervasive. Understanding why people turn to substances engages the full range of social determinants of health, as well as adverse childhood experiences, trauma, poverty, mental illness and chronic pain.

[*English*]

We have worked with experts to ensure we are pursuing evidence-based strategies to comprehensively and compassionately address this crisis. It is within this context that the Government of Canada has been actively working for many years, mobilizing efforts across a continuum of interventions that span prevention, harm reduction, treatment and enforcement, and working together to reduce harmful stigmatizing attitudes and behaviours.

Substance use prevention initiatives are tailored to reach people most at risk. For example, the “ease the burden” campaign is a targeted effort to reach men in the trades, a demographic disproportionately affected by the overdose crisis. This campaign, with over 26 million views, shows how we are raising awareness and reducing stigma in these populations.

Recognizing how important timely access to quality treatment services is, we have made significant investments to expand access, including specialized services for youth and much-needed withdrawal management, commonly referred to as detox.

The government has also made efforts to expand access to services that reduce harms and prevent overdose deaths. This includes the distribution of naloxone and widespread training. We have made it easier for communities to establish and provide consumption sites. There are currently 39 sites across the country, which have seen over 4.3 million visits, responding to nearly 50,000 overdoses. For many, these sites are the only direct experience people will have with health providers. As a result, there have been over 257,000 referrals to health and social services.

Simultaneously, our law enforcement and border officials are actively countering illegal drug production, diversion, trafficking and related crimes.

As part of the response to this crisis, the government also continues to support research that is helping us to better understand substance use in Canada and that allows for the development of evidence-based policies and programs.

● (1110)

[*Translation*]

Before I close, I wanted to mention that on October 30, 2023, the Minister of Mental Health and Addictions and Associate Minister of Health launched a renewed Canadian drugs and substances strategy. This strategy presents a compassionate, equitable, collaborative, and comprehensive federal approach to this crisis and may be of interest as you conduct your study.

In conclusion, it is essential to understand that federal actions alone will not end the overdose crisis. We stand committed to ongoing collaboration with provinces and territories, indigenous communities, families and people with lived or living experience.

We welcome the opportunity to inform your important study and are prepared to respond to any questions you may have.

[*English*]

The Chair: Thank you, Ms. Saxe.

We're going to begin right away with rounds of questions, beginning with the Conservatives and Dr. Ellis for six minutes, please.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Good morning, everyone.

Thanks for getting to this very important study.

Obviously, we know the statistics. Canadians know the number of people dying and, of course, 1,900 people have died thus far in 2023.

Ms. Saxe, maybe you could tell listeners out there what is the leading cause of death in B.C. in 10- to 18-year-olds.

Ms. Jennifer Saxe: For 10- to 59-year-olds in B.C., overdose from opioids is the leading cause of death.

Mr. Stephen Ellis: What about 10- to 18-year-olds specifically?

Ms. Jennifer Saxe: I believe the leading cause of death for the 10-to-18 age group is also overdose.

Mr. Stephen Ellis: Yes. It's a very sad state of affairs.

I guess I have a bit of a rhetorical question, but we'll get to that. What's it going to take to stop this experiment, the safe supply, safer supply, whatever euphemism we're going to use?

There's a recent article that came out on Friday from a person with lived experience who talked about being at Leslieville, the South Riverdale site, and was speaking about safe supply. Are you aware of that article?

Ms. Jennifer Saxe: I'm not aware of the specific article. I would need more details, but I know that there have been a number of articles about safer supply, as well as supervised consumption sites, in recent days.

Mr. Stephen Ellis: This article specifically talks about safer supply. It talks about a few other things, but is the Government of Canada aware that these so-called safer supplies are ending up in the hands of folks who previously have not used opioids?

Ms. Jennifer Saxe: What the government is doing right now is undertaking and investing in a suite of services to include prevention, education, harm reduction, treatment, recovery—

Mr. Stephen Ellis: I'm sorry. Maybe you misheard me. I'll interrupt you. I apologize for that.

Are you aware that these so-called safer supplies are ending up in the hands of folks who have never used opioids before? I didn't ask what the government was doing. I asked a very specific question.

Thank you.

Ms. Jennifer Saxe: The government is aware that there is a range of use regarding prescribed pharmaceutical alternatives that are being used in harm reduction and treatment processes for individuals who use substances.

We are listening to those. We are listening to concerns as well and taking those very seriously. There are a number of actions we are taking—

Mr. Stephen Ellis: Thank you for that. I'll interrupt you there.

We have a convention here that your answer will be the length of my question. Thank you.

Is the government aware that the price on the street of an 8-milligram tablet of hydromorphone has gone from approximately $20 a pill to $2 a pill?

● (1115)

Ms. Jennifer Saxe: Again, I would repeat that we understand there are a range of uses, perspectives and reports in terms of prescribed pharmaceutical alternatives. We are taking concerns that are being raised seriously. We are looking into those. We are taking a number of actions—

Mr. Stephen Ellis: Thank you very much.

I'm trying to be very kind here, but I'm asking very specific questions that you're really not answering.

Is the government aware and is your department aware that the on-the-street price for 8-milligram tablets of hydromorphone has gone from $20 to about $2 a tablet?

Ms. Jennifer Saxe: We are aware that there are reported concerns about the diversion of prescribed pharmaceutical alternatives, including as a result of the price of that.

Mr. Stephen Ellis: Is the government aware that these 8-milligram tablets of hydromorphone—the equivalent of about 30 tablets of Tylenol 3—are being used in high schools around this country?

Ms. Jennifer Saxe: I think the government is aware that the use of illegal drugs is absolutely of concern for youth across the country. That is why we're investing in prevention and education in a suite of services and supports, to—

Mr. Stephen Ellis: Once again, I'm going to interrupt you. I'm trying to be kind, but it seems you're purposely avoiding answers to my questions.

Is the government aware that the so-called safe supply is actually being used in high schools in Canada?

Ms. Jennifer Saxe: We are aware that there are people who are concerned that there is a diversion of prescribed safer supply.

Mr. Stephen Ellis: I guess if you're aware that people are concerned.... I'm sorry. If you are aware that people are concerned that this is happening, wouldn't that mean you're aware that it's happening?

Ms. Jennifer Saxe: We are taking reports of diversion seriously. There are a number of actions we are taking. We are committed to taking those actions. They include working with safer supply providers to understand the risk mitigation measures they are taking, including patient screening and urine drug screening, and working with health care providers and patients to ensure that risk mitigation measures are in place to reduce any diversion.

We are looking at evaluations and studies, and I'm happy to turn it over to my colleague at CIHR for further information on some of the evaluations we are doing on prescribed drugs.

Mr. Stephen Ellis: Thank you for that.

When the opioid experiment began—and I'm using the words of my colleague Dr. Hanley, which were in the text of this motion—what was the original null hypothesis that the government put forward for the experiment?

Ms. Jennifer Saxe: Could you repeat the beginning of the question?

Mr. Stephen Ellis: Yes. What was the original null hypothesis generated for this experiment? We all know it was an experiment. It has never been done before. In an experiment, you really have an idea of what you want to disprove.

What was it? Was this just something on the back of a napkin? I guess that's the question.

Ms. Jennifer Saxe: I apologize. I think you will have to clarify for me what you're referring to by “this experiment”.

Mr. Stephen Ellis: It's in the text of the motion that we're debating here today. This is a drug experiment, so what was the plan?

Ms. Jennifer Saxe: The government—

Mr. Stephen Ellis: I'm sorry. Was there a plan?

Ms. Jennifer Saxe: There's a very clear plan that the minister announced on October 30, which really directs where the government is going. It's the renewed Canadian drugs and substances strategy—

Mr. Stephen Ellis: I'm sorry. I'm going to interrupt you, because you said October 30—

The Chair: That's your time, Dr. Ellis. I'm sorry.

We'll go to Dr. Hanley, please, for six minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you, Mr. Chair.

Before I ask questions, I wanted to provide some opening remarks, given that this is a study that I initiated with a motion passed by committee earlier this year.

Mr. Chair, we have eight meetings, I believe, most of which will be taking place in the new year, in 2024.

We know that 2023 will be another tragic year for Canadians. In 2022, we saw 7,328 deaths. The current death rate is estimated to be 21 Canadians dying daily. Isn't it shocking that we can actually predict with more or less confidence that 600 or more Canadians will die of an opioid or mixed drug overdose between now and the end of the year? Despite this having been recognized as an emergency seven years ago, the death toll continues to be the same or to rise.

When I was CMOH in the Yukon, we witnessed the first fentanyl death occurring in April 2016, the same month that British Columbia's chief public health officer at the time, Dr. Kendall, declared a public health emergency due to a shocking rise in deaths in that province. That's continued to increase since.

Since those earlier days of the epidemic, governments have responded. Many wonderful things have happened. Naloxone kits, for instance, are everywhere in our territory and widespread around the country. We have had the first supervised consumption site in Yukon, north of 60, including one of the first sites in the country with an inhalation room. We've scaled up efforts and treatment in clinical opioid substitution, in harm reduction, and to some degree in prevention.

The Yukon declared a substance use emergency in January 2022, and recently revised its substance use health emergency strategy, just a few months ago, based on the four-pillar approach that we all know so well.

Yet the deaths go on. Lives and families are torn apart with overdose fatalities or injuries. We've done so much, yet the scale of our response has not yet matched the need.

As we take on this study, I plead with all committee members around the table to have one aim—one single aim in mind. I know I'll be thinking of my own two teenagers and their friends, and what more we can do to protect them. Let this be about saving Canadians' lives. Let's not make this about personal attacks or takedowns, or scoring political points. Let's take a hard look at what is working and what is not, and if something is not working, then let us examine why, learn and adapt.

To my colleague Dr. Ellis, “experiment” is really a word for taking a new approach. To your question about a “null hypothesis”, I think we could answer that our current model is clearly not working, so we need to take new directions.

Let us look at models of innovation and success that have shown promise or have been shown to work, either within our country or elsewhere. Let us be able to come up at the end of this study with urgent, thoughtful, evidence-based, compassionate, bold and intelligent recommendations as to what all of us can do to get this epidemic under control—as individuals, as communities, as governments at all levels.

I know that each one of us cares. Please, for the sake of Canadians, let's work together on this with respect, with humility, with urgency, and with the decency that Canadians expect of us.

I know I have only about two minutes left, but I'd like to bring back my questions.

Thank you all for being here.

Budget 2023 proposes an additional $359 million over five years to support a renewed strategy. Ms. Saxe, I wonder if you could describe some of the directions you intend to take with this renewed funding.

I'd like to save time for Ms. Hurley from the Public Health Agency to comment as well on that same question.

● (1120)

Ms. Jennifer Saxe: I will absolutely make sure to save some time for Shannon Hurley.

Thank you for that question and for your remarks.

The renewed strategy really builds on the previous strategy by ensuring that we have holistic, integrated action that cuts across prevention education and looks at the whole suite of substance use services, including harm reduction, treatment and recovery. It looks at making sure we're building on the evidence and taking a range of actions in terms of substance controls. It looks at law enforcement and at ensuring the appropriate controls are there for the misuse of substances.

Some of the key actions we're taking include a call for proposals for substance use and addictions programs to make sure we can invest in community-based programs. The call for proposals went out at the end of September. We received just over 600 applications at the end of November. We'll be reviewing those to make sure we can invest in promising, evidence-building, innovative projects at the community level.

I'll turn it over to Shannon Hurley in a minute to talk about some of the prevention work, building on the Icelandic prevention model-based program we have.

We're continuing to take action in terms of authorization and making sure people have access to harm reduction services, whether that's supervised consumption sites, access to naloxone, or drug-checking services so people can know what's in their drugs and health workers also can know what's in substances people are consuming.

There are a range of actions. I can turn it over to my colleague after, in terms of the public safety and law enforcement. There are a suite of surveillance activities, and targeted research and evidence we are looking to build up, including on innovative models, so we can learn and adjust as we are doing that.

For prescribed pharmaceutical alternatives and supervised consumption sites, we are looking at what the evidence is showing and we're monitoring those programs so we can learn, adapt and put in best practices.

Maybe I'll turn it over to Shannon on prevention.

● (1125)

The Chair: Thank you, Ms. Saxe.

We're past Dr. Hanley's time. I'm sure if another member wants to use part of their time to have some further comments with respect to that, then that may very well happen.

[*Translation*]

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

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

I'd like to welcome all the witnesses to the Standing Committee on Health.

In 2016, this committee tabled a report in the House of Commons that included 38 recommendations. One of these recommendations said that the Canadian drugs and substances strategy should be focused on reducing harm and that the government should define what harm reduction means.

Seven years on, could you briefly tell us what harm reduction consists of and what its goals are?

Ms. Jennifer Saxe: Thank you very much for the question.

Harm reduction continues to be a key element in the strategy, which was launched by the Government of Canada to address the overdose crisis and substance abuse. To be clear, let's say that harm reduction is part of a continuum of measures and care. It is based on accurate data, and it reduces harm and saves lives.

It's important to make every effort to reduce harm because of the growing toxicity and unpredictability of illicit drugs currently in circulation.

We are continuing our focus on harm reduction because not everyone has access to treatment services. Such services may not be available in some regions. Private treatment can be expensive or inaccessible. Harm reduction can help connect people and services.

Harm reduction is a medical and a health service.

Mr. Luc Thériault: Thank you, Ms. Saxe.

Ms. Lévesque, in the government's response to the committee, the emphasis was on tightening up the borders and the act. The example it gave was Bill C-37, which would give border officers more latitude to intercept fentanyl, because they would be able to inspect baggage weighing less than 30 grams.

Seven years on, it's perfectly clear that the illicit production of fentanyl has not changed since the passage of that bill.

What's missing? What's needed to tighten up border controls?

What could be done to make this action plan more effective, given that it is not currently producing the desired results?

Ms. Marie-Hélène Lévesque (Director General, Law Enforcement Policy Directorate, Department of Public Safety and Emergency Preparedness): Good morning.

I'm pleased to be here today.

Mr. Chair, I'd like to thank the member for his question.

The Department of Public Safety and Emergency Preparedness administers several areas. The Canada Border Services Agency has already implemented several measures, the most recent of which was creating a targeting centre for opiates, which we expect will yield rapid results. It has just been established. We want to collect accurate data, and to act on information received from the international community and law enforcement agencies.

Mr. Luc Thériault: So, seven years on, you're saying that you've fixed things only recently.

Is that right?

● (1130)

Ms. Marie-Hélène Lévesque: That's not all that happened. We are continuing to intercept huge quantities at points of entry and are taking action not only locally and nationally, but also internationally, on the basis of information we receive.

Mr. Luc Thériault: So that alone will not be enough to deal with the crisis. No matter how effective you and the measures you're taking may be, the fact is that after seven years, the problem has still not been fixed. Action is therefore needed on other fronts.

Ms. Saxe, after seven years of implementation, what is missing from this strategy that might make it more effective and thwart this crisis?

Ms. Jennifer Saxe: It's important. As Ms. Lévesque pointed out, we took steps that led to some progress, and the new measures planned for the renewed strategy really give us a range of measures.

Mr. Luc Thériault: Where has there been progress? Do you have any reliable statistics on the progress made over seven years?

Ms. Jennifer Saxe: Progress has been made in several areas, including supervised consumption sites, the number of lives saved and the number of people referred to other social or health services. On the public safety side of things, there have been seizures at the border.

Mr. Luc Thériault: So lives were saved, which means that without this strategy, these measures, and this action plan, there would have been more deaths.

Is that what you're telling us?

Ms. Jennifer Saxe: Yes, that's it exactly. There would have been more deaths.

That's indicative of how important it is to have collaboration between the federal government, the provinces and territories, experts, and people in the community, as I said in my opening remarks. Everyone, all Canadians have a responsibility with respect to stigmatization. We need to work together and increase our efforts.

The Chair: Thank you, Ms. Saxe and Mr. Thériault.

[*English*]

Next, we have Mr. Johns, please, for six minutes.

Mr. Gord Johns (Courtenay—Alberni, NDP): Thank you for being here and for the work that you're doing.

I want to reiterate what Dr. Hanley said about what's working and what's not working. Clearly, what we're doing isn't working. I like the idea of not only talking about models of innovation and success, but also using sound data so that we have evidence-based decision-making and policies that are going to respond to this crisis.

One thing we heard from doctors at the beginning, in 2016, when B.C. declared a public health emergency, was that they were calling for the federal government to also declare a national public health emergency. Can you explain why that hasn't happened?

The reason, and you've heard me talk about this many times—I met with all of you on this panel—is the need for a plan and a timeline, and that is not in the renewed Canadian drugs and substances strategy. It was something I outlined in Bill C-216, which was defeated by the Conservatives and most Liberals. That would have provided a timeline. That bill directed government to provide a timeline and a plan.

Why has no national public health emergency been declared?

Ms. Jennifer Saxe: The Government of Canada has recognized that the overdose crisis is a public health crisis. We've used a broad range of powers—

Mr. Gord Johns: You even said it was a public health emergency, so why haven't we declared it?

Ms. Jennifer Saxe: We've regularly put out that it is a public health crisis and that there are a number of actions, including investments of over a billion dollars that have been made in a suite of actions, including evidence-based actions and innovative actions. That's why we have the renewed strategy to help guide us forward, working in partnership with others. As you mentioned, with the renewed strategy, we really look at investment in a suite of services and supports. There are specific actions that we had. There are resources that have been associated and that were announced in budget 2023, and then, for timelines associated, there are specific actions that have been taken, like the call for proposals for the—

Mr. Gord Johns: I love all the buzzwords around a compassionate approach and an integrated, coordinated approach, but that requires a timeline and resources. I'm sorry, but $1 billion isn't even 1% of what we spent in response to the COVID-19 health emergency.

That's why we need to declare a national public health emergency, so that we can force everyone to the table and actually develop a plan with provinces, with municipalities and with indigenous nations so that it's a coordinated and cohesive strategy.

When I look at the expert task force on substance use, the Canadian Association of Chiefs of Police, which put out a policy platform a few years ago with what they were recommending, the chief coroner of B.C., B.C.'s First Nations Health Authority and now the death review panel in B.C.—it's unbelievable that we have a death review panel on this issue—they all have something in common. They've all cited that we need treatment on demand, recovery, prevention, education and a safer supply of substances. They've all been unequivocally clear.

Have any of them changed their position when it comes to safer supply—since that was brought up earlier in this conversation—that you're aware of?

● (1135)

Ms. Jennifer Saxe: I am not aware of changed positions.

We are aware that there are a range of differing perspectives and reports in terms of prescribed pharmaceutical alternatives. However, as you mention, it really is one action of many. No single action will—

Mr. Gord Johns: The reason why I'm bringing this up is that it was raised earlier.

When I talk about safer supply to replace the toxic, unregulated drug supply that's killing people in our country.... Have you brought together the data of the pilots? I know that Dr. Sereda in London, Ontario, is producing data. The data is significant: lower visits to hospitals, less hospitalization, less involvement in survival sex work and drug-related criminal activity for drug-seeking related crime. This is unbelievable, the stats that are coming out.

Have you compiled these and released the data of all the SUAP funding so that people have a better understanding of how successful these pilots are?

Ms. Jennifer Saxe: We are collecting data. We are evaluating programs. In terms of prescribed pharmaceutical alternatives, there are a number of studies under way. There are over 30 published evaluation results and some of them are quite promising.

The London study, as you mentioned, is one of them. The Ontario Drug Policy Research Network identified 20 publications and looked at promising outcomes, including reduced visits to emergency departments, reduced hospitalizations, reduced overdoses, reduced illegal drugs. There are a number of evaluations that have been undertaken by CIHR and the Canadian research initiative in substance misuse, CRISM, looking at the effectiveness of supervised consumption sites and of a number of different section 56 exemptions.

Mr. Gord Johns: Have you thought about reinstating the expert task force on substance use?

I think they could provide a pivotal role of being an external body with experts who could help go through that data and help make sure that the Canadian public has a third party in terms of evaluation of how that data is working, how the policies of the current government are working and how you're doing with your renewed strategy on substance use policy.

Has that been considered? Is that something the minister is considering right now?

Ms. Jennifer Saxe: The expert task force provided 21 recommendations that informed the renewed Canadian drugs and substances strategy.

Mr. Gord Johns: I'm looking for oversight, though. That's a necessary role, I think, in this situation.

Ms. Jennifer Saxe: We continue to engage with quite a number of experts. There has been an expert advisory group on safer supply, people with lived and living experience, councils. There are various expert groups. We continue to engage with a number of those experts, including in evaluation of data.

Mr. Gord Johns: They don't have accountability. There is no accountability.

The Chair: Thank you, Mr. Johns.

Thank you, Ms. Saxe.

Next is Mr. Doherty, please, for five minutes.

Mr. Todd Doherty (Cariboo—Prince George, CPC): Thank you, Mr. Chair.

There are a few things I could start off with. I could reply to Dr. Hanley's comment. This is deeply personal for me. I'm not here for sound bites, but I'm angry and I am frustrated. I've been very vocal and upfront about my family's struggles with this horrible epidemic. I've sat with family members of children who are now addicted and in the grips of addictions and also with families that have lost loved ones—young children, teens—to this horrible epidemic. This is deeply personal.

To our guests, thank you for being here. Thank you for the work that you're doing, but I have to say, whatever it is that we're doing is not working. Ms. Saxe, you even said so yourself: Since 2016, there have been 38,000 deaths. Whatever it is that we're doing is not enough. I get that you're one team and our provinces and others have to pitch in as well. It's not working.

My colleague talked about the experiment. An experiment is to see what works and what doesn't work. Throwing a billion dollars at it...and the leading cause of death for 10- to 18-year-olds in my province is overdose. It is not working.

What are the rates of diversion from government-funded safe supply?

● (1140)

Ms. Jennifer Saxe: As I mentioned earlier, we are working with all of our—

Mr. Todd Doherty: Do you have those numbers?

The Chair: Mr. Doherty, you took a minute and a half to ask the question, and then you interrupted her before she got into her second sentence.

Mr. Todd Doherty: Mr. Chair, when I asked the question, it was short.

The Chair: Ms. Saxe, if you have a more comprehensive answer, you can go ahead.

Ms. Jennifer Saxe: I would note that prescribed pharmaceutical alternatives build on medication-assisted treatment. When you speak about diversion.... First of all, drug trafficking is illegal. We've been very clear about that. Whether that's diversion of pharmaceuticals that have been prescribed for chronic pain, for medication-assisted treatment, or for—

Mr. Todd Doherty: Do you have the percentage of government-funded safe supply that's being diverted?

Ms. Jennifer Saxe: We are working with our projects to be able to.... They all have risk mitigation programs in place. We are looking at best practices.

Mr. Todd Doherty: I'm just looking for a percentage. If we don't have it, that's easy to deal with.

What is the average wait time to get somebody into recovery in Canada?

Ms. Jennifer Saxe: There's no good data across Canada, and there are no consistent indicators in that regard across all provinces and territories.

Mr. Todd Doherty: Do you have a range? Is it a week, two weeks?

I can tell you that in my province, it's sometimes 18 months or longer.

Ms. Jennifer Saxe: That's an excellent question. It's exactly why CIHI—working with the health transfers, which are going to be $200 billion, including $25 billion in new investments for mental health and substance use services—is working closely with provinces, territories and data partners to refine indicators and better collect consistent data.

Mr. Todd Doherty: Are you familiar with the letter from 17 leading addictions doctors or physicians? Have you met with that group?

Ms. Jennifer Saxe: I am aware, but I have not met with that group.

Mr. Todd Doherty: Are you familiar with the letter, from November 6, from 42 leading clinicians in addictions medicine? Have you met with that group?

Ms. Jennifer Saxe: We have met with a range of experts, and we continue to meet with a range of experts. We are continuing to collect data and evidence to better understand the concerns and make sure that our actions are grounded in evidence. This is what we've been saying.

Mr. Todd Doherty: I get that, Ms. Saxe. I'm specifically asking about the authors of these two letters. Have you met with either of these groups?

Ms. Jennifer Saxe: We have not met with them as a group.

Mr. Todd Doherty: Both of these groups say that safe supply is a nice marketing slogan, but it's not working. It's creating a whole new group that is addicted to opioids.

Would you agree with that? From what we know, safe supply is creating a whole new group addicted to opioids.

Ms. Jennifer Saxe: Prescribed pharmaceutical alternatives are—

Mr. Todd Doherty: All I'm asking is, would you agree with that statement?

The Chair: Ms. Saxe, there will be no more questions. Take the time you need to answer the question.

Ms. Jennifer Saxe: Prescribed pharmaceutical alternatives are one among many actions. We've been clear that we need a range of actions. No single action can be taken to resolve the overdose crisis in and of itself.

Mr. Todd Doherty: You didn't answer my question.

Ms. Jennifer Saxe: It's important to have a suite.

I will note that prescribed pharmaceutical alternatives build on the evidence. It's strong, peer-reviewed evidence of medication-assisted treatment that is used internationally in multiple countries.

Mr. Todd Doherty: She can't answer the question.

Ms. Jennifer Saxe: I think it's important to understand that there's medication-assisted treatment—

Mr. Todd Doherty: I do understand that.

The Chair: Your time is up.

If you could finish your answer, Ms. Saxe, without interruption, we can move to the next questioner.

Ms. Jennifer Saxe: Prescribed pharmaceutical alternatives build on a strong evidence base of medication-assisted treatment. There is a strong evidence base.

This is a new and emerging action that's being taken as part of a suite of actions. It needs to be closely monitored, so that we can learn from it and adjust as we need with the evidence and research we are looking at.

The Chair: Thank you, Ms. Saxe.

Next, we have Dr. Powlowski, who's online, for five minutes, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I want to preface my remarks, as several other people have done. Let's hope we can make this a non-partisan approach and try to find commonalities, instead of fighting with each other.

I did want to talk about toxic and safe supply. I'm not sure if I have the numbers right, but someone said there were 1,900 overdose deaths in 2023 so far. What percentage of those are narcotics? Can anybody say?

● (1145)

Ms. Jennifer Saxe: That's the number of apparent opioid toxicity deaths. I can state that 48% of accidental opioid toxicity deaths also involved a stimulant, and 79% of accidental stimulant toxicity deaths also involved an opioid. We are clearly looking at polysubstance—multiple substances—and increasing toxicity.

If we look at the drug toxicity and the level of fentanyl and contaminants like benzodiazepines and others in our supply since 2016, you will see a significant increase. There has been a significant change in our drug supply since 2016 that we are adjusting to or responding to.

Mr. Marcus Powlowski: Now, I know that when somebody has overdosed on multiple drugs they're often synergistic, but what is determined to be the cause of death primarily? Is the overwhelming cause of these deaths from fentanyl? How much is mixed so they can't really determine the cause of death?

Ms. Jennifer Saxe: Overwhelmingly, fentanyl is found. There's a combination of drugs that can be found, but if you look at provincial or national statistics, fentanyl is involved in more than 80% of these opioid toxicity deaths.

Mr. Marcus Powlowski: It would seem to me that one of the issues with safe supply is that safe supply.... If you're giving people narcotics, it's because they want narcotics or are addicted to narcotics. You're saying that a fair number of overdoses are by people who aren't specifically getting narcotics. They're doing crack or cocaine that turns out to be laced with fentanyl. The safe supply evidently wouldn't address that problem.

Ms. Jennifer Saxe: Some pharmaceutical alternatives can be for opioids. There are some prescribed pharmaceutical alternatives that can be for stimulants as well. It is not as commonly done and prescribed, but it does exist.

Mr. Marcus Powlowski: Are people prescribing cocaine and crack in B.C.?

Ms. Jennifer Saxe: They're not prescribing cocaine or crack. It's a prescribed pharmaceutical alternative. There are pharmaceutical alternatives such as Adderall or other medications that could be prescribed potentially.

Mr. Marcus Powlowski: A lot of people are going to do crack or cocaine, though, and unless you're going to provide a safe supply of that.... If you're getting toxic drugs because they're cut with fentanyl, you're not going to be addressing that with safe supply, I take it.

Ms. Jennifer Saxe: I think this is where it becomes important.... We're talking about prescribed pharmaceutical alternatives. It is the health provider who is prescribing and who sees what the best interests are in responding to the patient before them. They are working with their patient in terms of what is best to prescribe in that situation.

Mr. Marcus Powlowski: Where does the majority of fentanyl on the market come from?

Ms. Jennifer Saxe: There are fentanyl precursors that come into Canada or are produced in Canada. There are also imports.

I will turn it over to Marie-Hélène for additional information.

Ms. Marie-Hélène Lévesque: Since China scheduled fentanyl as a finished drug in 2019, CBSA has seen the number of seizures with finished fentanyl decrease dramatically. On the other hand, the seizure of precursors has increased. We're seeing increased seizures of precursors. We've also seen an increase in seizures of labs—in super labs. You will have seen some of the major drug busts that occurred both in Saskatchewan and British Columbia in recent months.

We're also seeing a number of reports from other countries. Australia, New Zealand and the U.S. are reporting that they are seeing the arrival of finished fentanyl through their borders that appears to be coming from Canada. This indicates that there could be a production of finished fentanyl in Canada.

● (1150)

Mr. Marcus Powlowski: Okay, I'd like to pursue that, but—

The Chair: I think you should pursue getting to the airport, Dr. Powlowski. Thank you for that.

[*Translation*]

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

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

In 2016, at hearings of the committee, Dr. Bonnie Henry, the provincial health officer for British Columbia, said that detoxification programs for users of opioids were not working, because the physiological dependence created by opioids required opioid substitution therapy, based on products like Suboxone. There was also discussion of Vivitrol at the hearings.

All of that led to recommendation 21 in a committee report, which I believe was adopted unanimously.

The recommendation reads as follows:

> That the Government of Canada improve access to medications for opioid addiction treatment such as Suboxone® and other effective medications not currently available in Canada, especially for people at high risk of complication and death.

In British Columbia, do you have data on the number of substitution therapies, access to these substitution therapies, and their efficacy in terms of medium-term recovery?

Ms. Jennifer Saxe: I don't have data specifically for British Columbia in front of me. We'd have to track it down.

Mr. Luc Thériault: Could you have it sent to the committee?

Ms. Jennifer Saxe: Our statistics on this have in fact already been published on a British Columbia Internet site. They report how many people have access to therapies…

Mr. Luc Thériault: Do you have an idea of which substitution therapies have been implemented?

Ms. Jennifer Saxe: There are some agonist opioid therapies. The chart published in British Columbia shows how many people have access to them every month.

Mr. Luc Thériault: Do you have an idea of the number of substitution therapies available in all regions of Canada? This seems to be a major treatment option to help people stop using opioids.

Ms. Jennifer Saxe: We've taken several steps to improve treatment access. We've changed the regulations...

Mr. Luc Thériault: You don't know anything about the results, the number of substitution therapies available, or whether they are effective. If they are effective, you don't know what it is that makes them effective.

Is that correct?

The Chair: Please reply briefly.

Ms. Jennifer Saxe: We are going to increase potential access to these treatments. After that it's up to the provinces and territories to take action. I know that British Columbia has developed a chart that shows access to treatment on a month-to-month basis. In Alberta, I'm pretty sure they have a chart showing the number of people who have access to agonist opioid treatment. However, the information is not available in all provinces.

The Chair: Thank you, Ms. Saxe and Mr. Thériault.

[*English*]

Next we'll go to Mr. Johns, please, for two and a half minutes.

Mr. Gord Johns: I'm going to go back to the need for a national public health emergency.

During COVID, we were able to work through jurisdictional barriers constantly, and within hours, with provinces, municipalities and territories, and with indigenous communities. We haven't been able to do that when it comes to the toxic drug crisis because of this lack of action.

I want to talk about jurisdiction, because there is a lot of politics going on here. We have had record amounts of deaths in B.C. under an NDP government, in Alberta, Ontario and Saskatchewan under Conservative governments, and in the Yukon under a Liberal government. In the U.S., 30 states have doubled in overdoses in the last two years, and in the top 10, the majority of them are Republican. This isn't a Republican-Democrat issue. It's not an NDP-Conservative-Liberal issue. This is a societal issue. This is a failure in terms of ideology within society. That's what I believe.

We went to Portugal this summer, my colleague MP Hanley and I, on our own dime. We learned what a response to a public health emergency looked like. They scaled up methadone delivery from 250 people to 35,000 in two years. They engaged the military to create labs, scale it up, and get it out to people.

Is this government looking at an emergency-type response? We haven't seen it yet. I really want to encourage everybody around the table here to work collectively, because that's.... The big win in Portugal was that the politicians took off their gloves, let the experts lead and supported them with the resources. That's how they actually got things done.

● (1155)

Ms. Jennifer Saxe: I think it's exactly the information and advice from experts that informed our renewed strategy, which looks at making sure we take some short-term urgent actions as well as long-term actions, and that it's an integrated suite of actions that take a compassionate approach. Again, we need to look at evidence-based actions and scaling those up. We also need to look at innovative approaches and, when we're taking those innovative approaches, make sure we are working with CIHR, CRISM and others to look at the evaluation, learning from those and implementing those changes, as well as learning from other countries, which we're doing.

Mr. Gord Johns: Ms. Saxe, we still don't have a timeline and a plan with resources to back those up. That's the problem. Without those, we're never going to get there. It's piecemeal and it's not working. Incrementalism kills in a health crisis, and so does disinformation.

Ms. Jennifer Saxe: I think that's exactly why, with this renewed strategy, we are looking at integrated action. We are working with our partners at Infrastructure on how we can better collaborate in terms of making sure there are housing supports as well. It's not just the health supports. We are working with Indigenous Services Canada and making sure that we can scale up our actions and that we can have integrated action. I think, with the renewed strategy, there are funds that have been allocated through budget 2023. They are clearly there.

Then in terms of timelines, we've taken specific calls for proposals for the SUAP. Maybe I can turn it over to Shannon now to speak a little bit about the prevention actions—

The Chair: I'm sorry, Ms. Saxe, but we're well past time.

We're going to move now, I believe, to Mr. Majumdar for five minutes.

Mr. Shuvaloy Majumdar (Calgary Heritage, CPC): Thank you. I appreciate it.

Thank you for being here.

I want to pick up on some of the questions my colleagues had earlier, so I'll get to the point.

How many minutes do I have?

The Chair: You have five minutes.

Mr. Shuvaloy Majumdar: That's great.

In September, you received letters. In October, you received letters from leading clinicians. Why are you not meeting with them?

Ms. Jennifer Saxe: We're meeting with a range of experts—

Mr. Shuvaloy Majumdar: That's except people who are proactively reaching out to you about dealing with opioid addictions.

Ms. Jennifer Saxe: We are interested in meeting with a range of experts with a range of different views, to understand those and to make sure that our actions, moving forward, can be grounded in data and evidence and that we have a better sense of how to inform this moving forward.

Mr. Shuvaloy Majumdar: Thank you for the answer, but you're still not answering why you intentionally decided not to meet with these ones.

Ms. Jennifer Saxe: We are happy to meet with a range of people and experts with differing perspectives.

Mr. Shuvaloy Majumdar: Perhaps you are, but are those the ones you agree with and who reinforce your thesis or the ones who have a constructive critical perspective that might be acted upon?

Ms. Jennifer Saxe: All views are important for us to consider.

Mr. Shuvaloy Majumdar: That's except for these people who have reached out to you multiple times and you haven't taken the time to meet them.

Ms. Jennifer Saxe: We've met, and will continue to meet, with people who have a range of different perspectives—

Mr. Shuvaloy Majumdar: You haven't met with these ones. They haven't even heard from your office.

I don't mean to come after you specifically. It's the minister, as well, whom the letter was addressed to, who hasn't been reaching out or responding to this. I'm frustrated, because I have to ask the question. Would you, as a professional, agree with these leading clinicians that a whole new group of people are becoming addicted as a result of this failed policy of unsafe supply? Would you agree that this is a possibility?

Ms. Jennifer Saxe: We are hearing a range of concerns and issues. That is one of the concerns we are hearing. That's why we are taking a number of actions, including looking at and re-reviewing the diversion prevention and risk mitigation protocols of different programs. It's why we're engaging with a range of experts with a range of views, to better understand the data and evidence to inform our actions moving forward, and it's why we're doing evaluations.

Mr. Shuvaloy Majumdar: That's the same answer you've provided for a lot of my colleagues already.

I want to take up Mr. Hanley's perspective on actually just getting to some facts here. Would you agree that it's in the realm of the possible that this policy is creating a whole new class of addicted people?

Ms. Jennifer Saxe: You're asking me a hypothetical question. What I'm saying is that we are looking at—

Mr. Shuvaloy Majumdar: It's not a hypothetical question. It's about whether this falls into the range of inputs and evidence you're considering, or whether it is not being considered to be evidence.

Ms. Jennifer Saxe: We absolutely take the concerns that we are hearing seriously, and that's why we are taking the range of actions that I have mentioned.

Mr. Shuvaloy Majumdar: Let me ask this. How many Canadians have died of opioid overdose since Health Canada started funding unsafe supply sites in 2020? That's a simple question. It's a policy that started in 2020. How many people have died as a result of this policy?

● (1200)

Ms. Jennifer Saxe: We have information on opioid toxicity deaths across Canada. As we know, there are a range of actions that are being taken by the federal government, by the provinces and territories and by community groups to reduce and address the—

Mr. Shuvaloy Majumdar: I can tell you the number, which should be carved into the desk of every person working on this, from the minister's office down to the analyst. It's 23,823 Canadians who have died from a policy that has not even been proven, through experiment or otherwise, to be effective. It's been dangerously ramrodded, as a matter of ideology, onto Canadians, and now we have a national crisis that, as my NDP colleague has said, the government won't even admit is a national crisis.

Ms. Jennifer Saxe: We've taken a range of actions, which include prevention, harm reduction, treatment, and enforcement actions. There has been a range of actions taken over that time in cooperation with others. I think we all see that there continues to be a crisis and that we absolutely need to take action, so that's why we're looking at how we scale up where there is strong evidence, promising practices, and promising community-based actions, trying some innovative actions as well.

Mr. Shuvaloy Majumdar: Let me ask about what Mr. Hanley presented earlier.

I'm not trying to create gotcha moments or to catch you off-script here.

Do you professionally think that this has been working?

Ms. Jennifer Saxe: I professionally think that we have some evidence-based actions that have been put in place. We know that supervised consumption sites have saved lives. We know that naloxone has saved lives. We know the information that drug checking has provided. We know that opioid agonist treatment is used worldwide—

Mr. Shuvaloy Majumdar: This appears to me to be—

Ms. Jennifer Saxe: —as the first line of response. We know that there are prevention actions that.... There are a range of actions that we know are effective.

Mr. Shuvaloy Majumdar: This appears to me—

Ms. Jennifer Saxe: There are also innovative actions that are new and that we need to build the evidence for—

Mr. Shuvaloy Majumdar: Forgive me. I think the convention of the committee is that we take equal amounts of time.

The Chair: You had your five minutes, and it's now up.

Mr. Shuvaloy Majumdar: Oh, well, thank you. I appreciate it. Thanks for your time.

The Chair: Next is Ms. Sidhu for five minutes, please.

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

Thank you to all the witnesses for being with us.

My question is for Dr. Weiss or Ms. Hurley.

With regard to a toxic drug supply that is literally poisoning people to death, can you expand on why supporting harm reduction measures is so important to stop the ever-rising death toll of the opioid and toxic drug supply crisis?

Dr. Weiss, you can start.

Dr. Samuel Weiss (Scientific Director, Institute of Neurosciences, Mental Health and Addiction, Canadian Institutes of Health Research): I think it's important to recognize that harm reduction is one of a spectrum of approaches that have been scientifically proven to be critical in tackling the toxic drug crisis. You've heard this morning about a number of different approaches to harm reduction, of which prescribing practices, including safe supply, are one.

However, the evidence also provides us with a clear sense that harm reduction without treatment services is less effective, and that treatment services without harm reduction are less effective. If we want to actually make inroads on the toxic drug crisis that exists today, we have to invest in the full spectrum of services, from prevention to harm reduction, treatment and recovery services. That's why, perhaps, the scientific community—beginning in about 2010-15, when we went from a crisis of opioid overdoses to the fentanyl toxic drug crisis—has stressed over and over again that communities need more resources to treat the toxic drug crisis.

Ms. Sonia Sidhu: Thank you, Dr. Weiss.

Ms. Saxe or Ms. Hurley, can you explain the various risks of forcing somebody who is not ready into treatment?

Ms. Jennifer Saxe: I'm happy to respond.

Seeking treatment for substance use is an individual choice for people who use drugs. Involuntary treatment can exacerbate stigmatization and can be a barrier to accessing life-saving services and life-saving care.

I think what we've been supporting is making sure that there can be evidence-based, person-centric, trauma-centred supports, including treatment, when and where people need them. That is not currently available across all of Canada, but it's certainly what we are looking to invest in and it's some of what we've been doing through our community-based programming with SUAP and others.

● (1205)

Ms. Sonia Sidhu: It was recently said that naloxone is a vital tool in harm reduction for the drug crisis. We also heard that the opioid overdose crisis is primarily affecting males aged 20 to 59.

What kind of awareness education campaign can be done to help this demographic?

Ms. Jennifer Saxe: That's an excellent question.

For men in trades, as I mentioned, we've been funding and investing specifically in an “ease the burden” campaign. That raises awareness of harms associated with the use of opioids and other substances, as well as the stigma, especially for men in those physically demanding trades, with regard to access and being able to speak about their concerns. Between September 2022 and March 2023, traffic to that campaign page exceeded 142.7 million views. We know that we can raise that awareness and reduce the stigma.

We're also looking at prevention for youth, for teens and young adults at festivals.

I'm happy to turn it over to Shannon to speak more about the prevention efforts we are undertaking.

Ms. Shannon Hurley (Associate Director General, Centre for Mental Health and Wellbeing, Public Health Agency of Canada): Yes, I'm happy to add that the Public Health Agency of Canada aims our public education efforts at specific audiences. We recognize how important it is to reach people with messages that resonate with them. We've developed messaging with youth for youth, for example, about different substances.

I know we're here today talking about opioids, but we're reaching youth on substances that youth are especially using in Canada: for example, alcohol and cannabis. We have other messaging for older adults and for pregnant people, just recognizing the importance of reaching people with messages that work for them.

Ms. Sonia Sidhu: Can you—

Ms. Jennifer Saxe: [*Inaudible—Editor*] mentioned is critical. When we developed our “ease the burden” campaign, it was really essential that we worked with people who had lived and living experience so that it resonated with them.

Ms. Sonia Sidhu: Thank you.

The Canadian—

The Chair: I'm sorry, Ms. Sidhu; that's your time.

Next we have Dr. Ellis, please, for five minutes.

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

I have a question for Ms. Saxe.

When Purdue Pharma supercharged the distribution of oxycontin, starting in the United States, it was generally accepted that this was a bad thing for society. Is that correct?

Ms. Jennifer Saxe: There were concerns then, at the beginning of the opioid crisis, in terms of the prescription of opioids and the implications that that had—

Mr. Stephen Ellis: I'm sorry, Ms. Saxe. I'm just going to interrupt you there.

Isn't it true that the Sackler family of Purdue Pharma was sued by the U.S. government for billions of dollars for that action?

Ms. Jennifer Saxe: That's correct.

Mr. Stephen Ellis: Thank you.

That would mean that it would be a bad thing, probably.

Answer with a simple yes or no.

Ms. Jennifer Saxe: There were many concerns, and the Canadian government expressed concern, absolutely. There were concerns.

Mr. Stephen Ellis: Okay, thanks.

Tell me this, then. Why is it a good thing that the Canadian government is now giving people 30 tablets of eight milligrams of hydromorphone for free?

Ms. Jennifer Saxe: The Canadian government is investing in certain programs that include prescribed pharmaceutical alternatives as one of a suite of measures.

Mr. Stephen Ellis: I'm aware of what they're doing. I'm just trying to get you to answer the parallel. It's quite obvious that when Purdue Pharma did it for money, it created a public health emergency. When the government gives these drugs away for free, we think it's okay.

Ms. Jennifer Saxe: The Canadian government is looking at providing a range of services, as I've said. Often these programs are part of a suite of services so that individuals can connect with primary health care, mental health services, housing and job training. It creates a connection to health and social services and supports.

Mr. Stephen Ellis: Ms. Saxe, all of that stuff makes perfect sense. Giving it away for free doesn't.

The other question I would ask you is this: On Canada.ca, it says, “A few grains can be enough to kill you.” Is that true?

Ms. Jennifer Saxe: That could be true, yes, depending on someone's—

● (1210)

Mr. Stephen Ellis: It's on Health Canada's website. It must be true.

Ms. Jennifer Saxe: Yes, it is.

Mr. Stephen Ellis: Is it there or not?

Ms. Jennifer Saxe: Fentanyl could, in certain quantities and depending on the—

Mr. Stephen Ellis: A few grains could kill you. I'm going to badger you on this, because it says it right on your website.

Ms. Jennifer Sax: Yes.

Mr. Stephen Ellis: Thank you.

Wow. That took a lot.

Tell me this, then: What sense is there in decriminalizing 2.5 grams of fentanyl? If a few grains could kill you, what sense is there in that?

Ms. Jennifer Saxe: If I can add, first of all, in the exemption for B.C., it is clear that trafficking of drugs.... That is pure fentanyl, and any trafficking of drugs remains illegal even under the 2.5 grams. When we are talking about the exemption in B.C., we are talking about the personal possession, personal use, of a total of 2.5 grams, which will include other substances that can be cut with whatever substance they're using.

Mr. Stephen Ellis: Thank you.

I understand all of that, but let's talk a bit about amounts.

From some American data—I used other data previously—a lethal dose is as little as 0.25 milligrams. That means 2.5 grams is enough to kill 10,000 people. It's cut with something, so let's cut it in half. That's 5,000 people. Let's cut it in half again, and that's 2,500. Let's cut it again, it's 1,250 people. That one person is allowed to carry.... Is that appropriate?

It's a simple question. Is it appropriate or not?

Ms. Jennifer Saxe: The threshold used in B.C. was developed based on a range of factors, including patterns of use. From the data we do have, including from law enforcement, a range of factors were considered to establish a threshold. It is a cumulative 2.5 grams. As I mentioned, trafficking even below the 2.5 grams remains illegal.

Mr. Stephen Ellis: Thanks. I'm not talking about trafficking.

I have one final question.

We talked about the addiction medicine experts who requested to meet with Minister Saks. They were talking about how this is not harm reduction. It is harm. It's not safe supply. It's reckless supply. It is reckless. It's reckless for people suffering from addictions. It's a disregard of our communities, a complete failure of monitoring and supervision, and an abrogation of responsibility.

Will the minister agree to meet with the physicians who wrote this letter?

Ms. Jennifer Saxe: I can't speak on behalf of the minister. What I can say is that we are—

Mr. Stephen Ellis: Will your department meet with them?

Ms. Jennifer Saxe: We are happy to meet with a range of experts with differing perspectives.

The Chair: That's your time, Dr. Ellis.

Go ahead and answer the question. Take 20 seconds if you need to.

Ms. Jennifer Saxe: From a departmental perspective, we are happy to meet with a range of experts with differing perspectives to better understand concerns, risks and benefits with the current actions that are being undertaken.

The Chair: Thank you.

Mr. Fisher, go ahead, please, for five minutes.

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Thank you very much, Mr. Chair.

Thank you, folks, for being here.

I want to ask Dr. Weiss if he could maybe give us a little bit of background on the early response to safer supply.

Dr. Samuel Weiss: I'm sorry. When you say “early response to safer supply”.... I'm not sure I understand the question.

Mr. Darren Fisher: What are some early results or a little bit of early data that you might have on the safer supply program?

I think maybe it would be good for us to understand and get clarity on tragic opioid and fentanyl deaths as they may or may not relate to safer supply.

Dr. Samuel Weiss: We have funded an arms-length study, through the Canadian Research Initiative in Substance Misuse, on safe supply programs in 11 sites across the country.

The early research results coming out suggest that for highly marginalized clients—those who have limited access to health services—safe supply is helpful and effective in reducing cravings, time on the streets and deaths. However, it has also been shown that it works best when wraparound services are also there. The critical element is that with wraparound services, clients are expected to attend and participate in allied health and social services. That's when safe supply is most effective.

I will also mention, of course, that safe supply really is part of prescribing practices overall, which started in the 1990s and led to the situation we're in today. The term “diversion” is also not new. It's been around since the 1990s because of prescribing practices.

When prescribing practices were curtailed, more people went to the streets. The second wave of the opioid crisis was when people could no longer receive prescribed opioids, so they went to the streets and started to overdose on heroin. The heroin, which was the second wave of the toxic drug crisis, was then supplanted in approximately 2010-13, when fentanyl arrived for the first time. It took over from heroin and became the drug of choice on the streets, where very small amounts lead to overdose deaths.

I think it's important to note that when we speak about safe supply, we're talking about part of a range of prescribing practices—good and bad—that have been part of how this crisis began in the first place. These would have to be considered scientifically as part of the go-forward regardless, because prescribing opioids is one of the few approaches we have right now for treating chronic pain and cancer pain.

● (1215)

Mr. Darren Fisher: Just to sum that up, the experts believe it has to happen within a suite of different actions to be successful.

Dr. Samuel Weiss: That's correct. It's with different actions, but most importantly it's within allied health and social services that seek to tackle the social determinants of health and the needs of individuals, to be able to attend to other elements that are causing them to seek opioids for both trauma and pain reduction.

Mr. Darren Fisher: Thank you.

Do I still have time, Mr. Chair?

The Chair: You have a minute.

Mr. Darren Fisher: I would like to ask a question of the folks from ISC.

Ms. Saxe spoke about the disproportionate impact on indigenous peoples. Can you talk a little bit about culturally safe and trauma-informed supports?

Ms. Jennifer Novak (Director General, Mental Wellness, First Nations and Inuit Health Branch, Department of Indigenous Services): Yes, I'm happy to do so.

It is clear that indigenous people in this country are disproportionately impacted by this crisis. In B.C. and Alberta, you're looking at an impact of five to seven times the rate of non-indigenous people.

For us at Indigenous Services Canada, we're really trying to connect people to services and to harm reduction products. That includes naloxone, but specifically opioid agonists, which we've been talking about today. We've been trying to access wraparound sites. Basically, 82 sites across the country are delivering opioid agonist treatment in over 100 communities.

We're also trying to get mental wellness teams. Jennifer Saxe mentioned that continuum of services. Those mental wellness teams are there. There are 75 of them serving 385 communities across the country.

What we're trying to do there is to get people to go through withdrawal management first, to stabilize people first, and then move them through opioid agonist treatment. It's also on-the-land training, healing centres, connecting them with culture and, really, what comes after. After they've gone through their treatment, what can we do to support people in a more longitudinal way?

We're really looking at innovative systems. We have an interesting pilot happening right now in Ontario. Most indigenous populations are in rural and remote areas, so we are trying to connect them with new virtual supports. The Oculus headset is one of them, where people can have access to wraparound services.

The Chair: Thank you, Ms. Novak. We're well past the time.

[*Translation*]

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

Mr. Luc Thériault: Mr. Weiss, if I have properly understood your previous answers, from a scientific standpoint, harm reduction should continue to be the key pillar of the strategy.

Is that correct?

[*English*]

Dr. Samuel Weiss: Harm reduction is one of the pillars. I would say it's not more important than treatment; it's one of them.

[*Translation*]

Mr. Luc Thériault: So if we had strictly relied on repression, there would probably be more deaths?

Right?

● (1220)

[*English*]

Dr. Samuel Weiss: Did you mean prescribed opiates, or did you mean supply on the street itself? I'm sorry. I didn't understand.

[*Translation*]

Mr. Luc Thériault: If the harm reduction approach had not been adopted, then scientifically speaking, there would have been more deaths.

Are you in agreement with that?

[*English*]

Dr. Samuel Weiss: Absolutely.

[*Translation*]

Mr. Luc Thériault: Okay.

What more should we be doing? What needs to be improved?

[*English*]

Dr. Samuel Weiss: What I would say is what we've heard from experts for many years. There has to be a coordination of care within communities. The communities have to play a critical role in this because that's where the problem is happening. It's different in different communities. In western Canada, there are opioids. In eastern Canada, amphetamines are a much bigger problem. The commonality is that they're all contaminated with fentanyl. A lot of that contamination with fentanyl is coming from organized crime. It is actually delivering that contamination within the country.

That said, we need a coordination of care. We have to overcome the fact that there are very few resources being provided for treatment and for harm reduction. We also have to combat the social determinants and the societal ills that are actually driving people to addiction.

What's critically important is that the stigma of illicit drug use is still overwhelming, including within the health system and within government itself. Until we destigmatize it, we have a significant challenge.

The Chair: Thank you, Mr. Weiss.

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

Mr. Gord Johns: From 2016 to 2021, we saw opioid toxicity deaths double here in Canada. Would you consider that a failure?

Ms. Jennifer Saxe: I'd consider it a public health crisis.

Mr. Gord Johns: Okay.

In the U.S., it went up 279%—more than doubled—and there was no safe supply. Many states didn't have safe consumption sites.

Would you consider that a failure?

Ms. Jennifer Saxe: I think those harm reductions are life-saving services, absolutely.

Mr. Gord Johns: We're not seeing a big difference. In terms of the number of deaths, in terms of policies, we've seen a failed North American strategy, really. We can look to Portugal, where they had 100,000 chronic drug users at the height of their crisis. Now they're down to 22,000. Over 70% of HIV transmission was through intravenous drug use, and now that's down to less than 2%.

Would you consider that a success story?

Ms. Jennifer Saxe: I think the comprehensive approach that Portugal took is absolutely a success and is something that absolutely informs our way forward.

Mr. Gord Johns: I can look at supervised safe consumption sites, for example. Since Insite opened, 20 years ago, how many people have died at a safe consumption site?

Ms. Jennifer Saxe: We have data on federally authorized supervised consumption sites. We issue exemptions as well, so provinces and territories can set up their own urgent public health need sites, often known as overdose prevention sites.

My understanding is that there has been one death at a B.C. overdose prevention site, but apart from that, I am not aware of any deaths at any federally authorized supervised consumption sites or any other overdose prevention sites.

Mr. Gord Johns: It would sure be hard to keep track of how many lives have been saved, but we know it's in the tens of thousands.

Lethbridge closed their supervised consumption site in 2020. They had 77 deaths last year, in the whole year. Already, by August 31 this year, they had 94.

Do you believe that the closure of their supervised consumption site is contributing to the cause of death in Lethbridge, Alberta?

Ms. Jennifer Saxe: I can say that supervised consumption sites are absolutely a life-saving service, and we have data around that.

Mr. Gord Johns: Would you call that a failed policy?

Ms. Jennifer Saxe: Again, I think having a suite of services, including harm reduction measures like supervised consumption sites, has been shown to save lives.

Mr. Gord Johns: I think the numbers speak for themselves: 94 people have died. By August they had already surpassed last year.

How much time do I have, Mr. Chair?

The Chair: None, but you have time to answer, Ms. Saxe.

Ms. Jennifer Saxe: I think I've provided the response. It is really the importance of having that suite of measures, including harm reduction measures, that save lives. Supervised consumption sites are one of several evidence-based harm reduction actions that can do so.

The Chair: Thank you, Ms. Saxe.

We'll have Mr. Doherty, please, for five minutes.

Mr. Todd Doherty: Thank you, Mr. Chair.

Of the overdose deaths that we know of, do we know, through autopsies, how many of those drug users tested positive for fentanyl? What's the percentage?

● (1225)

Ms. Jennifer Saxe: I think I mentioned earlier—and it varies for each year—that over 80% involves fentanyl.

Mr. Todd Doherty: Probably 90% is the number that I know of.

There have been 38,000 deaths since 2016. Would it be safe to say that, because of the stigma surrounding drug use and addictions, the number is likely considerably higher? Also, in the population base, there's homelessness and what have you, so those numbers.... How many of those deaths go unreported?

Ms. Jennifer Saxe: I would say that's the best data we have.

Certainly, our Public Health Agency colleagues work with coroner services in provinces and territories across the country to collect that data.

Mr. Todd Doherty: Again, I realize it's hypothetical, but it's feasible to believe that the number is likely quite a bit higher.

You all know the work that I do in mental health. We know that suicide numbers are likely higher because of the stigma surrounding that. Many of those deaths go unreported.

Could the same be said of these overdoses?

Ms. Jennifer Saxe: It's the best data that we have.

It is possible that there are additional deaths.

Mr. Todd Doherty: This is for Ms. Saxe or anybody else here. I'd like a short answer again. Of the billions of dollars we're spending—the government recently announced upwards of $20 billion of spending through the substance use and addictions program—what percentage of that money is going to data collection?

Ms. Jennifer Saxe: Data is collected through a variety of different—

Mr. Todd Doherty: Specifically regarding that money there, what's the percentage that's going to data?

Ms. Jennifer Saxe: In budget 2023, I can specifically speak to the fact that we're investing more than $50.8 million over five years, starting in 2023, to the Public Health Agency, as well as for vital data collection.

Mr. Todd Doherty: How much of that money is being spent on recovery?

Ms. Jennifer Saxe: Recovery is part of a suite of services and supports that are provided, so there are transfers we have made to provinces and territories. As you know, health services are largely delivered by provinces and territories, and so—

Mr. Todd Doherty: Would you agree with me, though, that the billion dollars we've spent to date fighting this crisis isn't working? If we don't have a targeted approach with this $20 billion and we're just throwing more money at an issue, you are going to be before this committee in another year, two years or three years with the same issues.

Ms. Jennifer Saxe: There are areas where.... Data and evidence are absolutely critical to understanding what is effective and what is working best or not, and I think Dr. Weiss spoke to specific details around some of the areas where we are collecting that data—

Mr. Todd Doherty: What are the metrics being used by the Public Health Agency of Canada to gauge the success of the programs we have?

Ms. Jennifer Saxe: There are a variety of different indicators. I can turn it over to Dr. Weiss, because there are a number of evaluations we have under way, and he can perhaps speak to some of the specific indicators and ways those are being evaluated.

Mr. Todd Doherty: Would you say that it's a success at this point?

Ms. Jennifer Saxe: I think there are areas where we have an evidence base—

Mr. Todd Doherty: The numbers are doubling and getting worse. Are we succeeding?

Ms. Jennifer Saxe: What I can say is that there are certain interventions where we have collected data and we see that there's an evidence base that there are absolutely lives being saved. There are other areas where we are learning and adjusting, but collectively—

Mr. Todd Doherty: Of the lives that are being saved, if there's an overdose and we know that we saved a life, do we know if that person has overdosed again, or how many—I'm trying to find the right word—have re-overdosed? What's the recidivism? I guess that's the word I'm looking for. When Canada says that we've saved over 75,000 lives or 50,000 lives, how many of those Canadians are still alive today?

Ms. Jennifer Saxe: I don't have a specific number for you.

What I can say is that this is exactly why we are looking at a suite of services and supports, so that we can ensure that people have access to treatment when and where they need it—when, along their journey, they're ready. We know that some people will go into treatment and then relapse. We know that some people will have access to life-saving services and then continue in treatment. We need an integrated approach, a compassionate approach, which is exactly what the government has done in its renewed strategy of making sure we have a full suite of services.

● (1230)

Mr. Todd Doherty: I agree with you.

Ms. Jennifer Saxe: We all need to work together to be able to deliver that.

The Chair: That's your time, Mr. Doherty.

Thank you, Ms. Saxe.

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

Mr. Brendan Hanley: Thank you very much.

Before my questions, I want to give a notice of motion. The intent of the motion is to have the minister appear as part of this study. The motion is:

> That, as part of its study of the opioid epidemic and toxic drug crisis in Canada, the committee invite the Minister of Mental Health and Addictions and Associate Minister of Health for one hour, and that the meeting take place no later than Monday, February 19, 2024.

I'm presenting that as a notice of motion.

First of all, I wanted to make a couple of comments.

Again, we're hearing a lot of focus on safe supply and on the assumption that safe supply is a concept that doesn't work. We know that there has been diversion of safe supply that certainly has been documented, at least anecdotally, by some of the experts who have written letters. We also know that diversion has always been an issue—for many years—with prescription drugs as well. I just want to make the point that diversion of safe supply does not mean that safe supply does not have an important role in the spectrum of approaches. Where there is diversion, we need to do our best to prevent it.

I did want to point out that the B.C. coroner has said, “We know for a fact that people are not dying (from safer supply), including children. The rates of death amongst those under 19 have not increased at all since safer supply was introduced”. That's within the B.C. context and is a quote from Lisa Lapointe.

I also think it's important to talk about some misconceptions about fentanyl and the issue of tolerance and the thresholds. The thresholds for decriminalization in B.C. were based on expert recommendations. There was a lot of back-and-forth, as we know, over a period of probably about a year, to agree on thresholds. The thresholds are really based on the concept of tolerance to fentanyl. People who are addicted to drugs become tolerant to incredibly high doses very rapidly. That is the rationale for the concept of using thresholds to determine decriminalization.

In Portugal—and Mr. Johns referred to the fact that we had an incredibly educational trip to Portugal together—the concept of personal possession in their decriminalization is 10 days of supply of whatever drug is determined. The threshold is based on a 10-day supply.

We forget in this discourse that criminalizing drug use is not only not working but actually causing harm, because the market is being flooded with ever more dangerous and toxic drugs. Criminalization adds to the stigmatization that prevents people from accessing care.

For my Conservative colleagues, I would ask, why would we or should we keep pursuing policies that are clearly not working?

How much time do I have?

The Chair: You still have a minute and a half.

Mr. Brendan Hanley: In my remaining time, would it be in order, Mr. Chair, if I were to move that motion to have the minister appear?

The Chair: The subject of the motion is the study that we're presently doing, so notice is technically not required.

It would be in order for you to move the motion.

● (1235)

Mr. Brendan Hanley: I understand. I would like to move the motion as previously read.

The Chair: The motion is in order.

The debate is on the motion to invite the minister prior to February 19. Is there any discussion?

I have Dr. Ellis and then Mr. Doherty.

Mr. Stephen Ellis: Thanks very much, Mr. Chair.

Thanks to my colleague for the motion.

I certainly think February 19 is a long way from now. I would suggest to you that a friendly amendment might be something in the order of January 15. We have some time available to us, and this is an important study. I think my colleagues all recognize this.

I suggest that continuing to delay this important study by not having the minister appear until February creates a significant time delay, in terms of allowing policies that we know are not working—as my colleagues have clearly mentioned—to continue. Allowing the minister to not, as suggested, meet with physicians who have a significant difference of opinion related to safe supply is, I think, dangerous to Canadians. Obviously, we know that no official from Health Canada, including the minister, has met with physicians with a contrary point of view. We also know the government doesn't have data, and it doesn't have a plan, either. It didn't have one from the very beginning.

I think waiting until February 19 will continue to put Canadian lives in danger and jeopardy. For that reason, I suggest we need to change the date to January 15 as an amendment, Mr. Chair.

Thank you.

The Chair: Okay. We have an amendment to delete “February 19” and replace it with “January 15”.

The debate is now on the amendment.

Mr. Doherty, go ahead, please.

Mr. Todd Doherty: I agree with my colleague about sooner rather than later. That goes to the same comment I was going to make about Mr. Hanley's motion.

I think it is important that we have ministers here, although I believe we're going to get the same gobbledygook we received previously. They don't know their file. They don't have the data, so I'm not quite sure what benefit we're going to get out of having them here, other than holding them accountable. We'll probably walk out more frustrated than we were when we walked in.

Mr. Chair, through you, I want to offer to my colleagues across the way that waiting until February 19 is too long. I think we would like to get on this. While it might have been Mr. Hanley's motion, it was Conservatives who pushed to get this study going sooner rather than later. I would ask the committee to consider early January dates, if not additional times within the next two weeks when we might be able to meet with the minister, so we can do the good work we're doing and get on to other projects.

Thanks.

The Chair: Go ahead, Mr. Fisher, and then I have Mr. Johns.

Mr. Darren Fisher: Thanks very much.

Thanks, Brendan, for moving the motion.

I think we can all agree that we would definitely like to have the minister here. I'm sure the minister wants to be here for this. We don't sit in January. We only sit until December 15 or so.

Would Dr. Ellis be willing to say, “no later than February 2”? We get back here on January 29. Could we say, “no later than February 2”? That way, it could be the first meeting when we come back in the new year.

The Chair: Mr. Johns, go ahead.

Mr. Gord Johns: I'm good with that.

If necessary, if the first week doesn't work for the minister, we can meet before the House comes back—if that needs to happen. I think that's reasonable. It meets everybody halfway.

The Chair: I see Dr. Ellis.

Mr. Stephen Ellis: Thanks, Mr. Chair.

Thanks to my colleagues.

Certainly, we've been able to meet at times outside the regular sitting schedule on other occasions. I think everybody very clearly knows—every Canadian out there watching and every person around the table—that this is an incredibly important issue to Canadians. Having a meeting with the minister during a time when we are not sitting is not setting any new precedent. It's not something unusual.

In a case that is incredibly important, I think this ask is very reasonable.

● (1240)

The Chair: Mr. Doherty, go ahead.

Mr. Todd Doherty: I would challenge our colleagues around the table. Mr. Johns, you've been up a number of times in the House, as have I, over the last eight years talking about this national health crisis that we have. Why don't we treat this as the crisis that it is?

There's nothing stopping us from coming early to Ottawa or doing it remotely, whatever is needed. I don't know why there's a hesitancy to try to meet as early as we can in January, if possible, prior to our coming back.

The Chair: Mr. Fisher, go ahead.

Mr. Darren Fisher: Thank you.

I agree. “No later than February 2” does not presuppose that it couldn't be an extra meeting sometime in January. I have no issue with that, if we stick to “no later than February 2”. We'll work with the chair and with the minister's office on getting that set up.

The Chair: Okay, I see no one else on the speakers list.

The amendment moved by Dr. Ellis was to replace “February 19” with “January 15”. There is a discussion around February 2, but we can't amend the amendment. The appropriate thing to do is to defeat the amendment, move a new amendment and then adopt it, if that's the will of the committee.

There's no one further on the speakers list, so we're ready for the question on Dr. Ellis's amendment.

Mr. Stephen Ellis: I'd like to request a recorded division, please.

The Chair: There will be a recorded division on the amendment for the date change. The wording of the motion indicates that the appearance of the minister would take place no later than February 19. What we're voting on now is to change “February 19” to “January 15”.

(Amendment negatived: nays 7; yeas 4)

The Chair: The amendment is defeated, and the debate is now on the main motion unamended.

Mr. Fisher, go ahead.

Mr. Darren Fisher: Thank you, Mr. Chair.

In agreement with Mr. Doherty, perhaps we could say “no later than February 2”. Again, that doesn't presuppose us not meeting sometime in January at the ability of the minister's office and with the work of the chair.

The Chair: The amendment is in order.

The debate is on the amendment.

If there is no debate, are we ready for the question? The question is that the motion be amended by deleting “February 19” and replacing it with “February 2”.

(Amendment agreed to)

The Chair: It's unanimous.

The debate is now on the main motion as amended.

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

The Chair: It's unanimous. The motion is adopted.

Thank you, Dr. Hanley. That's your time.

We'll go over to the Conservatives.

Mr. Majumdar, you have the floor for the next five minutes.

● (1245)

Mr. Shuvaloy Majumdar: Thank you.

We were discussing earlier some of the basic facts around this policy of safe supply. Maybe one of the things I could take a look at is that the diversion of hydromorphone to the black market has had massive impacts. What kind of impact did it have on prices that you are aware of?

Ms. Jennifer Saxe: As I mentioned, there are a number of concerns that have been raised. We are listening to those who have differing perspectives on prescribed pharmaceutical alternatives. We are also looking at the data and we are evaluating these programs, as is B.C.

Certainly, we are looking to get additional information to better understand the implications of how much diversion is going on, what risk mitigation measures we can put in place and some of the best practices. I can note that, in terms of actions we have taken from Health Canada, we are reviewing and working with our programs to look at those risk mitigation protocols to get a better sense of those.

Mr. Shuvaloy Majumdar: If we could dig a little bit into the substance of what you're providing here, when you are going to look at the impact on prices, what methodology are you going to employ to find out how government-provided hydromorphone has depressed black market prices?

Ms. Jennifer Saxe: From where I sit, we work with experts in evaluation and experts in this field to undertake third party evaluation of these programs.

I'm certainly happy to turn it over to Dr. Weiss to talk about some of what is being looked at in terms of the current third party evaluation of some of our prescribed pharmaceutical alternatives programs.

Dr. Samuel Weiss: If I may, for the evaluation of the safer supply, the most important questions that have been asked as part of this research are about the benefit to people receiving safer supply. The funding for this research did not include specific questions around diversion, which is more of a criminal justice matter than it is a health matter vis-à-vis determining whether or not people receiving safe supply have improved health outcomes, so I can't really comment on the matter.

Mr. Shuvaloy Majumdar: Did Portugal experiment with the fentanyl crisis?

Ms. Jennifer Saxe: Portugal, to my knowledge, is not experiencing a public health crisis in relation to fentanyl. When they put in their public health approach, they were really facing a crisis in terms of heroin.

Mr. Shuvaloy Majumdar: Did they have the supports in place prior to that?

Ms. Jennifer Saxe: They put in a range and a comprehensive suite of services and supports.

Mr. Shuvaloy Majumdar: Did Canada?

Ms. Jennifer Saxe: That is exactly what the renewed Canadian drugs and substances strategy specifically speaks to, and previously as well, but right now we're putting additional focus on taking an integrated, holistic approach that looks at prevention, harm reduction, treatment and recovery.

Mr. Shuvaloy Majumdar: I appreciate what you're saying, but did Canada do it in advance, or did it do it in response to a failed policy?

Ms. Jennifer Saxe: I think we are looking to continuously improve our response, and that is exactly why the minister announced the renewed Canadian drugs and substances strategy at the end of October, to look to the continued—

Mr. Shuvaloy Majumdar: I don't think it's fair to suggest.... Let me know if it's your professional opinion to believe that it's like comparing apples to apples.

Ms. Jennifer Saxe: What is compared with what?

Mr. Shuvaloy Majumdar: I mean the Portugal experience and its model and the Canadian model.

Ms. Jennifer Saxe: I think we look at a variety of different international experiences. We also look at our Canadian.... For the specific crisis we are facing in Canada, I would say that what the U.S. is facing is most like what Canada is facing right now in terms of the drug toxicity, but we also look at best practices internationally to inform our approach.

Mr. Shuvaloy Majumdar: Have you had a chance to meet with Portuguese officials?

Ms. Jennifer Saxe: We have met with Portuguese officials, as well as other previous officials who have been.... I personally have not gone to Portugal but have met with other Portuguese colleagues internationally, and other colleagues of mine have met with Portuguese officials.

● (1250)

Mr. Shuvaloy Majumdar: Are they presently experiencing an epidemic?

Ms. Jennifer Saxe: They take a range of actions. I can't speak to the specific drug toxicity they are facing, but it is not the same drug toxicity crisis we are facing in Canada in terms of fentanyl and in terms of contamination with benzodiazepines and other substances. Also, I think—as was mentioned before—that in Canada it is quite complex. It's not the same. We talk about an overdose crisis with people and the substances that are being consumed in B.C. versus the Maritimes versus the Prairies.

Mr. Shuvaloy Majumdar: Have they seen an increase in addictions—

The Chair: That is your time, Mr. Majumdar.

Finish your answer, Ms. Saxe, and then we're going to move on.

Ms. Jennifer Saxe: There are regional variations in terms of the drug toxicity and the substances people consume, which is important in terms of how we respond and in terms of the public health response we take. That's also why we need to be looking in a community-based way and working collectively to address it in specifically targeted responses.

The Chair: Thank you, Ms. Saxe.

Dr. Powlowski, go head, please, for five minutes.

Mr. Marcus Powlowski: Dr. Weiss, I wanted to ask you a question.

You made an interesting response to an earlier question. With respect to the early data, you said it showed that for those highly marginalized people, a bunch of parameters had changed, including a lower death rate from overdose. You didn't mention those people who are not highly marginalized.

What are the numbers with respect to people who aren't highly marginalized?

Dr. Samuel Weiss: Unfortunately, the numbers are vanishingly small because currently the safe supply programs are small in number and the number of people actually receiving safe supply is small. In the majority of cases, these are people in marginalized communities who have been seeking the safe supply.

The other issue, of course, is that we don't have an accurate number of the total number of people who are using substances and what type of substances they are. This is something we will be undertaking in some new research studies. In other words, if we're going to actually intervene through services of one sort or another, we need to be able to not just understand the number of people who are receiving treatment, but also understand the total number of people who are using substances. This is part of the research that is going to be undertaken going forward.

If more people can access the full suite of services, we'll have a better idea of the trends over time of improved outcomes for people who are addicted to opioids and other illicit substances.

Mr. Marcus Powlowski: Even if the numbers are small.... You said that the vast majority of people who are getting safe supply are marginalized, but you didn't say that no people who are not marginalized were getting it.

Are there any numbers for those who are not marginalized? What's that showing, even if the number is small?

Dr. Samuel Weiss: Again, I think the data to date on safer supply suggests that anyone who receives it together with allied services is at a lower likelihood of overdosing and having adverse outcomes from street drugs.

Mr. Marcus Powlowski: Let me turn to decriminalization.

In 2020, Portland, Oregon, passed referendum measure 110, which eliminated penalties for possession of small amounts of drugs. In the two years since—this is according to the Globe and Mail's numbers—the number of overdoses in the state has increased 61%, as opposed to 13% across the United States.

What is Portland doing wrong? In comparison, Portugal seems to be doing better.

What can we learn from Portland?

Dr. Samuel Weiss: I can't really speak to comparing and contrasting Portland and Portugal at this point.

What I can say—I think it was discussed previously—is that having in place community-driven, comprehensive wraparound services for people who use substances is critically important when we look to begin to destigmatize drug use. Decriminalization is really part of an effort to destigmatize and direct people who use substances to the health care system.

We need a health care system that treats addiction as a public health challenge and allows people to have access to those services in a user-friendly manner. We're definitely not there yet. We do not have adequate access to services. Without that, a lot of the efforts that are being made, which may be effective, will be less effective until the allied services are available.

● (1255)

Mr. Marcus Powlowski: I would ask the same question of people who are actually there.

Is that the problem with the Portland system? Is the problem so far with our safe supply system that we don't have adequate treatment for those who are addicted?

Ms. Jennifer Saxe: I don't think I'm well positioned to speak specifically to the Portland statistics. There are a variety of issues and a specific context around that.

In the Canadian context, I think Dr. Weiss really captured it. We need to be able to have a range of services available for people when and where they need it. Those are life-saving services and connection to health and social services—those wraparound services. When they are connecting, it is to health, housing and food security. It is a range of services to support people through their journey.

We know that people need to have access to treatment, but they may relapse. They may come in and out. We really need that comprehensive, allied suite of health services, as Dr. Weiss mentioned.

The Chair: Thank you, Dr. Powlowski and Ms. Saxe.

[*Translation*]

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

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

From the outset, it has been pointed out that the provinces, the territories and Quebec are responsible for applying policies on the ground and implementing the action plan.

Firstly, has the collaboration been working? How could it be improved to provide us with a much more accurate picture of what is happening on the ground?

I'm asking because I didn't get much information in replies to my questions about the status of things on the ground. Is that because information is not being transmitted? How could collaboration be improved to ensure that money spent on fieldwork has the desired effect?

Ms. Jennifer Saxe: We've been working with our counterparts in the provinces and territories. The Minister of Health, the deputy minister and senior officials like me, sit on various committees. We work closely with our counterparts in the provinces and territories to discuss our best practices and a wide range of measures.

For instance, we introduced the substance use and addictions program, the SUAP, under which some effective projects were implemented in the provinces. We organized some forums to exchange information on best practices. We believe it is extremely important to continue this collaboration, because others can learn from these exchanges.

That being said, some things could definitely be improved. For instance, we could improve data gathering, standardize indices, and improve the range of services and supports across Canada.

As we just said, it's truly important to work together. This collaborative effort ought not to come from just one partner, but all the partners, including the federal government, the provinces, the territories, and the communities. Work needs to be done with indigenous groups and health experts. Also required are assessments and data to allow us to track the impact of the programs we implement on an ongoing basis.

The Chair: Thank you, Ms. Saxe.

[*English*]

Mr. Johns will pose the final few questions for today's panel.

Go ahead, Mr. Johns. You have two and a half minutes.

Mr. Gord Johns: Thank you, Mr. Chair.

I'm going to read a quick quote from just two weeks ago in the Vancouver Sun. It states:

> In July 2020, the Canadian Association of Chiefs of Police expressed support for evidence-based medical treatment that included safe supply.
>
> Victoria Police Staff Sgt. Connor King said that based on his experience, Dilaudid is not the drug most people want and so the pills "are indeed being sold illegally."
>
> But various prescription drugs have been sold on the streets for decades, said King, a court-certified expert witness on the trafficking of fentanyl, heroin, oxycodone, cocaine, and methamphetamine. "There has always been Dilaudid and oxycodone and other powerful opioids in the teen environment in high school and university campuses."
>
> In addition, King said, "when I look at the coroner data, we're not seeing a link between safer-supply drugs and lethal overdoses."
>
> King called diversion of safe supply a "small piece" of an "enormous picture," as illicit drugs flow into B.C. via organized crime. Fentanyl coming into the province is highly toxic and deadly, and methamphetamines manufactured in Mexico and shipped or smuggled across the U.S.-Canada border are plentiful, powerful and cheap, he said.
>
> "There has never been greater availability of cheaper drugs that are more toxic than the situation we face right now," he said. "And none of that has anything to do with prescribed or safer-supply drugs."

Later, he went on to say, "I'm a fan of looking for alternate ways for people to access drugs that are going to keep them alive, but I leave that to the medical community to sort out".

We have heard similar responses from the City of Vancouver and their police department and the chief coroner of B.C. What are you hearing from police? Is there consensus? Overall, are you hearing that support is still there for moving forward with safer supply as a replacement to the unregulated toxic drugs?

● (1300)

Ms. Jennifer Saxe: As I mentioned earlier, there are diverse views. We know people who have expressed concerns. There are some who support it, as well. When we hear it, it is as part of the suite of services. It is a connection to health and social services. Someone who is reaching out for prescribed pharmaceutical alternatives is someone who's reaching out and connecting to—

Mr. Gord Johns: The reason I'm bringing it up is that these are experts. They're on the front lines.

The Chair: Mr. Johns, you have to let her answer the question. Your question lasted about two minutes and then you cut her off. Let her finish and then we're going to bid them good day.

Go ahead, Ms. Saxe.

Ms. Jennifer Saxe: There is a range of experts. There are experts in health services, law enforcement and the criminal justice system. We need to listen to a range of experts. They all bring their own expertise. There are some who have brought and highlighted the risks and benefits. There are some concerns. We need to look into those, as well. We need to look at what is working, where it is life-saving, and how we adjust so we can continue to improve the programs that we have. That's exactly what we're doing.

When we hear from the Canadian Association of Chiefs of Police, whether it is in terms of decriminalization or whether it is pharmaceutical alternatives, it is really looking at it as a suite of services that they are proposing.

The Chair: Thank you, Ms. Saxe.

Colleagues, that concludes the first panel. We're going to suspend briefly for the second one. Before we do, on the opioid study, we have not yet set a deadline for witness lists. May I suggest that the witness lists be in by the time the House rises, say, Friday, December 15, at 4 o'clock? Is everyone okay to have all their witnesses in by then?

Some hon. members: Agreed.

The Chair: Thank you. That will allow the analysts time to prepare a work plan over the winter.

To all of our witnesses, thank you so much for your patience and your professionalism, as always. We very much appreciate your being with us. This is the first step in a fairly long journey and study, and it has laid the foundation for all of us to be able to do our work. We're grateful to you for what you do and for your assistance to us in connection with this study.

With that, we're going to suspend while the next panel gets situated, so probably about five minutes.

● (1300)

(Pause)

● (1305)

The Chair: I call the meeting back to order.

Pursuant to Standing Order 108(2) and the motion adopted on November 8, 2023, the committee is beginning its study of the government's advance purchase agreement for vaccines with Medicago.

I would like to welcome the officials who are with us today.

From the Department of Public Works and Government Services, we have Andrea Andrachuk, director general.

[*Translation*]

Also with us today is Ms. Joëlle Paquette, the director general of the procurement support services sector.

[*English*]

From the Office of the Auditor General, we have Andrew Hayes, deputy auditor general, and Susan Gomez, principal.

Colleagues, we received notice during this meeting that the Auditor General herself wasn't able to be here. I don't have any explanation for you except that it was a development that was very recent.

First of all, to all of our witnesses who are here, thank you.

We have two opening statements, the first from the Auditor General.

I presume that will be you, Mr. Hayes. You have the floor for the next five minutes. Welcome to the committee.

[*Translation*]

Mr. Andrew Hayes (Deputy Auditor General, Office of the Auditor General): Mr. Chair, thank you for giving us this opportunity to discuss our report on COVID-19 vaccines in connection with the review of the planned vaccine purchase agreement signed by the government with Medicago. Our report was tabled in the House of Commons in December 2022.

I'll begin by acknowledging that this meeting is taking place on the traditional unceded territory of the Algonquin Anishinaabe nation.

With me today is the principal, Ms. Susan Gomez. She was in charge of the audit. The audit examined how the federal government purchased and authorized COVID-19 vaccines, and also how they were distributed to the provinces and territories to ensure that Canadians could be vaccinated.

In our meeting today, we will focus on the part of the audit concerning procurement. Overall, we determined that Public Services and Procurement Canada had supplied solid support to the Public Health Agency of Canada, enabling it to obtain enough doses of COVID-19 vaccines to vaccinate everyone in Canada. Between December 2020 and May 2022, the federal government purchased 169 million vaccine doses. Over 84 million of these were administered to the population.

● (1310)

[*English*]

Public Services and Procurement Canada used its emergency contracting authority. This provided the department with flexibility on a number of fronts, including using a non-competitive approach to procure vaccines from companies recommended by the COVID-19 vaccine task force.

The department established advance purchase agreements with seven companies that showed the potential to develop viable vaccines. We found that the department exercised due diligence on the seven vaccine companies. For example, the department examined whether the companies had the financial capability to meet the contractual requirements and were eligible to do business with the federal government. The department reached an agreement with Medicago on November 13, 2020.

The government's strategy was to secure agreements with several vaccine companies, in case Health Canada authorized only one vaccine. While this approach meant Canada could end up with a surplus if all seven vaccines were eventually approved, it also increased the chances of securing enough doses to support the largest vaccination program in the country's history.

Mr. Chair, we are happy to answer the committee's questions where possible. However, given the confidentiality of the agreements, we are unable to discuss details relating to contracting costs or fulfilment for any of the specific agreements.

This concludes my opening remarks.

Thank you.

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

Next, from the Department of Public Works and Government Services, we have Andrea Andrachuk for the next five minutes.

Welcome.

[*Translation*]

Ms. Andrea Andrachuk (Director General, Department of Public Works and Government Services): Good afternoon, Mr. Chair.

I'm pleased to be appearing before the Standing Committee on Health to discuss the work of Public Services and Procurement Canada on the advance purchase agreement for COVID-19 vaccines with Medicago.

I wish to acknowledge that this meeting is being held on the traditional unceded territory of the Algonquin Anishinaabe nation.

I am accompanied today by Ms. Joëlle Paquette, the director general of the procurement support services sector.

From the earliest days of the pandemic, the Government of Canada's objective was to secure safe and effective vaccines as rapidly as possible. Early in the pandemic, there were many uncertainties and it was unclear whether developing safe and effective vaccines was even possible. This uncertainty created high global demand and Canada made every effort to secure advance purchase agreements with vaccine companies for future promising vaccines.

Scientific and industry experts on the COVID-19 Vaccine Task Force advised that the quickest route for the government to get vaccines was to pursue a diverse portfolio of potential vaccines as early as possible.

Public Services and Procurement Canada, on behalf of the Public Health Agency of Canada, established seven advance purchase agreements with promising vaccine manufacturers, including Medicago, a Canadian supplier. The advance purchase agreement with Medicago was signed in November 2020 and included a firm commitment of 20 million doses, to be delivered before the end of December 2021, with options for up to an additional 56 million doses.

The contract was approved by the then Minister of Public Services and Procurement, following the approval of the Public Health Agency of Canada, and following approval by a Deputy Minister Committee for COVID-19 vaccines.

As Medicago had received authorization from Health Canada for its Covifenz vaccine in February 2022, the contract was amended to allow the delivery of doses before the end of December 2022.

As part of overall supply management in mid-2022, the Public Health Agency of Canada expressed an interest to reduce or eliminate Medicago dose deliveries, in an effort to right-size inventories, and prevent wastage and logistics costs.

Also at that time, Medicago was experiencing production challenges, which caused some delivery delays. Discussions were undertaken with Medicago to terminate the contract.

In February 2023, Mitsubishi, the parent company of Medicago, announced intentions to proceed with an orderly wind-up of Medicago operations in Canada and the United States and not to pursue the commercialization of the Covifenz vaccine.

● (1315)

[*English*]

The government recently shared that a $150-million non-refundable advance payment was made to Medicago in accordance with the advance purchase agreement, that Medicago met all terms for the payment, that the contract was terminated by mutual consent, that Medicago was released of its obligations under the advance purchase agreement and that no doses of Covifenz were delivered.

This advance payment was agreed to in negotiations in order to fund at-risk production of the vaccine prior to Health Canada authorization. In the termination by mutual consent, the government had no contractual right to request a return of the payment.

The government is committed to being as transparent as possible while respecting the confidentiality clauses in these vaccine purchase agreements. Significantly, this agreement with Medicago, along with the six others, was the subject of the Auditor General's report in December 2022. In April 2023, the government shared unredacted copies of the seven advance purchase agreements with the parliamentary Standing Committee on Public Accounts. Senior officials from Public Services and Procurement Canada appeared in two in camera sessions with the committee.

Mr. Chair, Public Services and Procurement Canada played a key role in supporting the Public Health Agency of Canada's efforts to ensure the delivery of COVID-19 vaccines as soon as we could acquire them, helping save Canadian lives.

Thank you. I'm happy to take your questions.

The Chair: Thank you very much.

We'll now begin with rounds of questions, starting with the Conservatives for six minutes.

Mr. Perkins, go ahead.

Mr. Rick Perkins (South Shore—St. Margarets, CPC): Thank you, Mr. Chair.

Thank you, witnesses.

My questions will all be for Public Services and Procurement Canada.

October 18, 2020, is when the first agreement was signed with Medicago for $200 million. Presumably on the advice of Health Canada and all the organizations, you signed that agreement. Were you aware that the World Health Organization would not do business with any company that is owned by a tobacco company?

Ms. Joëlle Paquette (Director General, Procurement Support Services Sector, Department of Public Works and Government Services): Thank you for the question, Mr. Chair.

We put a contract in place with Medicago for doses at a time when we needed—

Mr. Rick Perkins: I don't need an explanation about what the situation was like.

You knew Medicago was 40% owned by Philip Morris. Is that correct?

Ms. Joëlle Paquette: Yes, we did.

Mr. Rick Perkins: You knew the WHO would not interact with any company that had anything to do with tobacco, regardless of the efficacy of a vaccine.

Is that correct?

Ms. Andrea Andrachuk: I'm not sure whether or not we were aware. I'm just not—

Mr. Rick Perkins: It's an international agreement signed by the Government of Canada in 2005.

Are you not aware of the WHO's international agreement on the relationship with tobacco companies?

Ms. Andrea Andrachuk: With the advance purchase agreement with Medicago, the intention was to procure vaccines for Canadians to respond to the pandemic. It was an emergency contract for the sole purpose of—

Mr. Rick Perkins: I understand it was an emergency contract.

In other words, you weren't aware of it. You knew it would have no ability to.... Either you didn't know and didn't do your due diligence, or you were aware there would be no ability to have any kind of international purchase beyond this country. The reason this is important is that, when you signed for—according to the president of Medicago at the public accounts committee—$773 million in vaccines that were never produced, you knew all of those doses would have to be consumed in Canada. They could not be exported.

What's the purpose of signing a contract with a company and investing $200 million of taxpayer money for those dosage numbers, in addition to everything else the Auditor General outlined, 180 million doses of various vaccines? It seems totally irresponsible for the government to do that, knowing it wasn't possible to have those exported.

● (1320)

Ms. Joëlle Paquette: We put the contracts in place to obtain enough doses for all Canadians at the time. We did not know—

Mr. Rick Perkins: That's enough for five or six doses.

The Chair: Mr. Perkins, you took a minute to pose the question. You need to listen to her try to answer it for at least a minute.

Go ahead, Ms. Paquette.

Ms. Joëlle Paquette: We did not know, at the time, which vaccines would actually be authorized. No vaccine existed at the time we put these contracts in place. We took the risk of putting in contracts with various suppliers for enough vaccines for all Canadians.

Mr. Rick Perkins: You spent over $200 million as a commitment to develop a vaccine that was not mRNA and that was owned by a tobacco company, not knowing that the WHO agreement that Canada signed would prohibit it from going anywhere else in the world. It doesn't seem very responsible to me. Then, you contracted $773 million for doses, according to Medicago. This is a billion-dollar scandal over taxpayer money for zero doses received. You just admitted there were zero doses received.

Who owns the IP?

Ms. Joëlle Paquette: Medicago owns the IP.

Mr. Rick Perkins: Wow, that's unbelievable. That's $200 million of taxpayers' money to fund a company owned by the Japanese in order to develop a vaccine that I understand had over 70% efficacy. It got developed knowing it couldn't be released. On top of that, it was contracted for about.... I don't know how many doses $770 million would buy at $20 a dose. That's probably about 10 doses per person in Canada.

We're on the hook for $150 million. They never produced a single vial of the vaccine, and you think that's good.

The Auditor General thought this was good efficacy, too. It goes to whether or not they did a value-for-money audit. I don't know how spending $773 million on a vaccine that could never be produced or exported is good value.

What is the motivation for the department to sign such a horrible deal, when we don't even own the IP? Now the Japanese own the IP, on top of everything else. Is that correct?

Ms. Andrea Andrachuk: Medicago owns the IP.

Mr. Rick Perkins: It's a Japan-based company.

Ms. Andrea Andrachuk: It is owned by Mitsubishi.

Mr. Rick Perkins: Do you know how much Medicago paid for Philip Morris's remaining 40% in December of last year—almost a year ago?

Ms. Andrea Andrachuk: No, I do not have that information.

What I can confirm, as I mentioned in my opening remarks, is that the amount paid by Canada to Medicago was $150 million, not $200 million.

Mr. Rick Perkins: No, it's $150 million for the breaching of a contract—their inability to deliver the vaccines. We also paid almost $200 million of taxpayer money to develop the vaccine.

Ms. Joëlle Paquette: We put a contract in place with Medicago for 20 million doses. At the time, we paid the $150 million for at-risk manufacturing, because the company did not have an authorized vaccine at the time. They would have had to start manufacturing the vaccine prior to the authorization.

The Chair: Thank you, Mr. Perkins.

Thank you, Ms. Paquette.

Next, we have Mr. Jowhari, please, for six minutes.

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you.

First of all, good morning and welcome to our committee.

I have a preamble. It was during a very difficult time. Our government chose to take a multipronged approach. We signed, as you highlighted, seven advance purchase agreements. That's the purchase part of the vaccine. It was both international and, in the case of Medicago, domestic. We invested a lot of money into R and D, both domestically and internationally. We also realized that we really needed to build a domestic capacity.

When we look at Medicago, this is a cross between the very well-thought-out strategy of purchasing, which is hedging bets; focusing on R and D, both domestically and internationally; and building domestic capacity.

Was it a sound strategy? I would say yes. Did we execute it? I believe, when we look at the $172 million that was spent.... Did it generate the result? I would say, yes, it did, because we managed to get a vaccine approved by Health Canada. Did we know that the World Health Organization was not going to approve this vaccine because of its affiliation with a cigarette-manufacturing company? I don't know, and we are not 100% sure. That might be an area that's worth diving into a bit deeper.

On the issue of IP, the federal government, through various programs, invests in the work of many companies, and the IP remains with the company. I just finished making an announcement on Friday about a company, Visual Defence, into which the Government of Canada, through Scale AI, invested about a million dollars, and the IP belongs to the company. I'm not sure that who owns the IP should be the focus of this.

I think what we need clarification on...and this leads to the question I'm about to ask you. What did the Government of Canada pay $150 million for, aside from the $172 million, which we can justify? What did we pay the $150 million for, and what did we get as a result of that?

Anyone can answer that question.

● (1325)

Ms. Andrea Andrachuk: The $150 million was an advance payment. It was intended to support at-risk manufacturing by Medicago, meaning that Medicago had to proceed to conduct activities before it knew whether it would have Health Canada authorization. That represented a risk for the company. These payments were intended to fund those at-risk activities.

Mr. Majid Jowhari: Can you expand on what an at-risk activity means? In my mind, I'm looking at $172 million, and the $172 million went into R and D, setting up a facility, hiring people, doing R and D, growing, extracting, running clinics, etc.

What is the difference between the $172 million and the $150 million?

Ms. Andrea Andrachuk: As officials from Public Services and Procurement Canada, we can't speak to the strategic innovation fund amounts. For those questions, I would refer you to Innovation, Science and Economic Development Canada.

For the advance purchase agreement, the $150 million advance payment was intended for at-risk manufacturing, meaning activities leading up to the commercial-scale production of the doses that were intended to be done prior to Health Canada authorization. That was to enable Medicago to get doses produced as quickly as possible, so we could get them in the arms of Canadians.

Remembering the context at the time, we know that when we entered into this advance purchase agreement, there were no COVID vaccines approved anywhere in the world.

Mr. Majid Jowhari: In my mind, if I go back and say that we allocated $150 million to Medicago to start building the facility, with the anticipation that $172 million was going to pay off and that we were going to have a vaccine, and we wanted a manufacturer ASAP, that is where the money went. Am I right to understand this?

The terminology “at risk”, for a layperson like me, is a bit difficult. Is this where we spent the money?

Ms. Andrea Andrachuk: Due to confidentiality clauses in the agreement related to negotiations, we can't go into details on where the money was intended to be spent and what it may have been spent on, but we can say that it was for at-risk manufacturing.

Mr. Majid Jowhari: Okay, it was for at-risk manufacturing.

I have about 30 seconds left.

Can you explain why confidentiality clauses would still apply even when the contract was unfulfilled?

Ms. Andrea Andrachuk: Confidentiality clauses were included in all seven advance purchase agreements, and they survive the termination of the contract, meaning that even when the contract ends, those clauses remain applicable, both to the supplier—Medicago—and to the Government of Canada. It's a two-way confidentiality clause.

Mr. Majid Jowhari: Okay.

The Chair: Thank you, Mr. Jowhari.

[*Translation*]

Ms. Vignola, you have the floor for six minutes.

● (1330)

Mrs. Julie Vignola (Beauport—Limoilou, BQ): Thank you very much, Mr. Chair.

Ms. Andrachuk, you mentioned in your address that Medicago had met all the conditions of the forward purchase agreement signed with the Government of Canada.

Can you tell us what these conditions were?

Ms. Andrea Andrachuk: Unfortunately, I can't answer your question because of the confidentiality clauses.

Mrs. Julie Vignola: Okay.

I won't speak about the conditions, Mr. Hayes, but if they were met, I'd like to understand why $150 million was entered under the heading “Losses of public money due to an offence, illegal act or accident”.

Mr. Andrew Hayes: The advance payment was properly reflected in the government's financial statements. That year, a loss was recorded because the agreement between the government and Medicago was terminated without any doses of vaccine having been delivered.

Mrs. Julie Vignola: That must therefore be categorized as an accident. It is certainly neither an offence nor an illegal act.

Is that right?

Mr. Andrew Hayes: Yes, that is the case.

Mrs. Julie Vignola: All right. Thank you.

Ms. Andrachuk, would you agree that the World Health Organization, the WHO, decided to reject the vaccine, not because it was ineffective, but because a minority shareholder was a tobacco manufacturer?

[*English*]

Ms. Andrea Andrachuk: I understand that the reasons communicated by the World Health Organization related to the ownership of Medicago and not to the vaccine itself.

Again, our purpose for the advance purchase agreement was to procure vaccines. The purpose was not for donation. The purpose—

[*Translation*]

Mme Julie Vignola: Okay.

So it had nothing to do with the effectiveness of the vaccine and everything to do with the shareholder.

[*English*]

Ms. Andrea Andrachuk: Yes, exactly.

[*Translation*]

Mrs. Julie Vignola: Thank you.

Was the vaccine properly evaluated, or did they simply look at the list of company shareholders?

[*English*]

Ms. Andrea Andrachuk: I don't have that information.

[*Translation*]

Mrs. Julie Vignola: If Canada had contravened this WHO verdict, what would the consequences have been?

Ms. Andrea Andrachuk: In February 2022, Health Canada approved the use of the vaccine in Canada. We therefore didn't need WHO approval.

Mrs. Julie Vignola: But was the vaccine distributed?

Ms. Andrea Andrachuk: We never received the doses from Medicago because the contract was terminated.

Mrs. Julie Vignola: If the contract had not been terminated, Canada would have been able to distribute the doses, but not internationally.

Have I got that right?

Ms. Andrea Andrachuk: Yes, that's right.

Mrs. Julie Vignola: Aramis Biotechnologies recently purchased Medicago's headquarters.

By purchasing the headquarters and the attached greenhouse units, has Aramis Biotechnologies automatically acquired Medicago's intellectual property?

Ms. Andrea Andrachuk: I don't have that information.

Mrs. Julie Vignola: Thank you.

You said that seven advance purchase agreements had been signed for the vaccines. We know that the one with Medicago didn't work, but what about the remaining six?

Were vaccines received under each of the other six agreements?

Ms. Andrea Andrachuk: One more contract was cancelled, but the other five delivered.

Mrs. Julie Vignola: Which of the other contracts was cancelled?

Ms. Andrea Andrachuk: It was the contract with Sanofi.

Mrs. Julie Vignola: How much did that cost us?

Ms. Andrea Andrachuk: I don't have that information either.

Mrs. Julie Vignola: Okay.

Could you send that information to the committee, please?

Ms. Andrea Andrachuk: Yes, I will.

Mrs. Julie Vignola: Thank you very much.

Mr. Hayes, you spoke about 169 million doses. Do the 169 million doses ordered include those borrowed under the international COVAX mechanism?

Mr. Andrew Hayes: Yes, that figure includes all doses made available to Canada.

Mrs. Julie Vignola: All right.

Did we reimburse, if I can use that term, COVAX? Did Canada return the doses it had in hand under the COVAX mechanism?

Mr. Andrew Hayes: I don't know. That's perhaps a question for the department.

Ms. Joëlle Paquette: It would more likely be a question for the Canada Public Health Agency.

Mrs. Julie Vignola: So we didn't use all of the 169 million doses of the vaccine.

What happened to the tens of millions of doses that we didn't use?

Mr. Andrew Hayes: We completed our audit work and the report mentioned the figures we knew about at that time. At the moment, we don't have the data required to accurately tell you what happened to these doses.

● (1335)

Mrs. Julie Vignola: Okay.

So we purchased 169 million doses. We used 84 million. Let's assume that some of the doses had reached their expiration date before being used and that others were sent abroad.

Is that a fair assumption?

Mr. Andrew Hayes: I think so. It's also likely that some had been wasted for a variety of reasons.

I think your suggestions are correct.

Mrs. Julie Vignola: Okay.

So we paid for the wasted doses.

In the public account reports, what section would itemize these losses, or this waste.

Mr. Andrew Hayes: I'll have to ask the other audit teams. I'll be able to give you an answer later.

Mrs. Julie Vignola: Great.

Thank you.

The Chair: Thank you, Ms. Vignola.

[*English*]

Next, we have Mr. Davies, please, for six minutes.

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

To Public Works, on what date did the Government of Canada decide to release Medicago of its obligations?

Ms. Andrea Andrachuk: The contract was terminated in June 2023.

Mr. Don Davies: Can you explain why the Government of Canada decided, or consented, to terminate the contract and release Medicago of its obligations?

Ms. Andrea Andrachuk: The contract was terminated by mutual consent, meaning that both parties were interested and agreeable to the termination. Medicago—

Mr. Don Davies: I'm asking why the Government of Canada did it. I understand it was mutual. I want to hear why the Government of Canada did it.

Ms. Andrea Andrachuk: The Government of Canada, as part of its overall supply management, and seeking to reduce logistics costs and rightsize inventories, was interested in either reducing or eliminating deliveries of Medicago doses. This occurred at the same time that Medicago was experiencing some challenges in achieving commercial-scale production.

Mr. Don Davies: Was it because the WHO determined that Medicago would not be allowed to market its vaccines, because of its connection to the tobacco industry? Did that figure into the Government of Canada's thinking?

Ms. Andrea Andrachuk: The reason had to do with supply management, looking at the number of doses.

Mr. Don Davies: The government initially refused to provide any details on this loss, stating that this information could not be divulged because of confidentiality agreements with the contractor. I think you referred to that a few times today.

Paragraph 22.3(h) of the Government of Canada's contract with Medicago, which was disclosed to this committee in June 2021, says, "Canada will be permitted to disclose Confidential Information of the Contractor for the purposes of government administration and operations, and in the exercise of Crown privileges. For greater clarity, this includes reporting to the Parliament of Canada".

Can you outline why the Government of Canada did not believe that this provision would permit it to disclose the last $150 million to Parliament, when it explicitly says so?

Ms. Andrea Andrachuk: We make all efforts to respect the confidentiality clauses in the contracts. The suppliers of all seven advance purchase agreements have indicated how important this is for their business. Whether that clause could allow us to release additional information or not would need to be further studied, but—

Mr. Don Davies: Aren't transparency and accountability to Parliament and the taxpayers who pay this money important?

Ms. Andrea Andrachuk: The Government of Canada has made all efforts to be transparent with these contracts. We provided fully unredacted copies of all seven advance purchase agreements to the parliamentary Standing Committee on Public Accounts. Furthermore, unredacted copies of the contracts were provided to the Auditor General and subject to a report, and officials—

Mr. Don Davies: With respect, we forced the government to do that at the health committee as well when they were fighting us tooth and nail not to provide those contracts, but I'll move on.

In April 2022, Dr. Gaston De Serres, a medical epidemiologist at the Quebec national institute of public health, noted this:

> De Serres said the problems Medicago would have had in getting a COVID-19 vaccine with close ties to the tobacco industry approved by the WHO were "quite obvious," and that the federal government "should have known" this issue would arise before investing in it.
>
> "They wouldn't have to work hard to know that Philip Morris was also an important shareholder," he said.

Can you confirm whether the Minister of Public Works and Government Services was aware of Medicago's ties to big tobacco prior to signing an advance purchase agreement with the company?

● (1340)

Ms. Andrea Andrachuk: The Government of Canada was aware, but the purchase agreement with Medicago was intended to purchase doses for Canadians in response to the pandemic. World Health Organization approval was not required for that purchase and for us to get doses delivered for use by Canadians.

Mr. Don Davies: In 2004—almost 20 years ago—Canada ratified the legally binding WHO Framework Convention on Tobacco Control. This treaty states that a government should not accept, support or endorse partnerships with the tobacco industry or any entity or person working to further its interests. Given that Philip Morris International owned 21% of the Medicago shares when the Government of Canada signed its advance purchase agreement, can you explain why the government didn't believe this entity was working to further the interests of the tobacco industry?

Ms. Andrea Andrachuk: Early in the pandemic, there was intense global competition to secure vaccines. There were no approved vaccines worldwide, and countries were pursuing very aggressive procurement strategies to get doses as soon as possible. Because Canada didn't have strong domestic capacity, we didn't have a strong footing to procure vaccines. The goal of the government was to procure vaccines as early as possible to get them in the arms of Canadians.

Mr. Don Davies: I respect that, and that makes a lot of sense, but the issue here is that Canada was also a signatory to a legally binding treaty that said it would not sign a contract with a company with significant ties to the tobacco industry. That's the nub of the question here and that's why we lost $150 million, because ultimately, the WHO would not permit the Medicago vaccine to be sold commercially, which is why the taxpayers lost $150 million. What am I missing with that take on this?

Ms. Joëlle Paquette: The Government of Canada put a contract in place with Medicago to obtain vaccines for Canadians. They received Health Canada approval, and had we had the vaccine, we would have been able to vaccinate Canadians.

Mr. Don Davies: Why didn't we proceed in that respect, then?

The Chair: Thank you, Mr. Davies. That's your time.

[*Translation*]

Mr. Deltell, you have the floor for five minutes.

Mr. Gérard Deltell (Louis-Saint-Laurent, CPC): Thank you very much, Mr. Chair.

Ladies and gentlemen, welcome to the House of Commons.

It gives me no pleasure, Mr. Chair, to be here today.

I'm a guy from Quebec City. I was a journalist and I'm very familiar with Medicago, because I used to write about the company.

I find everything about this saga very troubling, because it's clear that it's been contaminated by a virus—not a medical virus, but an ownership virus.

On February 27, 2005, Canada and 181 other countries around the world signed the WHO Framework Convention on Tobacco Control, which specifically says in point 3 of article 5 of the convention that "Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry".

Since 2005, it has been clear that when the tobacco industry applies for funding, it cannot, according to the WHO, move forward. The application would not be recognized.

In 2008, Philip Morris International became a 21% shareholder in Medicago.

In March 2020, in the middle of the pandemic, it's understandable that everyone should want to find a solution. On March 23, the government announced that it would help companies conduct scientific research. The press release states that: "The funding will enable Medicago to rapidly advance their clinical trials and then expand production to respond to the pandemic".

Did you know at the time, Ms. Andrachuk and Ms. Paquette, that the Medicago company had a tobacco corporation as a shareholder and that it would accordingly never be recognized by the WHO?

A yes or a no will do.

Ms. Joëlle Paquette: The Public Safety Agency of Canada asked us, after receiving scientific advice, to proceed with the signing of a purchase agreement with Medicago.

Mr. Gérard Deltell: Here's my question: Did you know that Medicago had a tobacco manufacturer as a shareholder and that as a result, the WHO would never recognize the work that had been done?

Did you know, yes or no?

[*English*]

Ms. Andrea Andrachuk: We were aware of the partial ownership by PMI.

Mr. Gérard Deltell: Why did you go on?

Ms. Andrea Andrachuk: We could not presume what decisions the World Health Organization may or may not have taken.

[*Translation*]

Mr. Gérard Deltell: Ms. Andrachuk, how could you not anticipate that, when an agreement signed in 2005 by Canada and 181 countries states clearly in black and white that work in which the tobacco industry is involved will not be recognized?

How could you just assume that they would not abide by this agreement?

● (1345)

[*English*]

Ms. Andrea Andrachuk: The COVID-19 pandemic was an unprecedented situation.

[*Translation*]

Mr. Gérard Deltell: I know, but the wording is clear.

The Chair: Mr. Deltell, we on this committee adopted a rule according to which witnesses can give an answer that is as long as the question they were asked. I would therefore ask you to stop interrupting witnesses before they have had the opportunity to give a full response.

Mr. Gérard Deltell: Mr. Chair, that's why I'm asking for a yes or no answer.

Ms. Paquette, did you know, yes or no?

Ms. Joëlle Paquette: We knew that the company was partly owned by a tobacco manufacturer. The vaccines were purchased for Canadians, because we didn't know who would have a reliable vaccine for Canadians.

Mr. Gérard Deltell: So you knew that the WHO would not recognize Medicago's work.

Isn't that the case?

Ms. Andrea Andrachuk: We could not anticipate what the WHO would decide, given the uncertainty around the world owing to the pandemic.

[*English*]

It was never before seen. We were in completely new circumstances. We couldn't presume what the WHO would do.

[*Translation*]

Mr. Gérard Deltell: When the federal government awarded $173 million to Medicago in October 2020, did you warn the political decision-makers of the situation, yes or no?

Ms. Joëlle Paquette: You'd have to ask the people at Innovation, Science and Economic Development Canada.

Mr. Gérard Deltell: Did you warn the people at Innovation, Science and Economic Development Canada about the existence of this virus within Medicago ownership, which ensured that the WHO would never approve its vaccine?

Ms. Joëlle Paquette: We were not involved in that decision-making process. Canada signed an agreement with Medicago to obtain vaccine doses for Canadians at a time when no other vaccines were available.

Mr. Gérard Deltell: As Canada was a signatory to the WHO Framework Convention on Tobacco Control, does this mean that Canada breached its own signature?

Ms. Andrea Andrachuk: I can't answer that question today.

Mr. Gérard Deltell: Canada signed the WHO Framework Convention on Tobacco Control, and point 3 of article 5 is clear. There is to be no funding of research in which the tobacco industry is involved. That was precisely the case for Medicago, and that's why we are stuck with this problem today.

The Chair: Thank you, Mr. Deltell.

[*English*]

Ms. Sidhu, go ahead, please, for five minutes.

Ms. Sonia Sidhu: Thank you, Chair.

My question is for Public Works.

It's important to emphasize that the decision to halt the operation of the Medicago vaccine is not in any way related to the safety of the vaccine or to other technical reasons. Multiple research reports state that the Medicago vaccine was effective in preventing COVID-19 caused by many variants, with efficacy ranging from 69.5% against symptomatic infection to 78.8% against moderate to severe disease. According to the New England Journal of Medicine, the participants in these studies were from 85 centres across Argentina, Brazil, Canada, Mexico, the U.K. and the U.S.A., which pointed to the benefit of the vaccine for people worldwide.

Can you talk to us about the trial process and what information was made available to you about it?

Ms. Joëlle Paquette: You would have to direct that question to the Public Health Agency of Canada.

The vaccine task force studied the potential vaccines, and they provided advice. Then the Public Health Agency advised Public Services and Procurement Canada to proceed with advance purchase agreements with those seven vaccine suppliers.

Our role is to purchase on behalf of another government entity what they require in order to deliver on their programs.

Ms. Sonia Sidhu: Can you explain how risk was shared in this environment?

● (1350)

Ms. Joëlle Paquette: What risk?

Ms. Sonia Sidhu: On the advance purchase agreements, the agreement with Medicago was announced on October 23, 2020. Health Canada approved Pfizer's COVID-19 vaccine on December 9 of that year. In fact, all the agreements entered into were negotiated at a time when none of these manufacturers had approved products yet.

Can you tell us how that uncertainty affected PSPC's work in negotiating these advance purchase agreements?

Ms. Joëlle Paquette: We entered negotiations with all of these suppliers to obtain a share of their vaccines as soon as they would be available for Canada. We were in a position where globally all of these same vaccine suppliers were also trying to obtain agreements with other countries. The objective was for Canada to obtain agreements with them as soon as possible so that we would have a viable solution of a vaccine as soon as they obtained Health Canada approval.

We succeeded with Pfizer and Moderna in December to have vaccines for Canadians. It was a risk of possibly not having any vaccine with any of these suppliers, but we took that risk, not knowing which one would obtain Health Canada approval and when.

Ms. Sonia Sidhu: Thank you.

Can you tell us what exactly Medicago was contracted to do? What were the milestones that this contract work measured against?

Ms. Andrea Andrachuk: The advance purchase agreement with Medicago was awarded in November 2020, and there was a firm commitment for 20 million doses to be delivered by the end of December 2021, as well as optional additional doses of up to 56 million.

The contract was later amended. Because the Health Canada authorization was received in February 2022, the contract was amended to change the delivery of the 20 million firm doses to the end of 2022.

Ms. Sonia Sidhu: Mr. Chair, how much time do I have?

The Chair: You have 30 seconds.

Ms. Sonia Sidhu: I'll pass it on. Thank you.

The Chair: Thank you, Ms. Sidhu.

[*Translation*]

Ms. Vignola, you have the floor for two and a half minutes.

Mrs. Julie Vignola: Thank you very much, Mr. Chair.

Ms. Andrachuk, do you know whether the government is currently in negotiations with the Mitsubishi Chemical corporation to obtain the intellectual property rights on Medicago technology?

Ms. Andrea Andrachuk: We are not currently in negotiations. The contract has been terminated.

Mrs. Julie Vignola: For the time being then, we don't know whether Aramis Biotechnologies has purchased the intellectual property rights along with the plant, and the status of intellectual property is unknown.

Is that right?

Ms. Andrea Andrachuk: We at Public Services and Procurement Canada are not in negotiations.

Mrs. Julie Vignola: When it was publicly established that Philip Morris International was a Medicago shareholder, Philip Morris International sold its Mitsubishi Chemical shares. After that, Mitsubishi Chemical decided to wind up Medicago. Mitsubishi chemical is not itself bankrupt.

If there had been an agreement between the Government of Quebec, the Government of Canada and a third party, would we now be talking about a $150 million loss for the Government of Canada?

Would the company have been more likely to be able to continue its operations?

[*English*]

Ms. Andrea Andrachuk: I don't think we can presume what decisions Medicago may or may not have taken. That is not ours to speak to.

I can speak to the point of view of the Government of Canada, which was also conducting supply management activities, looking at all doses we received through the seven advance purchase agreements. For the part of the Government of Canada, that was a consideration on the side of Medicago.

I understand Medicago may also be appearing before this committee. Perhaps it is a question that could be further asked to them.

[*Translation*]

Mrs. Julie Vignola: Thank you.

The Chair: Thank you, Ms. Vignola.

[*English*]

The last round of questions for today will come from Vancouver, I believe.

Mr. Davies, you have two and a half minutes.

Mr. Don Davies: Thank you, Mr. Chair. No, I'm in Ottawa.

I'll pick up the thread. You stated that there are no negotiations currently going on between the government and Mitsubishi to obtain the IP produced by Medicago. Was there such negotiating going on, and if so, when did it end?

● (1355)

Ms. Andrea Andrachuk: To clarify, I'm here today as an official of Public Services and Procurement Canada. There are no negotiations currently being led by Public Services and Procurement Canada with respect to procurements.

I cannot speak to the full government on that point.

Mr. Don Davies: The reason I ask is that the Minister of Innovation, Science and Industry, François-Philippe Champagne, stated to the press on November 7—about a month ago—that the government was in the process of negotiating a settlement with Mitsubishi to obtain the intellectual property produced by Medicago.

Do you have any knowledge of that?

Ms. Andrea Andrachuk: The question would be better referred to Innovation, Science and Economic Development Canada.

Mr. Don Davies: Okay.

In November 2023, just a month ago, a former Parliamentary Budget Officer, Kevin Page, was quoted in the National Post saying, “It seems wrong that the PHAC refuses to answer your questions about how money has been spent or written off”.

Similarly, the current Parliamentary Budget Officer, Yves Giroux, commented that the government's initial refusal to disclose details about the $150 million lost due to the unfulfilled contract with the vendor was “highly unusual”.

Do you agree with that assessment?

Ms. Andrea Andrachuk: The Government of Canada is very careful to respect confidentiality agreements included in the contracts. The government has provided fully unredacted copies to the Standing Committee on Public Accounts as well as to the Auditor General to be inspected.

Officials from Public Services and Procurement Canada appeared—

Mr. Don Davies: If that's the case.... You interchangeably say you can't do it because of confidentiality and then you contradict yourself by saying that you gave the full, unredacted contracts—and you're here today talking about the contract.

I'm not clear—

Ms. Andrea Andrachuk: Those were all provided with appropriate confidentiality agreements in place with those who were viewing those agreements. The information they received was maintained confidential.

There was also a redacted copy of the seven advance purchase agreements provided to this committee earlier.

Mr. Don Davies: Finally, given the grave impact of tobacco on public health and the well-documented history of malfeasance from the tobacco industry, can you explain why the Government of Canada didn't take a strong position by refusing to enter into a contract with a company that had such strong ties to an international tobacco producer who is linked to a known carcinogen?

Ms. Andrea Andrachuk: The main goal of the Government of Canada was to secure safe and effective vaccines for Canadians as early as possible. The procurement strategy taken was all with that goal in mind. That is why there was a diverse portfolio of seven different vaccines pursued in order to get best chances. Given that there was a lot of risk at the time, we didn't know which vaccines, if any, would get Health Canada approval, and even if they did, we didn't know when they would be available.

The Chair: Thank you, Mr. Davies.

Thank you to all of our witnesses.

That concludes the round of questions.

Colleagues, I remind you that we're meeting on Wednesday evening from 6:30 to 9:30. There's one hour on this study and two hours on women's health.

To all of our witnesses today, thank you so much for your service to Canadians. Thank you so much for being available to come to committee and for answering our questions so patiently. This is our first hour on this topic, and there will be several others, so, once again, it's a good foundation for us to work from. We really appreciate your being here.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: We're adjourned.