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# Committees as Agents of Public Policy: The Standing Committee on Health

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by Bonnie Brown MP in collaboration with Nancy Miller Chenier and Sonya Norris

Long before phrases such as “democratic deficit” and “empowerment of MPs” became fashionable the 1985 Report of the Special Committee on Reform of the House of Commons (McGrath Report) called for a strengthened role for standing committees of the House in shaping public policy. It recommended “wider use of parliamentary committees to review draft legislation, to conduct general inquiries when policy choices have not been made, and to bring in draft bills.” Overall, it insisted that standing committees should play an important part in influencing policy through the legislative process. As a result the Standing Orders were modified to allow some Bills to be sent to committee before Second Reading. This has been done on a few occasions. However it was not until very recently that the government went even further and following the recommendation of the McGrath Report asked a Parliamentary Committee to review and report on draft legislation before it was even introduced in the House. The issue was assisted human reproduction and in 2001, Allan Rock, Minister of Health, asked the Standing Committee on Health to examine and formulate policy on this complex and controversial topic. This article reflects upon the use of this approach to giving members of Parliament a greater role in the legislative and policy process.



When the Health Committee began its consultation, assisted human reproduction had for more than a decade been the focus of numerous government and societal activities. From 1989 to 1993, a Royal Commission on the New Reproductive Technologies (RCNRT) studied the social, ethical, health, research, legal and economic implications. In its lengthy 1993 report entitled *Proceed with Care*, the Commission

made 293 recommendations. A central recommendation declared that reproductive technologies required a federal legislative framework immediately to implement prohibitions in areas such as selling human eggs, sperm, zygotes, or fetal tissue; advertising for, paying for, or acting as an intermediary for surrogacy; and using embryos in research related to cloning. The report also focused on the creation of the National Reproductive Technologies Commission (NRTC) to oversee licensing and to monitor reproductive technologies and practices.

In 1995, then Health Minister, Diane Marleau announced a voluntary moratorium on certain related practices, such as cloning of human embryos, commercial surrogacy, buying and selling of eggs, sperm and embryos, and other activities that were deemed to be unethical and socially unacceptable. In 1996, the new Min-

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ister of Health, David Dingwall, introduced Bill C-47, cited as the *Human Reproductive and Genetic Technologies Act*, in order to establish boundaries around some of the technologies and prohibit certain practices. This Bill included additional prohibitions against the use of human sperm, eggs, or embryos without the informed consent of the donor and against research on human embryos later than 14 days after conception or their creation for research purposes only. After receiving some legislative scrutiny in a House of Commons sub-committee, the Bill died on the order paper with the call of the 1997 general election.

Over the same period and behind the scenes, public servants were working on the issues raised by the Royal Commission. From 1993 to 1996, Health Canada coordinated a Federal-Provincial-Territorial Working Group to advise deputy ministers of Health. In 1996, departmental officials worked with an advisory committee of knowledgeable Canadians established to track moratorium compliance and emerging reproductive and genetic technologies.<sup>1</sup> In 1999, Health Canada brought forward an overview discussion paper<sup>2</sup>, and followed the next year with a workbook and feedback document.<sup>3</sup>

Against this background of continuous but incomplete efforts to regulate assisted human reproduction, Minister Rock turned to the House of Commons Health Committee. In May 2001, he tabled in Parliament a document entitled *Proposals for Legislation Governing Assisted Human Reproduction*. This draft of the legislation was accompanied by an implicit commitment to introduce legislation dependent upon the review by the Committee.

The Minister of Health indicated that the federal government was ready to move to the comprehensive approach advocated by the RCNRT.<sup>4</sup> The Minister had reasons to seek the perspectives of a committee representing diverse personal and political views. As he noted, "The issues raised by assisted human reproduction leave no one indifferent. They are complex and are important to many Canadians and to our society as a whole. The Government believes that it is important at this juncture that Canadians and their elected representatives in Parliament have an opportunity to discuss the draft legislation".

In agreeing to review the draft legislative proposals, the Health Committee was consenting to a process seen as one element of crucial reform for parliamentarians. At this point, the Standing Committee on Health became: a forum for public consultation, a filter for contentious debate, and an agent for policy development on an issue that had already consumed more than a decade of debate

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## The Committee as a Forum for Public Consultation

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When the Minister of Health approached the Standing Committee on Health, he wanted an open public avenue for an examination of the draft legislation on assisted human reproduction; advice on options for a possible regulatory body that would govern the implementation of the legislation and monitor developments, and a consideration of the structure and responsibilities of international regulatory bodies that oversee similar projects in other countries. In addition to the readily available evidence gathered from witnesses at meetings, the Committee would provide overall advice through its report and recommendations.

***Parliamentary committees play a key role in organizing public consultation through their inquiries into particular subjects.***

Public meetings provide a particular focus for public interaction and input into policy formulation. They are a place where Canadians, sometimes as individuals and often as representatives of a group, can meet, place their views on public record, and then examine and react to other views. In the process, Committee members can become aware of some of the choices that must be made among competing ideas and of some of the interests that promote specific choices. At the same time, department officials and ministerial advisers can use these public forums to stay abreast of any changes in the direction of the debate.

As the Health Committee organized its public meetings to gain understanding of the dimensions of assisted human reproduction, members became aware of the multiple demands that confront policymakers. Following an initial meeting with the Health Minister, officials from the department provided explanatory information over three meetings. To meet its information needs and to encourage public participation from involved groups, the Committee organized meetings that included the former Chair of the Royal Commission on Reproductive and Genetic Technologies and members of the Health Canada Advisory Committee on the Interim Moratorium on Reproductive Technology. Small groups of witnesses then addressed issues related to the medical technologies and medical practices, ethical and faith perspectives, surrogacy, embryonic and adult stem cell research, anonymous gamete and embryo donation, enforcement and inspection, therapeutic cloning, databases, registries and privacy, informed consent, regula-

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tory bodies and federal versus provincial jurisdictional issues.

In the absence of a travel budget, the Committee issued invitations to representatives from provincial governments as well as many fertility clinic directors to attend meetings in Ottawa. However, these efforts to elicit public testimony or written contributions produced little acknowledgement from provincial representatives while clinic directors seemed to rely on various medical associations to present their views. In addition to written briefs received from individuals affected by infertility, the collective concerns of the infertile community were represented on many of the diverse issue panels through related associations.

To gain knowledge from other countries, the Committee staff collected information and documentation from the United Kingdom, Australia, Germany, the United States, and others with relevant experiences of regulation. After this information was assessed to identify the structures and responsibilities that could be pertinent to the Canadian context, it provided background for teleconferenced meetings with international witnesses.

The Committee hearings were the source of many new ideas and suggestions for changing the proposals. Children produced through assisted human reproduction and other witnesses told Committee members of the negative effect of a secretive, anonymous system of donation of sperm, eggs and embryos. A panel of Catholic, Muslim, Jewish, Buddhist and Evangelical Christian representatives informed members of the widely divergent religious views about the status of the embryo. Ethicists revealed the divergent and evolving ethical views in their community. Scientists and other presenters provided revelations about new scientific or medical breakthroughs, revealing the speed of change in the field. Committee members learned more clearly the role of the fertility clinics and how they specifically interact with the research community.

Some groups expressed their discontent with the proposals and with the Committee process by sending multiple representatives to inflate the size of panels and by showing up in large numbers at significant meetings. Other witnesses representing the views of people who used or wanted access to the reproductive technologies pressed individual Committee members to hear their concerns.

Throughout the hearings, departmental officials were ready witnesses, frequently available on short notice for clarification of legal, scientific and policy questions arising from the "proposals for legislation". Along with ministerial advisers, they were regular attendees at the public meetings of the Committee. They provided a key

source of advice to the Committee while at the same time keeping the Minister informed of changes in the direction of the debate among committee members and of additional or new issues raised by witnesses.

### **Addressing the Complexities of Assisted Human Reproduction**

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In the public hearings and in other encounters, the Committee members heard from a wide variety of individuals and groups. They learned about the many different outcomes expected and desired from the assisted human reproduction legislation. For some, the primary concern was the well-being of the children resulting from the procedures; for others, it was the health and safety of the women undergoing the interventions. Some supported the potential benefits for scientific and medical research accruing from the ongoing work while opponents to this view called for an end to all research in the field.

Among the scientific research community, many expressed the desire to pursue research on embryonic stem cells. While embryonic research continued in areas such as fertility, miscarriages and congenital illness, researchers had felt restrained in their pursuit of embryo research involving stem cells. The scientific community was sensitive to the controversy surrounding this research and as legislation was anticipated, they took the position that embryonic stem cell research would not be pursued until legislation was in place. This position was supported by the Canadian Institutes of Health Research and by various associations representing ill Canadians who perceived embryonic stem cell research as their best hope for a cure and who hoped that it would soon be undertaken. In general, the scientific research community supported the legislation including the restrictions that it placed on researchers.

Numerous individuals in the infertile community and in fertility clinics indicated that they had continued to pursue their respective goals freely in the period following the Royal Commission report. Various commercial activities had developed around assisted human reproduction procedures. Infertile couples had successfully built their families on the services offered for a price by physicians, lawyers, and others. While these players claimed to welcome some regulation to the field, they were generally opposed to those parts of the Bill that restricted their activities. In some instances, the infertile community and others were involved in practices that were non-compliant with the moratorium. For example, there was a continuation of payment to sperm and egg donors as well as for surrogacy arrangements.

Other individuals and groups in the community were adamantly opposed to the use of human embryos in any

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research endeavour and were supportive of restrictions on the commercial activities of the infertility industry. Many were strongly in favour of the clauses that outlawed payment to donors and surrogate mothers. People who themselves had been born as a result of reproductive technologies wanted an end to the anonymity of sperm and egg donors. Some witnesses questioned the appropriateness of federal criminal sanctions in the area of reproduction.

***From this diversity of opinion, members of the Health Committee tried to find the path that could be supported by a broad range of Canadians who had no compelling personal or other interest in the subject matter of the Bill.***

To achieve consistency, the members developed a framework of principles that was then used to assess particular options. Their effort to find a consensus across the range of issues (ethical, scientific, health, economic, legal, political) posed a tremendous challenge. Ultimately, their report reflected the collective process of clarifying and making alternative proposals in the multiple problematic policy areas.

### **The Committee as an Agent of Public Policy**

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In the broadest sense, policy is whatever governments choose to do or not to do and Parliament is not always involved in the act of choosing. In many policy situations, the selection of the outcomes and the mechanisms for achieving them within a specified situation fall to other institutions. In 2001, however, the Health Committee agreed to participate in the development of the broad policy framework within which decisions about assisted human reproduction could be taken. Action was needed in relation to the issue and Parliament was asked to get involved in sorting out the multiple ideas and values.

While the Committee accepted the offer of the Minister to undertake the project, it quickly indicated that it did not feel constrained in its review. As its study proceeded, members were clear that they did not accept all of the policy directions suggested in the draft proposals. Most importantly, they identified a lack of connection between and among the various thrusts of the legislation. They could not find an underlying philosophical principle animating the proposals.

They agreed generally with the list of prohibited activities and with the broad areas designated for control.

They saw the need for national oversight of many aspects of assisted human reproduction. They were particularly pleased that there would be data collection that could be used to assess the short and long-term health effects of the infertility drugs and the various procedures for women and for the resulting offspring.

However, they also had numerous and varied questions that highlighted the enormous complexities of the subject covered in the draft proposals. Was research an appropriate use of embryos created for Assisted Human Reproduction (AHR) but no longer needed for that purpose? Was provincial equivalency a useful way to encourage uniform provincial legislative action in AHR? Were there enough limitations on surrogacy arrangements? Should the donors of sperm, eggs and embryos be compensated? Should donors remain anonymous? Could ensuring the availability of objective and independent counselling strengthen the informed consent provisions? Should the AHR proposals be administered by the Minister or by officials in an arms-length regulatory body? Should the legislation distinguish between clinical procedures and research?

As the Committee proceeded with its study, members applied their own perceptions to the various elements of the proposals and in so doing; they gained valuable insights into the underlying problems. As policy agents, they saw the tension among the medical, scientific, social and ethical perspectives. This in turn led them to develop different options than those proposed by the department in the draft legislation.

In common with other public policy agents, the Committee members tried to put a ranking order on the various options and attempted to ensure a balance among the often-contradictory ideas underlying each proposal. In doing so, they identified areas where the health department appeared willing to take action and other areas where it appeared to prefer inaction, or, at the least, a more passive role.

### **Concluding Observations**

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At the beginning of the process, MPs on the committee were enthusiastic about the challenge they faced. When they tabled their report in December 2001 called *Assisted Human Reproduction: Building Families*, they felt satisfied with a task well done. They demonstrated an increased awareness of specific practices and of particular legislative issues. They were more conscious of the competing policy and legislative demands of various individuals and groups across Canada.

In January 2002, the commissioning Minister, Allan Rock was replaced by Anne McLellan who tabled legisla-

tion in the House of Commons in May of that year.<sup>5</sup> Although Committee members were disappointed that key areas in the Bill did not follow the recommendations of their report, they undertook the work of hearing witnesses and reviewing the Bill on a clause-by-clause basis. This work was now complicated by a change in Committee membership and the appointment of new members who had neither been part of the earlier knowledge-gathering process nor of the consensus it had produced.

However, the Committee did manage to amend the Bill to make it more reflective of many earlier efforts before reporting it back to the House. Committee members continued to reveal strong disagreement with several of the legislative clauses. For example, members pushed for more controls on surrogacy and an obligation for independent professional counselling prior to all AHR procedures. In considering the particular form and composition of the regulatory authority and its relation to the Minister of Health and to Parliament, they called for guards against conflict of interest of members and a requirement for at least 50% representation by women on that Board.

Members continued to seek changes during debate in the House of Commons and during Report stage between January and March 2003, the Bill underwent seventeen additional amendments, ten of which were government amendments while the remainder came from Liberal members of the governing party. However, not all the changes reflected the earlier thinking of the Committee report. Two of the government amendments actually reversed changes made in the Committee during clause-by-clause consideration; specifically the calls for at least 50 per cent female membership and guards against conflict-of-interest on the proposed board of the regulatory authority.

From the perspective of parliamentary reform, there are several key observations from this committee experience. It is important to point out that this committee, composed of individuals from five different political parties and diverse personal and professional backgrounds, demonstrated the ability and willingness to work collectively and consistently in a very consensual fashion on a very difficult subject.

In a process that was new for all members, they examined in an open and responsive way a wide range of disparate policy, and ultimately legislative, options. They explored the nature of various tradeoffs that were important in arriving at a final decision on each aspect. In the process of hearings with the Canadian public and with the health department, they enhanced their own knowledge and that of the public during committee discussions. They set aside large amounts of time following the

public hearings to consider the drafting of the report. Enormous efforts were made to resolve differences through discussion and through compromises in particular wording of the report.

In taking on the task of reviewing draft legislation in a public way, the Health Committee demonstrated the value of informed parliamentary input into policy considerations. The process provided an opportunity for serious learning by parliamentarians about a complicated and controversial issue. In turn, it permitted an open and accessible dialogue among the general public, specific interests, departmental officials and parliamentarians that improved the legislative outcome.

While many speak blithely about parliamentary reform and empowerment of MPs, the AHR case demonstrates that it is more easily said than done. To be successful, Cabinet Ministers and their officials must make a genuine commitment to share their decision-making power.

Once embarked on a course of power sharing, it is important that a Cabinet Minister should remain in place until the project is concluded. If a new Minister is installed, his or her predecessor's commitment to share power should be honoured. When the power is to be shared with a Standing Committee, the membership of that committee should remain the same from start to finish.

The advantage to the Government is that group of MPs representing all political parties and all regions of the country have time to work out a consensus. When the consensus is reflected in the legislation that follows, the law is more likely to be one that most Canadians can and will support.

**Editor's Note:** At the time this article was written, before the House reconvened in September 2003, the Bill was still awaiting Third Reading.

## Notes

1. Health Canada, *News Release*, "Comprehensive National Policy on Management of New Reproductive and Genetic Technologies Proposed," June 14, 1996.
2. Health Canada, "Workbook for Purposes of Discussion Only - Issues and Related Questions, Ottawa, February 2000.
3. Health Canada, *Feedback Report - Discussions and Written Comments on Proposed Federal RGTs Legislation*, Ottawa, June 2000.
4. Health Canada, *News Release*, Ottawa, May 3, 2001.
5. Bill C-56, *An Act respecting Assisted Human Reproduction* was tabled in May 2002 and was reintroduced without change as Bill C-13 following prorogation in September 2002.