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**EVIDENCE**

## Wednesday, February 2, 2005

## Chair

**Mr. John Williams**

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● (1535)

[*English*]

**The Chair (Mr. John Williams (Edmonton—St. Albert, CPC)):** Good afternoon, ladies and gentlemen.

Pursuant to Standing Order 108(3)(g), our order of the day is chapter 4, "Management of Federal Drug Benefit Programs", of the 2004 report of the Auditor General of Canada, referred to the committee on November 23, 2004.

Our witnesses today are from the Office of the Auditor General of Canada. We have Mrs. Sheila Fraser, the Auditor General of Canada; Mr. Ronald Campbell, Assistant Auditor General; and Mr. Frank Barrett, a director in the office.

From the Department of Health we have Mr. Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch; Hélène Gosselin, Associate Deputy Minister; Leslie MacLean, Director General of the Non-Insured Health Benefits Directorate, First Nations and Inuit Health Branch.

From the Department of Veterans Affairs we have Verna Bruce, Associate Deputy Minister; Mr. Ron Herbert, Director General, National Operations Division; and Orlanda Drebit, Director, Operational Guidance and Direction Directorate.

We will try to wrap the meeting up around 5:20 because we have a report from the steering committee and I think a motion will be coming forward. We'll try to do that in the last few minutes.

Without further ado, Ms. Fraser, you have an opening statement.

**Ms. Sheila Fraser (Auditor General of Canada, Office of the Auditor General of Canada):** Thank you, Mr. Chair.

We thank you for this opportunity to discuss chapter 4 of our November 2004 report, entitled "Management of Federal Drug Benefit Programs".

As you mentioned, I am accompanied by Ronnie Campbell, Assistant Auditor General, and Frank Barrett, director, both of whom were responsible for this audit.

The use of pharmaceutical drugs is a fact of life for many Canadians and has fundamentally changed the face of health care. Federal drug programs spent $438 million in 2002-03, funding drug benefits for about one million Canadians. The cost of these programs has risen some 25% over the past two years.

Six federal organizations manage drug benefit programs: Health Canada for first nations and Inuit; Veterans Affairs Canada for veterans; National Defence and the RCMP for their members; Citizenship and Immigration Canada for certain designated classes of migrants; and Correctional Service Canada for inmates of federal penitentiaries and some former inmates on parole.

Health Canada, Veterans Affairs Canada, the RCMP, and National Defence all share responsibility for improving or maintaining the health of their respective clientele. They also have claims-processing databases that capture detailed information on some 13 million individual transactions of their clients each year. Nevertheless, we found that most of these programs failed to provide pertinent information about prescription drug use to health care professionals—information that could benefit clients.

[*Translation*]

For example, we found that the number of Health Canada clients that receive more than 50 prescriptions in a three-month period had almost tripled since our report in 2000, even after correcting for growth in the number of clients in the program. As well, in 2002-2003, Health Canada had hundreds of clients obtaining multiple narcotics from more than seven doctors and more than seven pharmacies. The same is true with the tranquilizer benzodiazepine. Unlike that of Veterans Affairs Canada, Health Canada system was not programmed to send alerts to pharmacists for the situations when these events occur.

In our 2000 follow-up of the 1997 audit of Health Canada's Program on First Nations' Health, we found that Health Canada had been making satisfactory progress in its drug use analysis and had shown a decline in the number of cases involving access to large amounts of central nervous system drugs. This intervention was stopped in 1999, however, pending resolution of the department obtaining consent from their clients. Our audit found that no analysis had been conducted between 1999 and 2004. This is the third time we have raised this issue with Health Canada. We are disappointed that it has not been resolved.

We also found that the government is paying tens of millions of dollars more than necessary each year because it does not take advantage of some well-known cost saving measures.

While we had many concerns, we also found some good practices in each of the organizations we examined. For example, Health Canada uses comprehensive risk-profiling techniques to identify pharmacies for audit. If these and other good practices were used by all the programs, we believe there would be significant benefits for the programs, without negatively affecting health outcomes or compromising operational activities.

● (1540)

[*English*]

We made several recommendations, including that the federal government establish an arrangement to develop a core formulary, pursue cost-saving opportunities, and establish a single-fee schedule for dispensing fees. This recommendation also entailed that the federal government develop a common auditing process of the 7,400 pharmacies in Canada. We believe that prompt action to these recommendations is in the interest of people who depend on these programs, and it is also in the best interests of taxpayers.

In their overall response the federal organizations agreed with all of our recommendations, and committed to providing our office with specifics and timing of actions to be taken within a few months. I understand that the Federal Healthcare Partnership plans to table a joint action plan representing commitments from all six organizations, by the end of this month. We suggest that the committee ask that it also be provided with this action plan and regular updates, and conduct appropriate follow-up sometime in the future.

Mr. Chair, this concludes my opening statement. We would be pleased to answer any questions the committee may have. Thank you.

**The Chair:** Thank you, Madam Fraser.

Before we turn to Madam Gosselin, the Associate Deputy Minister of Health, I think I'm correct in saying that you've given us a number of tables regarding your report. They will be deposited with the clerk, and if anybody would like to get a copy of these tables they can apply to the clerk of the committee and receive a copy of them at that time.

There's also a letter from the Minister of Health to Mrs. Fraser, the Auditor General. I believe that's been tabled with the committee as well. He has asked Health Canada to give priority to responding to the implementation of remedial measures to address the recommendations of the Auditor General. Again, that will be deposited with the clerk, and if anybody wishes to have a copy they may ask for it.

Madam Gosselin, it's over to you for your opening statement, please.

[*Translation*]

**Mrs. Hélène Gosselin (Associate Deputy Minister, Department of Health):** Thank you, Mr. Chairman. I am pleased to be here today to speak to Chapter 4 of the Auditor General's November report on the management of federal drug benefit programs. Health Canada welcomes the recommendations of the Auditor General. These recommendations and those of this committee have helped improve the Non-Insured Health Benefits program and indeed the safety of our clients.

I have been the Associate Deputy Minister of Health Canada for about five weeks. Therefore, I don't have much first hand experience with this program. However, I felt it important to be here today to demonstrate clearly the commitment of Health Canada's senior management to respond fully to all the recommendations of the Auditor General.

As you have just said, Mr. Chairman, the minister has also made clear his commitment to ensuring that all of the recommendations are implemented.

To answer your questions about the program, with me today are Ian Potter, who is the Assistant Deputy Minister of the First Nations and Inuit Health Branch, and Leslie MacLean, who is the director general of the Non Insured Health Benefits Program.

In addition, we have invited two colleagues who are also prepared to respond to your questions. They are Marie Williams, executive director of the Federal Health Care Partnership, and Bob Nakagawa, co-chair of the Independent Drug Utilization Evaluation Committee.

I would like to address the work done by Health Canada to respond to the key issues raised by the Auditor General's report, namely concerns with respect to client safety, the need for improved cost management, and the need for better coordination among federal plans.

We recognize that while Health Canada has put in place remedial measures to address the recommendations made by the Auditor General in previous years, our progress has been slower and analyzing the use of drug information generated by our claims process.

We have worked very hard with our First Nations and Inuit partners, and with health professionals, to find a way to achieve safer use of prescription drugs while taking into account privacy concerns with respect to sensitive health information. I am pleased to report today that we have put in place new measures to address clients at risk and that we will fully implement a robust drug use review system within the year.

● (1545)

[*English*]

In 2003 the non-insured health benefits program established a group of independent experts to provide guidance on analyzing drug use. The program now conducts analyses of drug use at the aggregate level and, thanks to a new approach to address the privacy of client information, also at the individual level.

This allows the program to contact health care providers to alert them to potential issues or problems. For example, in November 2004 a bulletin on the use of aspirin for diabetic clients was distributed to 15,000 health care providers. With the client's consent the program now also communicates individual drug use information to pharmacists when our analysis indicates that a potential issue or problem exists.

We also continue to monitor actively and to audit pharmacists' responses to online warning messages. In 2003 we had over 300,000 drug rejection messages, which resulted in pharmacists not filling prescriptions in 232,000 cases.

The second issue we have been working on is cost management. The non-insured health benefits program is the largest federal drug benefit plan. Some 8,000 pharmacies across Canada bill the federal government for claims made by some of the 750,000 people covered, many of whom live in remote areas. In 2003 there were 10 million drug claims totalling $288 million.

We agree with the Auditor General that more effort is needed to better manage costs, and we have put in place a number of measures to do so. For example, we have implemented new methods to bring our fees more in line with the provinces. Furthermore, we have reduced dispensing fees for some drugs, changed the way some drugs are listed, and promoted the use of generic drugs wherever appropriate. This alone has resulted in annual savings of $10 million.

Finally, with respect to increasing coordination among federal plans, I know that my colleague Verna Bruce will speak to this further as chair of the Federal Healthcare Partnership, but I would like to say that this remains a priority for Health Canada and that we will continue to work with our federal partners to move in the direction recommended by the Auditor General. I would like to note that as a part of this work we will be re-examining legislative options that could address the issue of the collection and disclosure of health information.

We feel that we have accomplished much, but we are fully aware that there remains a great deal more to be done. The action plan we have tabled with the committee details the steps we have undertaken to date and our plans going forward. We will be pleased to answer your questions today and to provide the committee with regular updates on our progress.

Thank you very much for your attention.

**The Chair:** Thank you very much, Madam Gosselin.

Now we'll turn to Madam Verna Bruce from the Department of Veterans Affairs for her opening statement.

**Ms. Verna Bruce (Associate Deputy Minister, Department of Veterans Affairs):** Thank you very much, Mr. Chair, for inviting us here today to talk about Veterans Affairs Canada's pharmacy program in relation to the Auditor General's November report. In our minister's words—and I quote—"It acts as a tonic to further improve our drug plans and provides Veterans Affairs Canada with an opportunity for even more focused collaboration with our federal health care partners."

[*Translation*]

I am pleased to introduce Mr. Ron Herbert, director general of our National Operations Division and Ms. Orlanda Drebit, Director of Operational Guidance and Direction. They will help me answer any questions you might have on our pharmacy program and our response to the report.

[*English*]

As chair of the Federal Healthcare Partnership, I would like to recognize Marie Williams—who is with us here today—and the work she has been doing with the partner departments in response to chapter 4.

Since 1994 the Federal Healthcare Partnership has capitalized on economies of scale for the purchase of health care benefits through negotiations on various types of medical equipment, supplies, and services, including oxygen, audiology equipment, vision care, and pharmacy. This collaboration has been and will continue to be a priority for Veterans Affairs Canada and has resulted in cost savings for several Veterans Affairs programs.

In addition, the Department of National Defence and the RCMP both partner with us on the federal health claims processing system, of which the pharmacy adjudication system forms a part. These partnerships have certainly been mutually beneficial; what is even more important is that they have also been beneficial for our respective clients and for all Canadians.

The Department of Veterans Affairs' pharmacy program is sizeable. This year we estimate spending $119 million on the pharmacy program as a result of an estimated 4.5 million transactions. We have taken measures to contain cost growth within the veterans affairs department and have been successful over the last five-year period in keeping growth at an average rate of 7%, despite the increasing age of our elderly veteran clients. Nevertheless, we always welcome any suggestions or recommendations that may help make our program more efficient and cost-effective.

I have tabled a draft action plan that outlines work already taken or planned in order to address the recommendations and observations contained in the Auditor General's report. For example, in Veterans Affairs we've learned more about establishing measurable objectives for pharmacy programs through the Federal Healthcare Partnership participation, and we've already created an initial draft of our objectives and performance measures.

Regarding moneys owed to the crown as a result of pharmacy audits, we believe we are making excellent progress in establishing and implementing a process to ensure that the amounts owing are reported in the public accounts and are expeditiously recovered. Now that we've established a process, the work will be ongoing.

One of the main issues highlighted by the Auditor General is adverse drug use. As she noted in her report, Veterans Affairs' drug utilization review process has been in place for seven years now. We have already increased the complement of resources attached to drug utilization review, and we've scheduled a workshop for next month to review existing criteria and to try to develop a more robust model.

I want to note that Veterans Affairs does take a holistic approach to managing client needs, including pharmaceutical needs. The drug utilization review process involves interdisciplinary case management, screening for risk, and ongoing monitoring, providing personal contact with our clients to ensure that all of their needs are being met.

I would like to assure committee members that we are addressing the situation cited by the Auditor General in which Veterans Affairs' clients, particularly senior clients, appear to be receiving quantities and/or combinations of pharmaceutical products that could have a negative impact on their health. We have requested the relevant files from the OAG and have already conducted an initial analysis. A team of health professionals will conduct a thorough review of these cases.

And while our drug utilization review process allows us to identify and deal with such potential issues, this review process must balance the identification and resolution of problems with limitations imposed by our regulatory and legislative frameworks, and the requirement to protect the privacy of the client. We are updating our drug utilization review policy, which was referenced in the Auditor General's report, to reflect the involvement of the Privacy Commissioner, as we were required to do.

Veterans Affairs Canada has agreed to lead a federal health care partnership working group to explore the recommendations around cost-effective drug use and system efficiency with respect to a centrally managed process.

In closing, I would like to thank you again for the opportunity to discuss our pharmacy program. It's a program we're proud of and one which balances the needs of our clients with the needs for cost-effectiveness.

● (1550)

**The Chair:** Thank you very much.

Again, you have also tabled an action plan. It will be deposited with the clerk and will be available, for anybody who would like to get a copy of it, by application to the clerk.

Mr. Allison, you're first. You have eight minutes, please.

**Mr. Dean Allison (Niagara West—Glanbrook, CPC):** Thank you.

And thank you to the witnesses for appearing before us.

My first question is to Ms. Fraser. In the 1997 audit the Auditor General noted that the department had been aware of problems with regard to prescriptions and drug use and had found no evidence that the ease of access to prescription drugs had changed in any significant way. The audit showed that the department had been aware of this problem for ten years.

I guess my question is, when I look at the 2004 audit, not only has this not been addressed, but from what I can see it's on the increase. Is that a fair perception of where we're at in terms of prescription drugs and their abuse?

**Ms. Sheila Fraser:** I think the statistics that we indicate in the report show there is a continuing, and I would say even growing, problem, although I would say—and I think the department could probably respond to this—that there were actions taken by the department. I think there was a whole issue around consent, which quite frankly diverted a lot of attention from other actions that could have been taken, perhaps, at least to identify remedial action that would have been possible without having consent. A lot of effort went into this whole issue of consent, and I'm sure the department can brief you on that.

While it's important to go back, the important thing is to look forward. Hopefully with the action plans that are being tabled and the commitments by the departments, when we do the next follow-up audit—and I can assure you there will be a follow-up audit—the situation will be significantly different.

● (1555)

**Mr. Dean Allison:** My question, then, to whomever, is has there been a change? Are we seeing an improvement year over year?

As I said, I see a report that says the department has been aware and nothing has been done for ten years. I see the 2004 audit that says the number of clients receiving 50 or more prescription drugs almost tripled since the 2000 audit. It talks about medium- and high-risk people being on the increase. Has anything really changed in the last 14 or 15 years?

In the back here, I see there have been recommendations that were to have been followed through prior to you arriving, yet nothing has been done. What's different this time?

**Mrs. Hélène Gosselin:** The short answer is yes, there have been improvements. I think in the report there was particular focus on the analysis of drug use by our clients. As Madame Fraser has noted, we spent a considerable amount of time and effort on trying to address the privacy rights of our clients.

But on the safety side, I would like to mention a couple of other measures that have been in place for a number of years in the program to try to address the safety issue. For example, since the 1990s we have had messages in our electronic system so that we can give real-time messages to pharmacists when they're filling prescriptions, so that if there is a possible interaction with another drug or if there are duplicate drugs, duplicate therapies, multiple pharmacies, they get a warning on their screen. That's a safety measure that has been in place for a number of years.

We have also been monitoring very closely the use of override codes by pharmacists. When they get these messages, they can override the messages and fill the prescription. We've been monitoring their use of override codes, auditing them, and where the codes have been used without appropriate justification, we recover the cost. We see that this is having an impact, because although the number of claims processed under the program has increased, the number of prescriptions filled through overriding warning messages has actually decreased.

**Mr. Dean Allison:** I appreciate that, but my question is that you say you have had a system in place for the last couple of years, yet we hear how there are 128 medium-risk and 94 high-risk clients who are receiving multiple narcotics simultaneously through a combination of seven or more doctors. If it's being monitored, how can this still happen?

**Mrs. Hélène Gosselin:** There might be a legitimate reason for these patients of those doctors to be receiving them.

**Mr. Dean Allison:** So if an individual is dealing with seven or more doctors, there's a legitimate purpose in that?

**Mrs. Hélène Gosselin:** There might be. Each case is individual.

We've also resumed individual drug use analysis. That's the point Madame Fraser was alluding to, which is that we have put in place a new approach to seek the consent of our clients or beneficiaries of the program and we have resumed analysing the drug use that they make so that we can provide even additional information to pharmacists, or indeed to physicians, where there are patterns like the one you're mentioning. Then it's up to the pharmacists and the physicians to look at the situation and to judge whether or not they should fill the particular prescription or whether they should take other steps to address the concern.

**Mr. Dean Allison:** I would just think it highly irregular that you would have over 200 clients receiving multiple narcotics simultaneously through seven or more doctors. I can see maybe a couple of doctors, but seven or more doctors doesn't seem to make a lot of sense.

The next question I have, though, is about the number of clients receiving 50 or more prescriptions having almost tripled since 2000. How do you explain that? I mean, 50 prescriptions is a prescription a week. I would think prescriptions would be filled for a month or two, or three months at a time. How do we explain that?

**Mrs. Hélène Gosselin:** We are looking into it, and I can ask Mr. Potter to give us additional information, but I will give you an example of some of the circumstances we're finding.

We might find doctors who give prescriptions in smaller quantities so that they can monitor more closely the progress of their patients, so they would get more prescriptions over time but with smaller quantities.

We're finding different answers to some of the patterns we've identified that would indicate possible concerns, but sometimes there are legitimate reasons.

It's the same answer for the one about seven doctors. For example, in some of the cases we've looked at, individuals have moved and have had difficulty finding family doctors, so they go to clinics.

I think Mr. Potter can give additional examples of some of the circumstances.

● (1600)

**Mr. Dean Allison:** Okay, thank you.

I'll go back to the Auditor General.

Once again, this doesn't seem very likely in terms of normal protocol in the real world, in terms of where we go to get prescriptions and have them filled. Can you explain it? This doesn't add up, as far as I'm concerned.

**Ms. Sheila Fraser:** As Mrs. Gosselin mentioned, there are, feasibly, cases where this could happen. I think we've mentioned even in the report other cases that initially would look unusual on the face of it and look suspicious, but there could be valid reasons.

The point we're making is that the department should be doing this analysis, quite frankly. It shouldn't be the auditor doing this sort of analysis to see what the trends are and analysing the data. There is a lot of data being collected, and the departments should be doing this kind of analysis on an ongoing basis to see what problems are potentially there.

We were able to do all of this without infringing on any privacy issues. We anonymized all the clients by using codes. So there are ways they can do this sort of work to see what the trend lines are, where the problems are. They can identify pharmacies that are giving out multiple prescriptions. That doesn't infringe on privacy things.

So there are many things, and many of the recommendations in here are things that can be done to help correct some of those issues.

**The Chair:** Thank you very much, Mr. Allison.

[*Translation*]

Mr. Sauvageau, please. You have eight minutes.

**Mr. Benoît Sauvageau (Repentigny, BQ):** Ladies and gentlemen, good afternoon. Welcome to our committee. My first comment and my first question are for Ms. Fraser.

I'm a little surprised, but sometimes good things happen when there is good faith. You tabled your audit report of which chapter 4 is of particular interest to us. We also heard from Ms. Verna Bruce and Ms. Hélène Gosselin. Both witnesses have said they accept all the recommendations and that they will do everything they can to implement them.

What is your reaction to what the witnesses said and to their responses with regard to chapter 4 of your report? Are you partially or completely satisfied with the follow-up?

**Ms. Sheila Fraser:** The Office of the Auditor General of Canada is never satisfied until another audit has been carried out which concludes that things have indeed changed. It would be premature for me to give you an opinion at this point. However, it is obvious that the departments have shown a willingness to act. They ask questions, they produce action plans which can eventually be followed up, and we even received a letter from a minister saying he is determined to act. So for me, this shows that there is a real willingness to implement our recommendations.

**Mr. Benoît Sauvageau:** You are perfectly right, we don't know what the results will be yet. However, Health Canada and the Department of Veterans Affairs have told us that they will implement a plan which will contain specific objectives and that they will give a copy of this plan to the Office of the Auditor General of Canada, to the Standing Committee on Public Accounts and to Parliament. We can't always presume that people are acting in bad faith. Once in a while, people can do well, isn't that right?

**Ms. Sheila Fraser:** In fact, I find it encouraging. I wanted to point out that there is a willingness to do what is necessary to address the problems we raised in our report. I hope that when we do our follow-up, we will find positive results.

**Mr. Benoît Sauvageau:** I would now like to turn to the representatives from Health Canada. About one million Canadian men and women are covered by your program. Correct me if I'm mistaken, but I seem to understand that the costs increased by 25 per cent over three years.

Is this normal, even if expenditures in the area of research and development are very high? Is the situation comparable in the provinces and territories? Are your standards three times higher than international standards? Can you tell us why costs increased by 25 per cent since the last audit?

**Mrs. Hélène Gosselin:** Mr. Potter can give you a more complete answer, but I can tell you that we are in the process of examining this issue. There are reasons why costs have increased, and it's because of the rising cost of pharmaceutical products and the increasing number of people covered by our program, that is our clients.

Mr. Potter can provide you more details on that subject.

● (1605)

[*English*]

**Mr. Ian Potter (Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health):** It's a pleasure to respond to that.

The Auditor General noted that the cost of the federal drug programs had risen 25% in the past two years. In that two-year period the overall percentage growth in drugstore expenditures—this would be with other drug plans.... The information gathered by a company called IMS indicated that in Canada the rate of growth would be 25%, so on average it's the same as the others. In some provinces, such as Quebec with its drug plan, it went up 27% and in others it was slightly less, but in that period it was about 25% on average.

[*Translation*]

**Mr. Benoît Sauvageau:** Fine. In her report, the Auditor General says that Health Canada should recover $2.1 million in over-payments to pharmacists. The overpayment to pharmacists by the Department of Veterans Affairs is $700,000, according to her report.

What measures have been taken to recover this money? After all, we are dealing with $2.8 million, which is not an insignificant amount.

**Mrs. Hélène Gosselin:** We have a program at Health Canada. It is part of our audit and recovery program.

Ms. MacLean can tell you more about how we proceed, but in fact what we do is recover money after conducting an audit which identified amounts paid out which should not have been.

**Ms. Leslie MacLean (Director General, Non-Insured Health Benefits Directorate, First Nations and Inuit Health Branch, Department of Health):** When we do our audits, we look at the claims to see if any information is missing. For instance, were there any valid reasons as to why a pharmacist may have ignored a warning? Are the prescriptions contained in the file in line with provincial regulations?

If those issues are not involved, auditors establish the amount to be recovered. That's when the process of clarification of the facts begins between pharmacists, the program and the auditors. As you can imagine, this process normally involves a lot of back and forth.

At the end of this process, an amount is established. It is sometimes recovered by not paying an invoice to a pharmacist. In English, this is called savings; in French, it is called *des économies*. Conversely, we sometimes recover the money when the pharmacist sends us a check. Of course, as Ms. Gosselin correctly pointed out, these amounts will be published in the next Public accounts.

**Mr. Benoît Sauvageau:** Fine. I still have a few moments left, Mr. Chairman. I have to say that the day before yesterday the committee heard witnesses from the Department of Indian Affairs and Northern Development. The calibre of the answers we are receiving today is markedly different from that of the answers we received then. I wanted to make that point.

In the research document prepared by our excellent research analysts, it says that the Auditor General, in point 4.106 of her report, recommends that:

> The federal government should establish an arrangement, characterized by a centrally managed process, which will permit it to [...] obtain the best value for each drug product listed on the core formulary;

If I correctly understood what you said in your presentations, you have made a firm commitment to completely implement this recommendation. You will set a timetable and objectives. So there is no problem with your implementing this recommendation with specific deadlines in order to save money. Is that what we are to understand?

**Mrs. Hélène Gosselin:** We have started a process together. Ms. Bruce is the chair of our partnership.

[*English*]

Do you want to add anything to answer this question?

**Ms. Verna Bruce:** Yes. In fact, it's an area we have been looking at very closely in terms of how the partners can work together. We believe there are opportunities here, and we will be working together on an action plan. We're taking the action plan very seriously. There are a lot of recommendations in the AG's report we do agree with.

We can't do everything at once. Our early process has been to try to identify which of those recommendations require us to work this year and which ones might be either more difficult or less fruitful in terms of cost reduction. We would look at doing them maybe next year or the year after. As the auditor has suggested, we'll be coming back to her with that action plan at the end of the month.

[*Translation*]

**Mr. Benoît Sauvageau:** Will you tell the committee what your timetable is so that we can also follow this process?

● (1610)

[*English*]

**Ms. Verna Bruce:** We would be happy to.

[*Translation*]

**Mr. Benoît Sauvageau:** Thank you.

[*English*]

**The Chair:** Merci beaucoup, Monsieur Sauvageau.

Mr. Murphy, please, for eight minutes.

**Hon. Shawn Murphy (Charlottetown, Lib.):** Thank you very much, Mr. Chairman. I want to thank the witnesses for attending here today.

I just have a couple of follow-up questions on this whole issue for you, Mrs. Bruce, in your capacity as chair of the Federal Healthcare Partnership and Associate Deputy Minister of Veterans Affairs. When I read all the material, your department seems to be doing a better job and seems to have a better handle on this whole situation. What I'm curious about is that when I read the material, I find that when you see instances of double doctoring or abuse of the prescription or pharmaceutical system, you seem to jump in and deal with it. Red flags go up and you seem to deal with it, whereas at the Department of Health they sense there are privacy restrictions that prohibit them from acting. How do you in your professional capacity deal with this issue where the other department can't?

**Ms. Verna Bruce:** Well, as you're aware, we're both bound by legislation of the Government of Canada, so the Privacy Act does become an issue for us as well. We've done a lot of work on our policies around privacy and consent, and I think the same thing happens in Health Canada.

In most instances people are quite happy to give you consent, but more than likely, if somebody doesn't want to give you consent, it's because there's a problem. It could be that somebody is suffering from addiction, or it could be that a particular mental illness doesn't allow them to make good decisions. In those instances we're working on protocols together.

It may be that we would still have to acquire the information and distribute it, but in instances like that we would go to the Privacy Commissioner first to advise him of what we were doing. It wouldn't stop us from doing it, but it would just give us an opportunity to make sure we were not violating an individual Canadian's rights, and we would count on the Privacy Commissioner to do that.

So in that instance Health Canada and the Department of Veterans Affairs are working closely together.

**Hon. Shawn Murphy:** What you're saying is if you see a problem in your files—and you would see the problem because it would all come through your file information—you try to get the consent of the client involved. If you don't get the consent, you still work on the file and you go right to the Privacy Commissioner and get his or her consent. Is that it?

**Ms. Verna Bruce:** Right.

**Hon. Shawn Murphy:** How long has this Federal Healthcare Partnership been in existence?

**Ms. Verna Bruce:** It's been in existence since 1994, a little over ten years. It started as a very small organization looking at some opportunities for cost reduction through joint purchasing, and it's really expanded in the last couple of years. We've made a lot of progress in a number of areas.

**Hon. Shawn Murphy:** My next question concerns the fact that these same procedures would probably be carried out in each of our ten Canadian provinces. I know the province where I live and Ontario both have a similar system, where they provide drugs to lower-income families and seniors, and they would be dealing with the very same problems federal agencies are. Has there been any analysis on best practices?

I know it's a big issue politically, where the pharmaceutical companies come in, they advertise these drugs, they say these drugs are much better than the drugs the person is on now, they convince the doctor of that, and there's always a lot of pulling and tugging between the medical community and the client as to what prescription drugs can be prescribed. I know it's always a big fight, but is your partnership, because Ontario's and other provinces' costs are probably as large as or larger than the federal government's...?

Perhaps I might ask you to comment on this as well, Mrs. Fraser. Has there been any dialogue with any of the provinces that are dealing with the very same issue, as I assume?

**Ms. Verna Bruce:** Certainly from the point of view of the Federal Healthcare Partnership, we are working with our provincial colleagues through the federal-provincial-territorial committees that have been established on health, so we do have the opportunity to work together there. That would be the first thing.

The second thing is that most of our programs tend to top up provincial programs, so within the veterans affairs department we work very closely with the provinces. The same would be true in many of the other programs. We work at it probably at two or three different levels. But you're right: there are huge provincial differences.

As we move forward, now we have the national pharmaceutical strategy as well, so it will be important to try to make sure that everything is moving together.

**The Chair:** Ms. Fraser.

**Ms. Sheila Fraser:** Mr. Chair, I think it might be of interest to the committee to know that this audit was done in conjunction with eight provincial auditors general. We developed the audit planning and the audit criteria together. Each auditor general of course conducted their own audit in their province, but we are using the same criteria.

Two provinces, Quebec and Nova Scotia, have already reported their results, and of the others, four will be reporting this spring and then two this December. We're looking to see if there are common messages that will come out of this such that we may make a kind of joint report to our respective legislatures. It has been a collaborative effort, and many of the same issues—cost savings and controlling drug costs—are coming up across the country.

● (1615)

**Hon. Shawn Murphy:** My comment on that is with current technology these things should be identified within seconds after they happen. It's unfortunate for the Canadian taxpayer, but it's more unfortunate for the individual concerned that these instances are allowed to continue.

That leads me to my next question, Madam Gosselin. I'm a little concerned about two things. One is your undertaking that you will be able to fulfill the recommendations of the Auditor General. I don't share that confidence myself. I see that it's probably going to take a fundamental change in the way your department operates in certain instances. I know you've only been in the job one month, but I'm sure you'll be brought back in front of the committee. Are you extremely confident that in six months' time, if you do appear back before this committee—and we are on the record now—the recommendations will be fulfilled?

**Mrs. Hélène Gosselin:** We've tabled with the committee a detailed action plan with timelines on the measures we've taken so far to respond to the most recent report. We've also tabled a longer action plan to detail all the steps we've taken to respond to the previous reports of the Office of the Auditor General. We've put detailed timelines in the report that we've tabled on the most recent report and we intend to come back and provide updates on our progress. And yes, we're committed to move forward.

We've already made some progress on the recommendation in the most recent report. We've already resumed the individual drug analysis that Madam Fraser was referring to. We're doing it at the aggregate level. We're looking at the issue of multiple pharmacists as well and we will be implementing an additional warning code that Madam Fraser has recommended we implement. So we're well on our way to respond to the recommendations made in the most recent report.

**Hon. Shawn Murphy:** I have one last question, Madam Gosselin, and that deals with the instance when your computer files indicate the clear examples of multiple prescriptions, multiple doctoring. I would suspect that if you delved into it deeper, you'd probably find offences under the Narcotic Control Act, maybe even the Criminal Code. Double doctoring is an offence. When a client goes to a physician, gets a narcotic, and goes across the street to another physician and gets another prescription for the same drug, we're dealing with a violation of a federal statute. At what point in time do you throw up your hands and say no, we've got to jump in here because the client is violating another federal act?

**Mrs. Hélène Gosselin:** We do undertake the analysis, as you say, and we have a group of internal pharmacists as well who review this analysis so that we don't highlight or use information inappropriately. We have a group of specialists that do review this information. We can report professionals to the relevant associations that regulate them, and if need be, we can also alert the appropriate authorities.

Leslie, did you want to add some information on this?

**The Chair:** Your time is up, Mr. Murphy.

The answer that I didn't hear to Mr. Murphy's question was when people go to a doctor and they are breaking the Criminal Code or another statute, do you take action?

**Mrs. Hélène Gosselin:** Yes, we do.

Leslie.

**Ms. Leslie MacLean:** As Madam Gosselin was saying, we're just completing our second run of data analysis for the three groups of clients identified at risk in the Auditor General's chapter. As Madam Gosselin said, we're then doing detailed clinical analysis and follow-up with pharmacists and prescribers. Where offences are reported, we're putting in place our protocols now to report people to the regulatory authorities, and of course that does include enforcement authorities as well.

**The Chair:** You seem to put this emphasis on pharmacists. What about individual Canadians? You seem to be sliding around that.

The other question is, have you ever reported anyone or any pharmacy for breaking the Narcotic Control Act or any other piece of federal legislation, including the Criminal Code? Have you ever done that?

● (1620)

**Ms. Leslie MacLean:** I know that in the past when the program was doing those detailed retrospective analyses, yes, health professionals were reported, not only to their regulatory bodies but I understand to law enforcement authorities and to clients of the program as well.

**The Chair:** So that's an ongoing program now.

**Ms. Leslie MacLean:** As we re-begin our retrospective drug-use analysis, protocols around reporting people to appropriate enforcement authorities will be part of what we address.

**The Chair:** Okay, it didn't quite answer your question, Mr. Murphy. You may have a very brief question to wrap this up.

**Hon. Shawn Murphy:** Just very briefly, if I may, and I guess it's to the Auditor General, the information indicates that the cost of the program.... And I know the profile of the veteran would be totally different, and this may not be a relevant question, but it looks to me as if we're spending $438,000 for approximately one million people, which equates to $438 per person. Is that in line with the average Canadian?

**Ms. Sheila Fraser:** I'm afraid we didn't do that kind of analysis.

**The Chair:** Thank you, Madam Fraser.

Mr. Christopherson, please, eight minutes.

**Mr. David Christopherson (Hamilton Centre, NDP):** Thank you, Chair, and thank you all for your presentations.

I'd like to revisit the issue of the number of prescriptions in a three-month period, because I'm still not clear how we got to where we are, why you didn't do anything about it sooner, and exactly what you're doing now. Maybe I'll just give you a chance to restate all of that for me.

**Mrs. Hélène Gosselin:** We've been tracking through our system: we have messages in our electronic system that alert pharmacists to duplicate drugs, duplicate therapies, multiple pharmacies. So we use a number of automatic messages when the pharmacists fill the prescriptions to alert them to potential problems. That's been in place for a number of years, since the 1990s.

**Mr. David Christopherson:** May I ask a question right there? I'm sorry to interrupt, but to get to the point, I don't have a lot of time. You're saying you put that in place for a number of years, and yet the Auditor General has raised this as an ongoing concern. I can ask her directly, if you wish, but it would seem to me that it's not satisfactory or it wouldn't be raised as an ongoing concern.

**Mrs. Hélène Gosselin:** What we stopped doing after we were alerted to privacy concerns was a retrospective analysis of the drug use of our recipients. For example, right now we've resumed doing that. We resumed that last year, in 2004. Each quarter we analyze for our high-risk users or high-risk narcotics, for example, the drug use of the beneficiaries for the last three months. That's what we stopped doing for a number of years that the Auditor General has particularly noted. We stopped because we were trying to find an approach to implement consent of our recipients. We've now done that and we've resumed these analyses.

**Mr. David Christopherson:** You chose not to go the legislative route.

First of all, I'll give the Auditor General a chance to comment on that before I plow ahead.

Go ahead, Ms. Fraser.

**Ms. Sheila Fraser:** I just want to make the point that the analysis that is in this report is analysis that we did in our office from data that we obtained from the various departments. The problem was that, for instance, Health Canada had stopped doing that analysis. That was one of the major issues, as we said, that they have to resume doing this analysis, which they have now done, to be able to identify trends, to then try to take corrective action. We would produce, for example, that certain trend lines were up, but the department wasn't able to explain because they hadn't done the analysis recently.

**Mr. David Christopherson:** By trend lines, you're talking about the triple increase since 2000?

**Ms. Sheila Fraser:** That's right.

**Mr. David Christopherson:** Fair enough. It's a good thing we have the Auditor General there as the safety net, but I'd be curious to know how a ministry could sit by and let these kinds of numbers build to that degree before it did anything. How can that be?

**Mrs. Hélène Gosselin:** We had in place other safety measures in the system, as I've said. Safety has always been very important to the program. We've tried to develop an approach to respect the privacy rights of Canadians. It's not an issue that is only unique to Health Canada. Privacy vis-à-vis sensitive health information is an issue for everybody who works in the health care sector. I can ask Mr. Potter to detail some of the steps the department took during those years to try to address this issue. I will say that we've resolved that issue now and we've resumed the analysis. The program was active trying to address that issue during the years when we didn't do the analysis.

**Mr. David Christopherson:** Fair enough, and I don't want to beat a dead horse. Obviously you're on the right track.

But before you comment, Mr. Potter, you should be reminded that in April 2001 the committee asked you specifically, sir, about how long this was going to take. You said no, that's not correct, we will not be waiting four years. You were right: it took five. With that as context, go ahead, sir.

● (1625)

**Mr. Ian Potter:** Yes, thank you very much.

Throughout this period, as Madame Gosselin said, we continued to provide the warning messages to pharmacists and we strengthened those warning messages to the pharmacists—so there is a warning.

One of the things we did was we made mandatory the point-of-sale system, so pharmacists had to use the interactive system. They couldn't just fill out the prescription and mail it to us. We made the messages, such as drug-to-drug interaction and others, mandatory. These were rejection items, so there were two types of warnings on the system. One was just notification and the other was a rejection. That is, if the pharmacist could not explain why they overrode the warning message, they would not get paid. We increased the numbers that were in the rejection category.

I believe at the time I did testify before this committee that we had a system in place that would resolve the privacy concerns of individuals. We had at that time the support of the national chief of the AFN. We had a major program going on in terms of informing our clients across the country.

We found that there were issues that crept into this area between first nations and Inuit, who believed that the program of dealing with privacy, seeking their consent to deal with privacy, was dealing with issues around treaty rights or aboriginal rights, and we found significant resistance in people filling out the forms for that reason.

We then worked with the Privacy Commissioner and with the Department of Justice to find a new way of dealing with it, and I regret that it's taken us this long. I wish we had had this in place.

We now have a process that meets the tests of the law. It's supported by the Privacy Commissioner. It's also supported by our clients and by the professionals we deal with, who are essential in this process of providing the safety to the clients.

We introduced the new process in the summer of this year. We started in the spring, in April. We have now started the individual retrospective drug utilizations, where we identify clients at risk, have the pharmacist examine them, and start to call the pharmacists or the doctors who are involved. The Auditor General points out that we did not do that for a period of time. She is quite correct. We are now doing it, and we will now put in place a system....

**The Chair:** Go ahead, Mr. Potter.

**Mr. Ian Potter:** We will put in place a system by the fall. When we have identified a risk client, we will put a stop payment on that client's file so that the pharmacist will not be able to charge us for any drugs that client has until that client contacts us and we can deal with them or they have their pharmacist or physician contact us to deal with the problems that we believe may exist. So we are—

**Mr. David Christopherson:** Okay, thank you.

**The Chair:** This will be your last question, Mr. Christopherson.

**Mr. David Christopherson:** Yes. It's a shame we can't spend a little more time on why that happened, because it makes us a little nervous. If it takes you that long to act on one recommendation, how long is it going to take you to act on others?

I want to refer to the Auditor General's report on page 36, to the last point, and it will be the Department of Veterans Affairs that will be answering this.

You get a sort of a satisfactory mark, but only halfway. Again it comes back to the issue of cost savings. I'm looking at the progress to date: "The Department has explored less costly means of providing over-the-counter drugs but has not implemented a process that would lead to significant cost savings."

Why the half measure?

**The Chair:** A quick response.

**Ms. Verna Bruce:** We have looked at that from a couple of perspectives. We have a real concern about over-the-counter drugs and how they interact with prescription drugs. One of the ways we've tried to manage that, particularly with our elderly clients, is to make sure we have prescriptions for over-the-counter drugs too, so that when a veteran goes to get a prescription filled, the pharmacist can say, "No, if you take ASA with this particular prescription, it could cause a serious heart attack", or whatever.

We've tried to find a way of capturing that information and reducing costs at the same time, and we looked at a number of ways of reducing costs where we couldn't capture the information. Now it's something that our other partner departments are working on as well, so we're looking at whether or not there might be some other possibilities to do that.

● (1630)

**The Chair:** Thank you very much, Mr. Christopherson.

Mr. Fitzpatrick, please, eight minutes.

**Mr. Brian Fitzpatrick (Prince Albert, CPC):** I'm pleased to hear that somebody's trying to develop a system that might get some results, might be well managed, and might work. With a lot of these departments, we seem to be jumping around from one failed experiment to another, but I guess we have to hope that your good intentions on this one will work out and that Shakespeare will be wrong in saying that the road to hell is paved with good intentions.

I'm going to recount some experiences I've had in my riding of Prince Albert. I must say that my sense of the report of the Auditor General is right on. In the summer of 2003, a group of pharmacists in my riding—you have to understand that in the city of Prince Albert, we have a high number of aboriginal people—came to see me, in my office, to talk about the problems they're encountering with the bureaucracy in this town. It was not the bureaucracy in the province—they didn't have any problems with the prescription drug program for the non-aboriginal people—but the barriers that you people were creating in this town. They had the president of the Saskatchewan Pharmaceutical Association in with them as well, and he fully supported them. He said this was a problem he was hearing all over the place. I want to go over some of these points.

They were appalled that as professional people, providing benefits to people, they did not have access to the information. This privacy argument that you people want to make, and so on, just does not register with people. A famous jurist once said there was no such thing as absolute rights, and he used as an example a person standing up in a crowded theatre and yelling "Fire!" That's when freedom of speech stops. I would say that when we're talking about sharing important, vital information among health care providers, quite honestly, there cannot be an absolute on privacy. I think a lot of people in this town have taken that to the extreme. Maybe they're trying to hide things in this town—I don't know what they're up to with this cloak of privacy—but the health care providers are very disturbed about it, and the medical doctors are too.

I'll remind you folks that in 2000 we had the Stonechild people in this committee begging this government and the bureaucracy to respond to the drug abuse problem that was happening among first nations youth in this country. If I'm hearing the Auditor General's report correctly and I'm hearing the pharmacists correctly, this problem hasn't been remedied. It may, in fact, be worse. It sounds as though there may be a system in place now, finally, and that you're going to deal with it, but it only comes from prompting from the Auditor General. Who in the world is managing this circus in this town, if you have to have an auditor come in and explain to you that you should be doing something on this? Are you underpaid, or what's your problem?

That isn't the only problem. Pharmacists had actually hired people in their pharmacies to constantly phone and to get approvals on prescriptions that came from doctors, and to keep copious records and details on it. Then, lo and behold, after they were approved over the phone, and so on, they come in with these audits. And I saw the audits. I'm not exactly sure what standard or what they're looking for, but these audits, to me, did not make a whole lot of sense. They were disallowing prescriptions that had been approved over the phone. The pharmacists were out $12,000, $13,000 or $14,000 on things that were quite regular within the provincial health care system. Most of them were really puzzled at why they weren't auditing and dealing with the problem of abuse over prescriptions, which would be the obvious thing to do, but that isn't what we were doing in this town.

To take the cake, at that time they had these stupid consent forms. The Master of the Rolls in Great Britain at one time, Lord Denning, would have referred to these consent forms—I saw them—as adhesion contracts, which means they aren't any real, true consent; they were basically telling these people to sign these consents or you're not getting drugs. That's not consent. I think something like four percent of the people had signed up, but the pharmacists were terrified of this thing. They wondered what kind of bureaucratic jungle they were going to be creating. Is my person going to have to phone in to Ottawa when they come in with a prescription and ask them if they've got a consent form?

Another problem I have with this whole thing, if it had been taken to its logical conclusion, is that we could have had the gun registry number two set up. There has to be a better way of dealing with this issue other than creating another huge bureaucracy.

● (1635)

I would like somebody here to respond to these concerns. I'm only relaying very legitimate concerns on this issue from health care professionals in my riding. There are three of them. I'd like some satisfactory answers to those things.

**The Chair:** Do you want it from Health Canada, Veterans Affairs, or the Auditor General? Do you want all three to comment?

**Mr. Brian Fitzpatrick:** I don't think the people from the Department of Indian Affairs are here today, are they?

**The Chair:** No, it's Health Canada. Sorry.

**Mr. Brian Fitzpatrick:** Okay, Health Canada.

**The Chair:** Health Canada, a brief response, please.

**Mrs. Hélène Gosselin:** I'll try to address it.

I think you're right in saying that a lot of people have concerns about some of the privacy issues. There's concern about access as well, and we're concerned about it.

We want to provide our recipients with access to the safe drug therapies that their doctors prescribe. That's our objective. At the same time, we want to respect their privacy rights. It's why we've worked with pharmacy associations and doctors' associations to try to find an approach that would work. We knew there were concerns out there. We certainly didn't want to build a bureaucracy.

I'm pleased to say that we think we have found a way that will work. We've implemented it. We seek the consent of our recipients. We do the analysis of drug use, and we provide that information to the people who can actually do something about it, the pharmacists and doctors who treat these patients. The information that we have enhances their own professional judgment, and it provides them with information that they can use to enhance the safety of their patients. It's very important.

I know there were a lot of people who were worried about this issue. It's not an issue, as I said before, that's unique to us. It's an issue that you find throughout the health care system.

**Mr. Brian Fitzpatrick:** What happened to the person who came up with this consent form? Is he still around?

**The Chair:** Mr. Fitzpatrick, did you want a response from Mrs. Bruce and Mrs. Fraser too?

**Mr. Brian Fitzpatrick:** Yes, okay.

**The Chair:** We're running out of time.

**Mr. Brian Fitzpatrick:** Maybe you could comment on a conceptual....

**The Chair:** We only have about a minute left. Why don't we get Mrs. Bruce and Mrs. Fraser to wrap up your opening statement?

Ms. Bruce.

**Ms. Verna Bruce:** From the Department of Veterans Affairs perspective, we do ask our veterans and our clients to sign consent forms. Most of them do. Once they sign the consent form, then we can share information.

Again, the physicians prescribe and the pharmacists dispense. Our job is to pay for it. We try, as much as possible, to monitor the high-risk cases and provide information.

**Ms. Sheila Fraser:** All I can say, I guess, is that there are issues around privacy that have to be respected. I am not an expert on that. If the committee wants more information, you might want to consider inviting the Privacy Commissioner to come and talk about the issues and what some of the solutions might be. We are really not able to deal with that appropriately.

**The Chair:** You're down to 15 seconds, Mr. Fitzpatrick.

**Mr. Brian Fitzpatrick:** It's my observation, talking to these folks, that this privacy issue is not a big deal in the provinces, not to the extent that it is in Ottawa. It seems to me that we've probably gone too far.

If I'm a patient concerned about my health care, does it not make sense that health care providers would share vital information? It's in my interest and the public's interest to do that.

**The Chair:** I'm going to wrap it up.

I think that the question is this. Can you confirm this, Mrs. Fraser? There's a federal Privacy Act and there are provincial privacy acts, and they're not the same. It appears that the federal one is a little more restrictive, shall we say.

**Ms. Sheila Fraser:** I know there are different acts. As to whether the federal one is more restrictive or not, I can't comment on that.

Again, I would suggest that you invite the Privacy Commissioner.

**The Chair:** Okay. I don't think we need to continue that.

Thank you, Mr. Fitzpatrick.

Mr. Lastewka, please, eight minutes.

**Hon. Walt Lastewka (St. Catharines, Lib.):** My question, coincidentally, Mr. Chairman, was along the same line. Since I was involved with the Privacy Act, and gave it quite a lot of consideration, I find this very surprising that it would take five years to resolve, and that with the departments, with the Privacy Commission and with the Auditor General, we were not able to come to a faster resolve on this.

I think it would be good, Mr. Chairman, to have the Privacy Commissioner here to find out what happened over five years whereby this could not be resolved in an expeditious way, because when I read the auditor reports, and I read in them that this is the second or third or fourth or fifth time that this has been mentioned in an audit report, I get very concerned that there's an action plan developed just to get through the resolve of the audit to the next audit. So I'm deeply concerned that we implement the action plan, and if we're not going to implement the action plan, to know why we're not, and work with the Auditor General's office on a resolve. I think that's the part in government that we seem to be missing, that the Auditor General does her work to bring forward recommendations, the department does its work to either agree or disagree and to come to a resolve in order to find the best resolve for the taxpayer. I think sometimes we lose sight of that. So, Mr. Chairman, I hope we would take the recommendation to learn from someone, specifically the Privacy Commissioner, why it took five years to resolve.

I want to go on to the next item, and that is where the Auditor General has made a number of recommendations in 4.71, and so forth, that the departments could be saving money.

Item 7 under the Auditor General's report says:

> We also found that the government is paying tens of millions of dollarsmore than necessary each year because it does not take advantage ofsome well-known cost-saving measures.

I'd like to have the people respond on their action plans to take advantage of.... As I read the Auditor General's report, it's about taking advantage of best practices, or people who have best models for getting the best dollar for the drugs, and so forth. I think she has given some examples.

So my question to the two departments would be what are you doing to take advantage of the recommendation that the Auditor General has brought forward on saving money within your departments?

● (1640)

**Mrs. Hélène Gosselin:** I will ask Verna Bruce to lead with some of the things we are doing together as part of the Federal Healthcare Partnership.

**Ms. Verna Bruce:** On behalf of the Federal Healthcare Partnership, I would like to tell you about some of the things we have started to take a look at around cost.

One of the things we are doing is taking a look at what those best practices are. The Auditor General has described them in her report. We are going to be using the opportunity to understand how those work in each individual department and what parts of those best practices can be transferred to other departments, because all of our programs are very different. The program for the Correctional Service, for example, is very different and I would say more minimalist than the program we have in Veterans Affairs, where we try to provide maximum choice and maximum quality. So we're trying to find what those best practices are and how they translate from one department to another.

There are a lot of recommendations there around the potentials for bulk purchasing, looking at reference-based pricing. Through Veterans Affairs, we have agreed to lead a working group to look at those recommendations around cost management. Even in the instance in terms of bulk purchasing, different departments are doing bulk purchasing in different ways. We know that Health Canada does some bulk purchasing for some of the very isolated areas. In Veterans Affairs Canada, we do bulk purchasing through Ste. Anne's Hospital, but that was not part of the audit. There is bulk purchasing being done by National Defence, RCMP.

So it's getting everybody together to take a look at what we're currently doing now and how you can adapt that for the future, but also recognizing that for Veterans Affairs we will probably always want our clients to be able to deal with their local pharmacy. We have 7,500 pharmacies across the country. In Health Canada, many of your clients will probably always be dealing with pharmacies as well. So in a pharmacy environment, what are the things we can do to try to leverage the opportunity to get better prices, even when drugs are being dispensed through pharmacies? So we have a lot of work to do in terms of understanding what we're currently doing, and what the opportunities are to move forward.

● (1645)

**Hon. Walt Lastewka:** I would like to have someone tell me when the working group is going to come to a plan. Are we going to go into working groups for five years? What is the timeline that you've put out for all this?

**Ms. Verna Bruce:** We will have, by the end of February, our first plan in terms of how we're going to approach this. I should also say that through the Federal Healthcare Partnership we have already made some savings. It's not like we've never done this before. We've done some work in the province of Saskatchewan already, for example. We've saved at least a couple of million dollars there. We have done things in the past. It's a matter of how you try to take those successes and build on them. We will have the first cut at our plan for how we're going to be approaching this by the end of February.

**Hon. Walt Lastewka:** Mr. Chair, how much time do I have left?

**The Chair:** You have one minute left. Do you want to add it on to when you come to your time?

**Hon. Walt Lastewka:** Yes.

**The Chair:** We'll now move on to the second round, which is a five-minute round.

Mr. Harrison, you're first.

**Mr. Jeremy Harrison (Desnethé—Missinippi—Churchill River, CPC):** Thank you very much, Mr. Chair.

First, I'd like to say what a pleasure it is to sit with the Auditor General in this committee. My constituents hold the Auditor General in very high regard, I must say, and as I've told her as well, my grandfather actually has two pictures on his wall, one of which is John Diefenbaker, for whom he worked for twenty years, and the Auditor General is the other one.

I would like to first draw attention to a quotation from the Veterans Affairs Canada performance report for the period ending 31 March, 2004. The quote in this report says it also informed Parliament that it is developing a departmental aboriginal outreach strategy in consultation with aboriginal organizations to "ensure that eligible First Nations, Métis and Non-Status Indian veterans and their spouses are informed about, and benefit from, the full range of programs and services that VAC offers".

Mr. Chair, as many members of the committee know, this is an area in which I am greatly interested, the issue being the treatment of aboriginal war veterans—and quite frankly, the mistreatment accorded aboriginal war veterans by the government after the Second World War and after Korea as well.

I actually have a motion in Parliament right now that has gone through second reading and will be going to third reading, I would imagine, in March, dealing with recognizing the historic inequality of treatment and calling for the government to take action to redress this.

This is my question on this particular issue. To find the department is just now developing an aboriginal outreach strategy.... It has been 60 years since the end of the war and only now we're talking about developing a strategy for outreach. We have at most 2,000 aboriginal veterans left in this country, and only now we're seeing the Department of Veterans Affairs developing an outreach strategy. My first question on this is what is the status of this proposed outreach strategy? Has some additional work been done on this in the past year, and has there actually been a strategy put in place?

**Ms. Verna Bruce:** The question of providing services to aboriginal veterans is one that's very important to us. In Veterans Affairs we don't differentiate our veterans by status, so we can't tell whether you happen to be of an ethnic descent or an aboriginal descent. We treat all of our veterans the same.

What we've come to understand is that there are lots of veterans in the country who don't access Veterans Affairs programs, whether they're aboriginal or non-aboriginal. We have been trying in a number of ways to reach out to different groups of veterans to make sure that they are eligible for benefits from Veterans Affairs Canada. We had a major outreach to our merchant navy veterans and we identified a lot of merchant navy veterans who did not realize they were eligible for benefits from us. We've identified that with the first nations, the Métis and status, there are large numbers of them who are not aware that they're eligible for benefits from us.

We've had a number of projects to do that—

**The Chair:** I'm going to interrupt here.

The question actually revolves around not that Veterans Affairs is looking after all the veterans, whatever their nationality and origin may be, but are people getting benefits from you and also from Health Canada too if they are aboriginal? Are you aware if there is any cross-matching on these issues?

● (1650)

**Ms. Verna Bruce:** We would deal with our veterans in terms of benefits they're eligible for as a result of a pensioned condition.

**The Chair:** Yes, but if an aboriginal is getting benefits through you at Veterans Affairs Canada by virtue of the fact that they are a veteran, and they're also going to Health Canada by virtue of the fact that they're an aboriginal, do you people talk to each other on that issue?

**Ms. Verna Bruce:** That's a good question.

**Mr. Ian Potter:** I think the answer to the question is, in general, there's an effort by drug plans to coordinate benefits. We wouldn't likely see a pharmacist submitting the bill to the Department of Veterans Affairs—

**The Chair:** No, no. My question was, do you, Health Canada and Veterans Affairs, talk to each other regarding the same client being paid? You talk about these statistics. The Auditor General has given all these statistics about multiple users and so on, but we could have someone going to both departments and you wouldn't even know about it. Is that correct?

**Ms. Verna Bruce:** The answer, according to our staff, is that we do talk to each other on individual cases.

**The Chair:** So the issue is that a person cannot go to Veterans Affairs and get multiple drugs and get the same multiple drugs from Health Canada because you would catch it. Is that correct, Mr. Potter?

**Mr. Ian Potter:** There would be only one prescription for one payer.

**The Chair:** No, that's not my question. Can somebody go to Veterans Affairs and to Health Canada, and would you catch it?

**Mr. Ian Potter:** The bill is submitted by the pharmacist.

**The Chair:** We have multiple pharmacists and multiple doctors all submitting bills. Would you catch a veteran getting paid by the Department of Veterans Affairs and then coming to you and getting a different prescription, and you pay it as well? Would you be aware of what they're doing?

**Mr. Ian Potter:** If it is a different prescription, the answer is no.

**The Chair:** The answer is no. Okay, that's what I wanted.

Sorry to interrupt, Mr. Harrison.

**Mr. Jeremy Harrison:** Thank you, Mr. Chair.

I must say, I find it astounding when you say that in the veterans affairs department there's no differentiation or ability to tell even how many aboriginal veterans are provided drug benefits.

The Department of Veterans Affairs was responsible for paying the $20,000 that was accorded to aboriginal veterans by the government not too long ago. There was a fairly comprehensive process for identifying first nations veterans—not aboriginal veterans, but first nations veterans—through that process. I believe there were about 1,900 or so veterans identified through that process. The department has the records for that, but you aren't able to tell me, of those 1,900, how many are receiving veterans benefits.

**Ms. Verna Bruce:** We don't have the numbers here today, but we can readily tell you that. For those who applied for that program but were not receiving veterans benefits, we did an outreach to them to determine if in fact they were eligible for other benefits and services.

**Mr. Jeremy Harrison:** Okay. The last question I was going to ask is how many veterans were being provided the drug benefits. I would appreciate an answer on that at some point.

**Ms. Verna Bruce:** We'll get you the exact number.

**The Chair:** Please advise the clerk, and we will advise the committee.

Thank you very much, Mr. Harrison.

[*Translation*]

Mr. Thibault, you have five minutes and 30 seconds.

[*English*]

**Hon. Robert Thibault (West Nova, Lib.):** Merci.

Madame Fraser, thanks again for appearing at the committee, as you do quite often, and again with an enlightened report. I am pleased to see the reaction of the Minister of Health to your report and your guarded optimism that we will resolve some of the outstanding problems.

I'm sure you will be very pleased to know that you are on the wall in Mr. Harrison's grandfather's home.

My question would be to Health Canada, and perhaps all of you would be interested in this. When we look at the question of best practices and we look at veterans and we look at the RCMP and we look at the military and we look at those other Canadians the Canadian government has responsibility for, as well as the non-insured health benefits recipients, there appear to me to be a lot of differences. That is, differences in the way it is administered, differences in the type of clientele and the potential when you look at bulk purchasing.

Could you quickly describe how that would affect the implementation of the recommendations, and how you resolve that on a go-forward basis?

**Mrs. Hélène Gosselin:** Thank you for the question. I'll answer that, but maybe Madame Bruce will want to add to it, because she is the chair of the Federal Healthcare Partnership.

Basically that's why the various departments and providers of insurance programs at the federal level have come together. As you know, the clientele we serve are very different, and they're also geographically dispersed across the country—different age ranges, and different communities. So we've had to bring the various departments together to first of all learn from the best practices from the various plans.

Every department has some best practices, and we're trying to share them. Some of them are applicable to other departments. Some of them are more difficult to apply, either because of the way they deliver the program, or because they serve a more limited population. But the intent of the Federal Healthcare Partnership is to try to find horizontal issues on which the department can work together.

For example, we'll be working together to explore having a common formulary among the various departments. I would also note that some of our federal partners are working with us at Health Canada to look at these issues with the provinces as well. These issues are relevant to provincial programs as well. We've undertaken work on the national pharmaceutical strategy with the provinces to try to address some of these issues.

Verna.

● (1655)

**Ms. Verna Bruce:** I would just add that Madame Gosselin has covered it very well. Where we can work together on things we will, but some of the programs are so different that we're not going to try to squeeze everything into the same box. Where we can learn from each other and work together we will, but there will always be a few little things that will be different. In Veterans Affairs we don't have to worry about pharmaceuticals for operational readiness, but we have huge issues around palliative care. So there will be different issues, but we'll work together on the core.

I have the answer to the question from the honourable member about the number of veterans receiving pharmaceutical services from Veterans Affairs. Right now we're servicing 113,000 veterans.

**The Chair:** Thank you, Ms. Bruce.

Mr. Thibault.

**Hon. Robert Thibault:** Thank you.

Like Mr. Lastewka and Mr. Fitzpatrick, I have some concerns or wish to have more understanding on the question of the Privacy Act, it's implications, and maybe the roadblocks it's given to us in implementing the recommendations of the Auditor General in the past two reports. Mr. Lastewka was part of the drafting of that, and maybe he was part of the problem. I don't know.

I assume there's this thing of a new act coming into place, and people interpreting it in different ways. Could you explain to us if indeed there has been some change in thinking—some ways of applying, composing, or dealing with the Privacy Act, the question of implied consent, or act of consent—and how you're dealing with that on a go-forward basis?

**Mrs. Hélène Gosselin:** You're quite right that the privacy legislative framework has been changing as we've been working on this particular issue. I'm not a Privacy Act specialist, but I can tell you that the privacy issue we were preoccupied with occurred when we were doing the retrospective drug analysis and trying to communicate that information to pharmacists. That's where the privacy concerns vis-à-vis the rights of Canadians came into play.

It did not affect the other safety measures we had in place—the warning messages, the de-listing of drugs, or the limiting of access to drugs. All of the other measures vis-à-vis safety were in place throughout those years. So we stopped doing the drug and retrospective drug analysis for a number of years to try to find a way to put in place additional safety measures, but at the same time respect the privacy rights of Canadians.

It wasn't necessarily doing the analysis, but it was communicating the results of that analysis where the analysis indicated a potential problem about drug use of an individual Canadian to a pharmacist or a doctor. We were sharing information we had because we had collected all of these claims, so we knew what they were using. We were sharing that information with a pharmacist or a doctor, so we had to find a way to get consent—that's the advice we got.

Mr. Potter mentioned before that we tried different approaches to that and some of them did not work. But we have now found a way to do it, and we do seek the consent of the clients. Where we've identified that there might be problems we seek their consent, and with their consent we share the information with the pharmacist, and even with the doctor when the case requires it.

So we've resolved that issue, and we've resumed that particular analysis that we stopped doing.

● (1700)

**Hon. Robert Thibault:** On this seeking of consent, as was mentioned earlier, there's the problem of treaty rights, individual rights. There is also the question of the active participation of the pharmacists, which could be very difficult. How have you worked with those groups? Do you have the cooperation of those groups, or is this a unilateral action by yourselves?

**Mrs. Hélène Gosselin:** Thank you for question. We have collaboration. We set up an independent advisory committee to provide us with guidance. It's made up of members from the professional community who work with us.

I should also point out that privacy is an issue, as I mentioned before, for many in the health care system, and it's an issue for the provinces as well. The provinces have been working with us on some of the privacy issues, because as we move forward in trying to implement new initiatives such as the electronic patient record, we will have to deal with the privacy issues. The intent is to try to share some of the health care information on individual Canadians with many doctors and pharmacists who may have to treat these Canadians, so they get better and safer care. But we will have to resolve some of those privacy issues, so in that context we will be re-examining the legislative issues surrounding collecting and sharing health care information.

**The Chair:** Thank you very much.

[*Translation*]

Mr. Gagnon, please. You have five minutes.

**Mr. Sébastien Gagnon (Jonquière—Alma, BQ):** My questions are for Ms. Fraser and deal with the tens of millions of dollars in overpayments. Did you analyze in detail how much money could have been saved? Were these millions of dollars in overpayments made in a single year or over the course of the audit period? Lastly, is this the first time that this recommendation was contained in a report?

**Ms. Sheila Fraser:** We did not assess how much money could have been saved in all. We based our conclusion on case studies which were presented in our report.

For instance, there is one drug which the Department of National Defence paid less for than Health Canada, or for what it cost in British Columbia, I believe. This is included in table 4.10, which indicates that between $10 and $13 million a year could have been saved. And this is only for a single drug over a single year. There are other such cases. We did not conduct an exhaustive study. However, if the cases mentioned in the report alone had been managed differently, millions of dollars could have been saved each year.

I have just been told that it is the first time that we study the issue of costs in our report. It's the first time that we have studied all the drug programs.

**Mr. Sébastien Gagnon:** I am shocked. You mention the figure of $15 million and then you claim that tens of millions of dollars could have been saved. If, over the last 10 years, no measure was taken, perhaps hundreds of millions of dollars have been overspent.

Can you assure us today—and my question is for the representatives of the various departments—that there is a willingness amongst departments to deal with a single negotiator or buyer? Had the $100 million or so been saved over the last 10 years, we could have afforded to hire such a person, or such a service, and save taxpayers' money.

Can you assure us that this will be done quickly?

[*English*]

**Ms. Verna Bruce:** I can respond to that on behalf of the Federal Healthcare Partnership.

That is one of the options we're looking at in terms of the potential around a negotiator for prices, and different ways of purchasing. We'll have a better feel for that by the end of the month, in terms of what we'll be looking at pursuing.

[*Translation*]

**Mrs. Hélène Gosselin:** I would like to add that Health Canada is working with its federal partners to develop measures which would put in place common buying practices. We have also implemented several measures which are specific to Health Canada to try to save more money and manage our costs better. In doing so, we have addressed several recommendations.

We still have a lot of work ahead of us, but we have tried to put in place some measures. Perhaps Mr. Potter can give us some specific examples.

● (1705)

[*English*]

**Mr. Ian Potter:** We've put in place measures so that generic drugs are used and we get the best price available. Where there is a generic equivalent—and that is a process that is approved by the provinces—we will pay for only the cheapest generic equivalent. The pharmacists have to charge us that or we won't pay for it. We've put that policy in place, and in some cases it has actually reduced our expenditures by about $6 million in the last year.

We've also put in place new schedules to deal with methadone. We reduced the dispensing fees on methadone. We're negotiating new arrangements with the pharmaceutical associations in each of the provinces in order to get a better price. We have to balance the price we're trying to get with the pharmacist in those negotiations with the need to assure that there is access. We can't develop a price at which the pharmacist will refuse to serve our clients. We're negotiating across the country, and as Verna Bruce indicated, we're looking at working with other departments on collective negotiations with pharmacists.

We've done more active auditing of the pharmacists, and the Auditor General remarked on how we've put in place measures to make sure the pharmacists were following the requirements and billing us only according to the planned provisions.

**The Chair:** Thank you, Monsieur Gagnon.

Mr. Wrzesnewskyj, five minutes, please.

**Mr. Borys Wrzesnewskyj (Etobicoke Centre, Lib.):** Thank you.

Just following up first on some comments that Mr. Harrison made, does the Auditor General know who the auditor general was at the time of Diefenbaker, and are portraits available?

I'm just kidding.

**Ms. Sheila Fraser:** I could find that out if the committee wishes.

**Mr. Borys Wrzesnewskyj:** Actually, what I'd like to do is follow up on Mr. Lastewka's line of questioning.

In the opening statement that the Auditor General provided, point 7 refers to well-known cost-saving measures. If they're well-known cost-saving measures I assume they don't really require a lot of study; they require implementation. What specifically has been implemented and what are the savings to date? And if some of these well-known measures do require some round-tabling, what are the timelines? Is there a specific time at which we'll see implementation?

**Ms. Verna Bruce:** From the perspective, again, of the health care partnership, there are some very well-known cost-saving measures, and one is bulk purchasing. As I mentioned earlier, different departments do different amounts of bulk purchasing.

Speaking for Veterans Affairs, we will always want to use a retail pharmacy for most of our clients. So how you would do bulk purchasing when you're dealing with a retail pharmacy would be a little bit tricky, but there might be other methods you could use to try to negotiate prices, which is what Health Canada was talking about.

It's fair to say that we recognize there are opportunities for cost savings, and individual departments have been doing individual things. The opportunity is there now to take a look at which ones generate the greatest savings in the shortest amount of time and what priority to start working on. That's what we're working on at the present time.

**Mr. Borys Wrzesnewskyj:** What I'm asking is do we have an exact timeline? Is it three months, four months, six months? How long will this take?

**Ms. Verna Bruce:** We'll have that at the end of the month.

**Mr. Borys Wrzesnewskyj:** Excellent.

The other question I have is when you talk about bulk purchasing, is there a policy dealing with generics or are we looking at the possibilities that are opening up with generics?

**Ms. Verna Bruce:** From the partnership perspective, I think you've heard Health Canada talk about their policy. In Veterans Affairs, 46% of the drugs we dispensed last year were generics. I can't tell you what the policies are of the four other departments, but I know they probably have them.

Again, that's the value of working together.

**Mr. Borys Wrzesnewskyj:** This is my last question.

There were 308,000 rejection messages, and approximately 75,000 of those were overridden by the pharmacists. I assume those overrides take place in a very short span of time. Is there an audit that takes place afterward? If 25% of these rejections are overridden, what kind of audit takes place to take a look at those very quick decisions that are made?

● (1710)

**Ms. Verna Bruce:** The Auditor General has pointed out that at Veterans Affairs Canada we have some work to do in that area, and we agree. Health Canada has a different approach, and we can learn from them.

**Mrs. Hélène Gosselin:** The numbers you see are numbers for our program, and we do an audit after. You're quite right: the override messages happen very shortly after. We go in, and we audit pharmacists after the fact, and we look at the reason for using those overrides. There are a number of reasons that could be legitimate. The pharmacist could speak to the doctor and discuss the situation because of the condition or disease of the client. And there might be a valid reason for the use of a particular drug, so they would document that and override the system.

Where we find there's no valid reason for the override, we identify a potential recovery, and then we enter into discussion, as Madam MacLean explained earlier, with the pharmacist, because there may be some information they have that wasn't in the file.

So there is a process, we do audit. And it's interesting to note that since we have had this process in place we have seen that the number of prescriptions that have been filled with overridden messages is declining, even though the overall number of claims in the program is increasing. So we're having an impact.

**Mr. Borys Wrzesnewskyj:** Thank you.

**The Chair:** Thank you very much, Mr. Wrzesnewskyj. I am working on getting that pronunciation right, and one day, hopefully, I will get it right. I do apologize if I don't get it right.

**Mr. Borys Wrzesnewskyj:** Borys.

**The Chair:** No, I prefer it to be a little more formal.

By the way, Ms. Bruce, you mentioned that you want to have this report by the end of the month. I think it might be advisable that you send it on to our clerk, because if this committee is going to have some recommendations we wouldn't want to recommend something that you have already resolved. So is it possible for us to get a copy of it?

**Ms. Verna Bruce:** We're giving it to the Auditor General at the end of the month and we would be happy to share it with you as well.

**The Chair:** Okay, that would be appreciated.

Okay, Health Canada, in your performance report last year, tabled in the House a few months ago, you were talking about, and I'll quote here:

> In a few instances, where client safety or inappropriate use of the system may be a concern, the NIHB Program will seek the express consent of clients to share their personal information with health care providers. This consent will be provided verbally or in writing.

You're getting verbal consent. How good is that?

**Mr. Ian Potter:** This is an approach that we have verified with the Privacy Commissioner and it's also the advice of the Department of Justice that this is valid consent.

The process we are putting in place is that when we identify a client at risk, whose consent to discuss their situation with their doctor we don't have, we will put a "hold, do not pay" on the file and will send a request to the pharmacist. So when that client comes to the pharmacy the next time, and the pharmacist enters his prescription, the pharmacist will get a message that says "have the client call us or read the client this consent form". And if the client then says you have consent, he gives consent to the pharmacist to call us. The pharmacist can call us and we can then talk to the pharmacist about our concerns. And that is the process we are putting in place.

**The Chair:** You're putting this in place? This is going to be a legitimate way of doing business for you?

**Mr. Ian Potter:** Yes, it is.

**The Chair:** What happens if English or French happens to be their second or third language, and they really don't understand what is going on?

**Mr. Ian Potter:** We will be working with the pharmacists to see that they have the information in multiple languages so they can address clients from different language groups.

**The Chair:** How often does this verbal consent happen?

**Mr. Ian Potter:** Our expectation is that it is not very frequently. When we did the last quarterly review, we went through all of our clients. In a period of over a year we had something like 500,000 clients. Using the criteria that were established by the drug utilization committee, which is made up of professionals, we identified a few hundred clients. Those few hundred clients are reviewed by the pharmacist, and sometimes the pharmacist can say this is not a problem, just by looking at the case. For example....

● (1715)

**The Chair:** If you have a client at risk, someone who has multiple prescriptions, and this is the first one that he is bringing to you, are you getting verbal consent each and every time, or on what basis? These clients are at risk because they're getting four doctors and five pharmacists and ten prescriptions in a three-month period. Are you still dealing with verbal authorizations to waive the Privacy Act?

**Mr. Ian Potter:** Each time the client brings a prescription to the pharmacist and the pharmacist attempts to fill it and we are paying for it, there is a message sent to the pharmacist.

**The Chair:** I know that; you've said it.

**Mr. Ian Potter:** And if the pharmacist overrides that and feels it is legitimate, then the client could be visiting a number of pharmacists. The pharmacists will get messages if the client visits another pharmacist.

**The Chair:** You're missing my point, Mr. Potter. I'm asking a clear, specific question.

We're talking about these high-risk clients, the ones who go to multiple doctors and multiple pharmacists, not somebody who, for the first time in ten years, has shown up at a doctor and said "I need a prescription". Sure, you wouldn't have him on file. But these other people are those who are going on a very regular basis and you're getting verbal....

What is your policy in accepting verbal waivers of the Privacy Act? How many times will you accept a verbal waiver from one person?

**Mr. Ian Potter:** We only need one consent to share the patient's information. We put on a stop payment so they cannot access our program. They could fill their prescription and get paid if they pay it themselves, but they will not be able to access our program.

**The Chair:** So if he were in a drugstore two years ago, or last year, or last fall, or whatever, and there's a yes, that it's okay and there's no problem, he can come back today and you will have accepted that verbal approval from way back when as legitimate, which he may not even remember—is that what you're saying?

**Mr. Ian Potter:** The parameters around how long these would last will be set in consultation with the privacy advisers.

**The Chair:** So at this point in time, you're prepared to accept a verbal authorization from last year to approve a prescription this year, or maybe even next year, depending on what the Privacy Commissioner says?

**Mr. Ian Potter:** Yes.

**The Chair:** Is there any capacity for that person to withdraw his consent?

**Mr. Ian Potter:** Yes, there is.

**The Chair:** Does he ask each time he goes to the pharmacy: You gave a verbal approval six months ago—do you still want to have that on file, or do you want to withdraw it?

**Mr. Ian Potter:** No, we wouldn't be asking for that every time. We don't ask.

The process and the privacy rules that we have in place make the assumption that people give an implied consent for us to manage their program when they choose to access our program to pay for their drugs.

**The Chair:** In the same same way that when I swipe my VISA card it's implied, since it's on my card, that I agree with the conditionalities that I signed up for when I got my card?

**Mr. Ian Potter:** That is the provision we are operating on; that's the provision many health providers are operating on.

**The Chair:** So if you have this implied consent by virtue of the fact that the person uses your program, why is there this great paper work, privacy, signing, and so on, if you can just do it on a verbal implied basis?

**Mr. Ian Potter:** It's only when the individual looks at risk and when we want to share that person's health information with a number of different health professionals.

In your situation, where you said the patient had visited six or seven doctors or six or seven pharmacists, when they show up at the pharmacy, and we've identified them as a high-risk patient, what we're asking is to be able to talk to those other pharmacies and say, "This patient is visiting all of you. Do you understand there may be a problem?" That is where we need the consent of the individual—only in those circumstances. A verbal consent, if it's given in an informed manner, we understand to comply with the requirements of the Privacy Act.

**The Chair:** Ms. Bruce, do you have the same kinds of problems?

**Ms. Verna Bruce:** We're bound by the same legislation—

● (1720)

**The Chair:** Yes, I know.

**Ms. Verna Bruce:** And we do have similar kinds of concerns.

**The Chair:** Concerns, but do you have the same problems?

**Ms. Verna Bruce:** We have the same problems, but when we have our written consents on file, they're on file forever. If we have a verbal consent, we've a note in the file, and right now we treat the verbal consent the same as a written consent. But we have the same problems.

**The Chair:** So you accept verbal authorizations as well. How long are they good for?

**Ms. Verna Bruce:** We haven't tested it.

**The Chair:** So one day you may end up in court and find out you're on the wrong side of the law.

**Hon. Robert Thibault:** I just want to make a quick point, and I wonder if it's worth commenting on.

I think within the two programs there's a very big difference that legally, in the process, probably makes a difference. With one of the programs you apply to it, but with the other one you're born with the right to access it. You don't apply to become part of that program necessarily, but you grow into it. So at one point you actively have to promote the implied consent.

**The Chair:** I'm not sure, because the Privacy Act is a privacy act, and that's what the concern is. Anyway, I'm concerned about it.

I always make a point—and I've told the Auditor General this—about performance reports; I consider them to be very self-serving and fluffy. You talk about the "evolving privacy environment", but I'm not aware that we've actually dealt with any changes in the legislation.

Do you have a closing comment, Madam Fraser?

**Ms. Sheila Fraser:** Thank you, Mr. Chair.

I'd just like to close by saying I believe the issues we have discussed today are important. There's obviously the question of cost, but perhaps even more important is the health of the clients served by these programs.

We were disappointed that the findings of our audit were not better than they were and that many of the problems have been there for several years. I am, however—what was the term—guardedly encouraged by the commitments that have been made by the departments to address the issues and to develop an action plan with clear timelines. I would like to assure the committee that we will be doing a follow-up audit at some point in the future, and I would hope our audit findings will be significantly different from the ones in this report.

**The Chair:** Thank you very much, Madam Fraser.

I am going to continue the meeting, but we'll suspend momentarily to allow the witnesses to withdraw.

We have two items of business. One is the report of the steering committee, and then there's a motion, which I think will be coming forward in Mr. Christopherson's name, that was discussed in the steering committee yesterday as well.

● (1722)

(Pause)

● (1724)

**The Chair:** We're back in business.

Ladies and gentlemen, I have the report from the Subcommittee on Agenda and Procedure of the Standing Committee on Public Accounts, which met yesterday. This is the fourth report.

> Your Subcommittee met on Tuesday, February 1, 2005, to consider the business of the Committee and agreed to make the following recommendations:
>
> 1. That in relation to studies agreed to be undertaken by the Committee, Members be invited to submit to the Clerk the names of any witnesses pertinent to any said study.

So if you have someone you feel should be considered as a witness, contact the clerk and let the clerk know.

The next is only in principle at this time:

> 2. That the Committee agree to travel to Iqaluit, Nunavut and Natuashish, Labrador, during the week of May 1 to 6, 2005

—and that may be debatable—

> to hold public hearings, and that the necessary staff accompany the Committee, with budget and itinerary details to be submitted to the Committee for its consideration at a later date.

That is only in principle. We're not going to go through the logistics of developing any ideas on work plans, witnesses, and costs unless we agree in principle. This was something I wanted to do last year when the Auditor General tabled some reports regarding our first nations.

But perhaps it would be a good idea if this committee went to Iqaluit to wave the federal flag and talk to the parliamentarians up there and perhaps went to Davis Inlet to look at the issues of gasoline sniffing, education, and the other problems they have there. Again, the Auditor General had tabled a report on that.

This is only the concept of whether we should think about going up there. This is not a commitment; this is only whether we should do the work to find out if we are in agreement on doing that.

> 3. That the Steering Committee host a luncheon during the week of February 21, 2005 for Mr. Bernard Scemama, Head of the economic and financial comptrollership of the Department of Economy and Finance, Republic of France

—who is coming to town.

> 4. That the motion respecting the rules governing rounds of questioning as adopted by the Committee on Tuesday, October 24, 2004, meeting no. 2, be put on the agenda....

We'll discuss that. Mr. Christopherson would like a second round. I think there is likely some agreement that this is agreeable, and we'll discuss it among ourselves next time.

Next, again just to ensure that everybody is comfortable with the final reports:

> 5. That prior to the final adoption of any report by this Committee, the Clerk be instructed to circulate to all Members a copy of the final draft version for review and approval—

—48 hours before it's totally finalized.

A number of members said that while they have agreed to the changes, they would like to see that in writing before we table it, but it's not the intent that it come back to be debated in committee again. It's just that if they have a serious concern that the final report is not in accordance with the blues, the transcripts of the meeting, then they can raise it with the researcher, the clerk, or me. If it is out to lunch and the matter cannot be resolved, it may come back to committee. It's just so they'll feel more comfortable with the final sign-off .

So we're going to try to work with that. However, I do caution everybody that confidentiality is important if these reports are going to be circulated to each and every person prior to being tabled in the House.

Now, Mr. Murphy, you had a question on number two, I believe.

● (1725)

**Hon. Shawn Murphy:** I did have a question on number two, but I think you addressed it, Mr. Chairman. You said we're thinking about it now; we're not—

**The Chair:** We're just thinking about it. There's no point in thinking about it if the committee says don't do it, but I think it's a good idea. We'll come back to the steering committee and then to this full committee for approval. This is not a decision at this point in time.

Mr. Fitzpatrick.

**Mr. Brian Fitzpatrick:** This is just for clarification on point two, Mr. Chair. Say we're travelling to these communities. When we stop at one of them, what's the plan?

**The Chair:** The plan is that we hold a public accounts committee hearing just as we did this afternoon, with witnesses, likely from first nations and Inuit communities. As I said, they are within the parameters of the Auditor General's report. For example, she had an observation on the issue of the relocation of the village from Davis Inlet to Natuashish, and therefore it's in the mandate of this committee to take a look at that.

And I thought it would be good to take the public accounts committee to areas of this country that basically never see their federal government. Therefore, all I'm asking you for is approval in principle at this point in time.

Mr. Murphy.

● (1730)

**Hon. Shawn Murphy:** As everyone is aware, 2005 is the year of the veteran. When Ms. Bruce was here, she was going to hand out pins to the members and the staff here, and I'll do that.

**The Chair:** You can do that.

Are we all agreed on this report? Can the report be adopted as presented?

**Some hon. members:** Agreed.

**The Chair:** Also, you may recall that on Monday I felt there was the agreement of the committee that we have a motion to ask the Department of Indian Affairs to prepare a plan under the name of....

Monsieur Sauvageau?

[*Translation*]

**Mr. Benoît Sauvageau:** Mr. Chairman, I think there's only one problem. If we adopt this report, we will be violating recommendation 5, which gives us 48 hours to read the reports.

I'm joking, I wasn't being serious.

Recommendation 5 says that we have 48 hours to look at the report before tabling it. But if we adopt it now, we will not have had those 48 hours.

Just kidding. It's a joke.

[*English*]

**The Chair:** Fine.

Mr. Christopherson, please.

**Mr. David Christopherson:** Thank you very much, Chair.

There's a notice of motion in front of the committee. I would first seek unanimous consent to waive the said 48-hour rule so I can introduce this on behalf of the steering committee.

**The Chair:** Well, you can read the motion and I will do that part.

**Mr. David Christopherson:** I move that the Department of Indian Affairs and Northern Development be ordered to prepare and complete no later than April 30, 2005, a coherent action plan in consultation with the Office of the Auditor General with realistic deadlines for implementation of proposed initiatives; to address the Auditor General's observations and recommendations contained in chapter 5 of the November 2004 report on a point-by-point basis; and to present the same to the public accounts committee soon thereafter.

**The Chair:** Thank you, Mr. Christopherson.

Before we proceed, as I said, this was largely agreed to on Monday, but the formal process is that we have received this notice of motion. If we're going to consider it now, are we in agreement to waive the 48-hour notice?

**Some hon. members:** Agreed.

**Hon. Walt Lastewka:** It was all discussed on Monday, so we have the 48 hours.

**The Chair:** We considered it last Monday.

Mr. Sauvageau.

[*Translation*]

**Mr. Benoît Sauvageau:** I unreservedly support the motion and do not want to change its wording. However, for the benefit of committee members who were not here yesterday, I simply want to remind you that this would happen in collaboration with the Standing Committee on Native Affairs and Northern Development.

At a certain point, a joint committee could meet, but I don't want to include that in the motion. I think everyone is acting in good faith so I don't want to amend the wording of the motion.

[*English*]

**The Chair:** Yes, there is no question about that. I think that for something of this seriousness, though, we would then have a joint meeting with the Indian affairs committee.

Mr. Lastewka.

**Hon. Walt Lastewka:** I'm looking at the motion and I just want to get clarification from the clerk if the motion as written is proper, that we order a department.

**The Chair:** The clerk advises me that we can order the department to present a plan, the same way as we can call witnesses and subpoena people.

We have a 15-minute bell. Is there any further discussion? There being none, let me call the question.

(Motion agreed to)

**The Chair:** Thank you very much.

The meeting is adjourned.

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