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Chair

Mr. Rob Merrifield

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● (1110)

[*English*]

The Chair (Mr. Rob Merrifield (Yellowhead, CPC)): Let's call the meeting to order.

I want to start by thanking our panellists for attending and coming forward on the important issue of pharmaceuticals.

We look forward to your presentations to the committee, as the committee decides whether, perhaps in the fall, we want to look at this as a larger study to see if there is something we can do that would be productive for the committee's time.

I want to again thank you all for coming. We'll start in the order that I have.

For the committee's information, we will start with an hour and a half. We'll have the questioning, as well as the presentation time. We'll then go into an in camera session on the report of the committee on fetal alcohol spectrum disorder. There is also one motion before the committee that we'll be dealing with during the public time and perhaps an appointment position that we'll deal with at the same time. That's for the committee's information.

We'll now move on to our witnesses, and we will start.

We have Mr. Brett Skinner from the Fraser Institute, Ken Fraser from the Fraser Group, Barbara Mintzes from the University of British Columbia, and Ingrid Sketris from Dalhousie University.

Thank you again for coming.

We'll start with Mr. Skinner. You have 10 minutes.

Mr. Brett Skinner (Director, Departments of Health and Pharmaceutical Policy Research and Insurance Policy Research, The Fraser Institute): Thank you. And thanks to the committee for inviting me here today. It really is a pleasure to address this body. It's the first time I have addressed a parliamentary committee, so it's quite an honour. Of course, I invite your questions and answers at the end of the presentation I'm about to give.

There are three areas I would like to address, which relate directly to research being conducted by the Fraser Institute. The first one I'd like to address is the price of patented medicines and the fact that I believe it is not the cause of unsustainable health care costs in Canada. Secondly, I'd like to address issues related to the cross-border drug trade and why I believe it remains a threat to Canada's drug supply and trading relationships. And thirdly, I would like to discuss issues related to the fact that governments are rationing access to new medicines in Canada, and hopefully offer some explanations for that.

Let me begin with the price of patented medicines. The evidence indicates that average prices for patented drugs in Canada have in fact grown at a slower pace than the general rate of inflation for all other goods and services in the economy. They are therefore increasing at a slower pace than they are allowed to grow under federal price controls.

Other evidence indicates that prices for patented medicines in Canada are also lower than those in the majority of countries the federal government uses for international comparisons through the Patented Medicine Prices Review Board and are, on average, 43% below U.S. prices for identical drugs, based on research done by the Fraser Institute, which relies on a large sample of the 100 top-selling products in Canada in 2003.

There are two main reasons why drugs are believed to be accounting for a rising share of health expenditures: the introduction of expensive new medicines that are simply treatments that did not exist previously for conditions, and the increasing use of drugs to replace other forms of medical treatment.

The evidence indicates that new drugs and the substitution of drugs for other medical therapies are positive developments. Research shows that they lead to net cost savings, when all health spending is accounted for, and to significant improvements in human health.

To follow up on this, I'd like to say that if drug prices are perceived to be a problem in Canada, the problem is really with generic drug prices. Canadian prices for generic drugs are higher than international prices for identical drugs, based on PMPRB research. Based on Fraser Institute research, the difference in price is, on average, 78% higher than the U.S. price for identical drugs, based on a sample of the 100 top-selling generics in Canada in 2003.

This is significant for Canadians in terms of the cost savings that are lost. If Canadian generic drugs were priced at the international median for the same products, Canadian buyers of generic drugs would save $800 million annually. If Canadian generic drugs were priced at the even lower U.S. price levels for the same drugs—which are the lowest in the world, by the way, and are a proxy for free market prices—and if lower prices pushed our generic substitution rates to the much higher U.S. rates that we have observed, Canadian buyers of generic drugs would realize nearly $2 billion in direct annual savings and nearly $5 billion in total annual savings,

I'll move on now to the evidence I'd like to present on the cross-border drug trade. The trade remains a threat to Canada's drug supply and trading relationships, and this is because while the value of the cross-border drug trade in prescription medicines has flattened at about $0.5 billion annually, based on the most recent data from IMS Health Canada, this is largely because generics are making up an increasing proportion of the prescriptions sold. So the total volume of trade likely remains very high. More worrisome, I believe, is that political momentum for legalizing the cross-border trade is rising dramatically in the United States. Evidence indicates that the number of annual attempts to legalize the cross-border drug trade at both the state and federal levels in the United States has risen from three per year in 2002 to 84 per year as of September 2005.

Interestingly, most of the proposals being put forward under these attempts would legalize bulk purchases from Canadian pharmacies to supply U.S. federal, state, and local public employees, as well as recipients of social programs like Medicaid and Medicare, a group of consumers that is nearly four times larger than Canada's entire population. As a previous health minister once stated, Canada cannot be the drug store for the United States.

Evidence also indicates that the cross-border drug trade is not based on free trade principles, as some have claimed. The trade relies on Canadian government interference in the market through price controls that permanently fix the gap between U.S. and Canadian prices. But more interestingly, and perhaps more threatening to our trading relationships, cross-border pharmacies are also trading in stolen intellectual property.

Data from IMS Health Canada show that medicines that are still under active patent protection in the United States account for nearly 50% of the value of sales of Canadian generic drugs through Internet pharmacies to the United States. The data show that nearly 50% of the value of generic drugs being traded through cross-border Internet pharmacies is for active patent products in the United States.

The third area I'd like to cover is the fact that governments are rationing access to new medicines in Canada compared to other countries. Canadians are not getting timely access to new medicines. Research indicates that Health Canada approves fewer new medications than other countries, and when Health Canada does approve a drug it takes much longer to do it than in other countries. Data suggest that the common drug review process is also being used to ration access to new medicines for recipients of public drug benefits. The CDR recommends less than half the drugs it reviews for reimbursement, and the provinces approve even fewer of those drugs, even though these drugs have already been approved as safe by Health Canada and are available in other countries.

Governments across Canada are rationing access to very expensive new life-saving medicines affecting small populations but are paying for affordable health care services for everyone. A good example of this is the drug Herceptin. Last fall I did some research on this and published an op-ed that showed that eight out of 10 provinces were refusing to reimburse for the drug Herceptin. It is a very effective treatment for breast cancer, one that the FDA thought was so effective in the United States that it stopped testing it and released it to the market early to prevent thousands of women from being relegated to an early death. Yet eight out of 10 provinces were not funding it last fall, in spite of the fact that the additional expense of covering the drug would have added only 1.6%, for example, to the Ontario drug budget.

Why is this occurring?

The reason governments are rationing access to safe and effective new medicines is because public health spending is unsustainable. Even a small additional amount of spending cannot be accommodated. In seven out of 10 provinces, public health expenditures are on pace to consume more than half of total revenues from all sources available to the provinces. When I say “all sources”, I mean including federal transfers. This will be by the year 2022. It will continue on that pace if nothing changes.

Governments are under extreme spending constraints, and that's why any additional expense related to medicines is a problem. The problem is not with the price of medicines, it is with the growing utilization of medicines and the inability of governments to cover that bill because of unsustainable health care financing.

I believe the only reason that governments get away with rationing access to medicine instead of making reforms in health care is because sick people don't represent a lot of votes. The data that I had access to from the population health research unit at Dalhousie University on the medicare records for everyone in the province of Nova Scotia on an anonymous basis indicated that about 21% of the population spends zero dollars on physician services in any given year. In fact, 96% of the population spent less than $1,500 on physician services in any given year; only 4% spent more than that. What that tells you is that the distribution of illness in the population is not widespread. Very few people are sick. That tells you that sick people don't represent a lot of votes, and there's very little incentive I think for our policy-makers to resist rationing access to new technologies. Instead, rationing is a way to maintain the facade of sustainability.

That is the conclusion of my comments, and I would like to welcome your questions.

● (1115)

The Chair: Thank you very much.

You have presented a lot of interesting figures there. I'm sure there are going to be some good questions on that.

We'll now move to the Fraser Group, Mr. Ken Fraser. You have 10 minutes.

Mr. Ken Fraser (President, Fraser Group): Thank you, Mr. Chair.

Thank you for your invitation to participate in this discussion today on prescription drugs. My name is Ken Fraser, and I'm president of the Fraser Group, a firm that provides technical and market research about employee benefits and group insurance.

For clarity, we are not associated with the Fraser Institute.

Today I will provide the committee with some research findings regarding the financing of prescription drugs through public and private drug insurance programs. My colleagues—including Dr. Richard Shillington, who is with us in the audience today—and I have been studying the issues of insurance coverage and the distribution of financial costs since 1996. Hopefully the following observations from our research will be useful for the committee.

Canada does not have a comprehensive national program or policy infrastructure around insuring the cost of pharmaceutical therapies. Despite this, a substantial system of drug insurance has evolved that does in fact provide the great majority of Canadians with reasonable financial security with respect to drug expenses.

There are, however, significant regional variations and disparities in this system of coverage. The most significant gap lies in Atlantic Canada. We estimate that approximately 25% of the population there would suffer financial hardship should they need expensive medications. In the case of truly catastrophic health needs, these Canadians would probably face the loss of their homes and be destitute. We have had such cases reported in the media.

Most of the regional variations are due to differences in publicly financed social insurance drug programs. Private drug plans, mostly sponsored by employers and labour unions, cover approximately 58% of the population, with minor provincial variations.

Drug expenses represent a significant financial exposure for all Canadian families. It's not uncommon for a family's drug expenses to exceed $10,000 or $20,000. Although it is rare, we have seen expenses exceed $250,000.

Many social programs and the federal tax system use a threshold of 3% or 4% as a measure of financial stress with respect to medical care costs. Using this threshold of 3%, four million Canadians require drugs that cost in excess of 3% of their family income. This includes 51% of those who are over age 65 and 8% of those who are younger than age 65. These numbers are before any reimbursement from drug plans. This group of individuals, with high drug expense needs relative to income, account for 66% of all drug spending outside of hospitals.

If we define the catastrophic drug expense to be the portion of the drug expense that is in excess of 3% of income, then 42% of all drug spending would be categorized as catastrophic. Our research shows that 89% of Canadians are protected from catastrophic drug expense by public and private insurance programs. Another 9% of the population has substantial but incomplete coverage. This leaves 2% of the population with no coverage whatsoever. They would be exposed to financial ruin in the face of severe drug expenses.

In conclusion, I would ask that the committee understand that access to the health benefits that can be derived from prescription drugs rests in large part on access to the financial mechanism of public and private drug insurance programs, particularly for those individuals with high needs relative to income. Maintaining and improving this system of drug insurance is a necessary part of ensuring that all Canadians—no matter where they live, or the level of their income, or the status of their health—have access to appropriate and timely medical treatment.

Thank you.

● (1120)

The Chair: Thank you very much for your testimony. Actually, we look forward to further reports on catastrophic drug coverage, but that was very interesting testimony.

We'll now move to Barbara Mintzes from the University of British Columbia. You have 10 minutes.

Dr. Barbara Mintzes (Centre for Health Services and Policy Research, University of British Columbia): Thanks very much for inviting me to speak to you today.

The focus of my remarks is going to be on direct-to-consumer advertising of prescription drugs. In the health committee's April 2004 report, “Opening the Medicine Cabinet: First Report on Health Aspects of Prescription Drugs”, this was one of three key issues addressed.

The recommendations of that report were to maintain the prohibition on direct-to-consumer advertising in the Food and Drugs Act and that Health Canada put additional resources into enforcement and bring in active surveillance, corrective actions if there are problems, sanctions against companies that are illegally advertising drugs, and to report annually. The committee also recommended that independent information be made accessible to the public and be publicly financed.

The other thing the report highlighted was the issue of reminder advertising. These are branded ads like the Viagra ads you see on TV, which state the brand but not the indication.

The report—with which I would agree—states there is no justification from a public health perspective in allowing reminder advertising. It suggested that the 1978 price advertising clause that has been interpreted since November 2000 to allow this type of advertising be rescinded because nobody is advertising prices anyway—if I can summarize the report.

So what has happened since April 2004? I would say the recommendations made by the committee are, if anything, much more pressing today, or more pressing than they were, for three main reasons.

One reason is that following the global withdrawal of the arthritis drug Vioxx, the idea of a large-scale public health disaster coming out of a heavily advertised drug is no longer hypothetical; it has actually happened.

Second, we've seen a continued growth in reminder advertising and unbranded, disease-oriented advertising in Canada with no apparent regulatory response.

And third, we now have a charter challenge by CanWest MediaWorks, which is challenging that the Food and Drugs Act prohibition is an infringement on their freedom of expression.

I will give you a couple of examples of unsafe and unnecessary medicine use that's been stimulated by advertising. When the global withdrawal of the arthritis drug Vioxx occurred in September 2004, at that point Merck & Co., Inc. had spent more than $500 million U.S. advertising this product to the U.S. public. Vioxx is no more effective for arthritis symptoms than alternative arthritis drugs. It's costlier. In British Columbia we've probably prevented harm very effectively because we did ration access to a greater extent than other provinces.

The first study to show an increase in heart attack risk was published in late 2000. So for four additional years, Merck continued to advertise this drug heavily to the U.S. and New Zealand public, where direct-to-consumer advertising is legal, and elsewhere to health professionals.

Dr. David Graham, who is a senior official with the U.S. FDA, used drug use data in the U.S., plus the results of clinical trials, to estimate how many people had been harmed. He estimated approximately 40,000 deaths from heart attacks as a result of Vioxx use would otherwise not have occurred. One of the questions I wondered about was how many of those were stimulated by advertising. I did a bit of a back-of-the-envelope analysis of this, looking at advertising spending versus total sales and then market research data on returns on investment on direct-to-consumer advertising. If you take the blockbuster returns—which Vioxx definitely was—you have about 16,000 of those 40,000 deaths that would have occurred as a result of excess sales stimulated by advertising. That's a rough estimate, but it certainly gives you some idea that there is a cause for concern in the rapid escalation of the use of newer drugs.

● (1125)

The other issue that's of concern with direct-to-consumer advertising is the promotion of unnecessary medicine use for everyday life problems—the medicalization of life.

In 2005 there was a 60% increase in sleeping pill use in the U.S. Why is this? Is there suddenly an epidemic of sleeplessness in the U.S.? Well, no. What's happened is that two sleeping pill manufacturers have been vying for market share and have been very heavily advertising their products to the public. Sepracor spent $270 million U.S. advertising Lunesta to the public. Ambien was advertised to the tune of $90 million U.S.

We know that the continued use of sleeping pills can lead to a risk of dependency, an extra risk of falls and fractures in the elderly, and traffic accidents. There have also been systematic reviews of the clinical trial evidence on these drugs. There's no difference in the direction or the magnitude of effects with the newer versus the older products. You're looking at a situation where, for a person over 60, use for more than five consecutive days is more likely to lead to harm versus benefits.

As a general overview, these are a couple of examples. I could go on, but I won't.

In the U.S. the industry brought in voluntary guidelines about a year after the Vioxx disaster. The most concrete change was that they have agreed not to run any reminder advertisements anymore on television in the U.S.

What's happening in Canada? Well, we've seen an increase in advertising, and the same companies are running reminder advertisements in Canada without any kind of regulatory response. We've certainly seen no reduction in the volume of made-in-Canada ads, no change following the committee's recommendations, no change post-Vioxx, no change after the U.S. voluntary industry guidelines, and no improvement in enforcement.

If I can give you an example, I was involved in a complaint with a women's health organization, Women and Health Protection, about a televised advertising campaign for Celebrex. Celebrex is a very similar drug to Vioxx and is in the same class. There's evidence of increased heart disease risks with Celebrex as well. Health Canada has put out a safety advisory as a result, telling physicians to prescribe it with caution, at a low dose, and for a short period of time.

We submitted our complaint to the Minister of Health and to Health Canada on March 14. We saw no evidence of any kind of regulatory response, and we haven't even had the courtesy of a response to that complaint.

What's happening from a regulatory perspective?

There was a complaint in 2005 about an ad campaign for Xenical, an obesity drug. This was not a brand ad campaign, but it was being advertised to women who wanted to lose a few pounds, a use that it's never been approved for. On the complaint that we submitted to Health Canada at that point, we did get a response, which said that it was perfectly legal because the brand had not been mentioned and the company had not been mentioned. From a public health perspective, we certainly haven't seen a shift in the regulatory response to these kinds of advertising.

The other thing that has happened is that we've seen ads, for example, like the TV ads for Celebrex, which would be illegal in the U.S. on public health grounds because this is a product with what's called a “black box warning” of serious safety risks. Reminder advertising is not allowed for drugs with black box warnings in the U.S. because of safety concerns. Although our law is more strict, we have had such a lax approach to enforcement that we're actually seeing things happening in Canada that are not allowed in the U.S.

The other major change is the challenge to the Food and Drugs Act prohibition by CanWest, which I would like to briefly highlight. This is a challenge by our largest media company on the grounds that the prohibition is an infringement on their freedom of expression. Yes, I can see a grin about that.

If you think about it, as a media company, they can run any editorial content they would like to on prescription drugs and any TV program they would like to on prescription drugs. What they are prohibited from doing is selling advertising space to prescription drug manufacturers. This is really a case that has everything to do with trade, competition, and lucrative advertising contracts.

● (1130)

Given my concern, from the outside, and having been concerned about the shift in response to enforcement of the law, what I would like to ask is whether adequate resources are being put into defending the law against this case. That's certainly a question for the committee.

In conclusion, I would like to say that the committee's recommendations are as valid as ever, but the real question is, what can be done to implement them?

Thank you.

The Chair: Thank you very much.

Your testimony reminds some of us of some of the testimony we heard during that time period and the subsequent study that came from it. It's very valid today as well. Your point is well taken. Some of the questions that were asked under that study may still be just as valid.

Let's go on to our last presenter, from Dalhousie University, College of Pharmacy, Ingrid Sketris. You have 10 minutes.

Dr. Ingrid Sketris (Professor, College of Pharmacy, Dalhousie University): Thank you.

I would like to thank you for providing me with the opportunity to come and speak to you. I'm a pharmacy professor with the CIHR/CHSRF-funded chair in drug use management at Dalhousie, and I've been there for 25 years.

I'm going to talk about goals of pharmaceutical policy. Then I'm going to give you two cases, one of inappropriate drug use and another of drug use where you could have a more efficient system. Finally, I'm going to talk about selected medication management strategies.

Jacobzone from the OECD defined the goals of pharmaceutical policy as improving health, fostering efficiency, improving cost-effectiveness, obtaining best value for money, preserving equity, and other—industrial policy. As Canadian jurisdictions set and refine their goals related to pharmaceutical policy, we need to determine how well they are performing against the goals, and have systems to measure them.

My first case illustrates the identification of an unsafe drug in the general population. In the 1980s, evidence was generated to show that Chlorpropamide, a drug for diabetes, was less safe than alternatives for the treatment of diabetes. It could cause low blood sugar, sometimes causing coma and hospitalization.

The Drug Evaluation Alliance of Nova Scotia funded a program to decrease Chlorpropamide use, and all seniors were switched to more appropriate therapy. But look at the time it took. The evidence came out in the 1980s, but in 1995 we still had 1,500 seniors in Nova Scotia receiving the drug. We put together an intervention that took people off the drug. In 2003, eight out of ten provincial pharmacare programs still funded the drug. In 2004, the Auditor General of Canada discussed the Beers criteria, which suggested this drug should never be used in seniors, and in 2005 there was a CBC radio show on the Beers criteria.

The key message is that even once the evidence is in, it can take a very long time to change habits and ingrain practices to adopt better practices. There needs to be a systematic approach to monitoring drugs after they are marketed in Canada, especially in susceptible populations such as children and seniors. Real-time electronic clinical decision support systems need to be developed to alert physicians to drug disease, drug interaction, and other problems.

On the next slide you'll see pictures of a mask that's used for asthma, and puffers. About three million people in Canada have asthma and bronchitis, so this is an important therapeutic area. The masks, or wet nebulization, are more costly, less efficient, less portable, have more bacterial contamination, and are less convenient. The puffers, which are supported by Canadian and international guidelines, have equal efficacy and cost about one-tenth as much.

In Nova Scotia we were paying about $2 million for the masks, and then the Drug Evaluation Alliance of Nova Scotia did an intervention that decreased the use of masks considerably. In just two years the DEANS group got patients switched from masks to puffers, which saved the government about $1 million per year and gave patients a simpler, more convenient approach. It was better for the patient, easier to provide, and it saved money.

The point of these two examples is to illustrate that there's room to improve the quality of medicines used and the cost-efficiency in the pharmacare program.

I would next like to talk about strategies that could be used to improve medication use. There are many stakeholders in pharmaceutical policy, and there need to be more opportunities in Canada where stakeholders can be brought together.

In Australia there's a national strategy on the quality of use of medicines. The Australian pharmaceuticals advisory committee is a representative council with about 30 members from diverse groups. So it includes the brand-name and generic drug industries, doctors, social workers, physicians, nurses, and journalists. They look at trying to set goals for the quality use of medicines in the country and how the various players can help implement those goals.

● (1135)

The next slide is on strategies for government. In Canada there are 19 federal, provincial, and territorial pharmacare programs. They differ in eligibility requirements, the drugs they provide, co-payments, and methods they use to manage programs. They use a mixture of legislative, financial, and educational approaches. These plans need to continue to work together to learn from each other and other countries on what works, what doesn't work and why, and what the trade-offs are.

Strategies are also needed to provide doctors, pharmacists, and other health professionals with tools to make good choices. Close to 400 million prescriptions per year are written by Canada's 60,000 physicians, and dispensed by Canada's 29,000 pharmacists, so a strategy that comes from Ottawa can't help all of those physician, patient, and doctor interactions. We also need tools to give to those individuals.

We also need strategies that target health organizations: the health delivery sector, information technology, drug utilization, and post-marketing surveillance. There are over 22,000 drugs on the Canadian market and an estimated 7,000 drug interactions. Busy physicians cannot keep all this information in their heads. They rely on a small set of drugs they know well. Both electronic health records and clinical decision support systems can help them take care of patients, especially when they are unfamiliar with drugs or new drugs.

Finally, I couldn't be a researcher without saying that research is important, so the pharmaceutical system in Canada needs a strong research underpinning. It's critical to understand the theories related to physician prescribing behaviour. Synthesis of the best international evidence provides useful information from Canada. New knowledge about drug effects and their use is needed, and this needs to be communicated to the decision-makers and practitioners. A strong network of post-marketing surveillance is needed to determine safety and effectiveness under real-world conditions.

In summary, do not expect that one policy will have huge breakthroughs in cost containment. Continuous improvement matters, to improve outcomes for patients and cost-effectiveness. As baby boomers age, it is ever more critical to put in place systems to manage the pharmaceutical system for sustainability.

Thank you for your attention.

● (1140)

The Chair: Thank you very much for your testimony.

We'll move to questioning. We'll start with the official opposition for ten minutes.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): Thank you very much to all of you for your comments. They were very informative and helpful in this important area. Many of you have done a tremendous amount of work, so the information you have provided is going to help many members on this committee.

I want to ask you a question on the national pharmaceutical strategy. During the first ministers conference in 2004, it was stated that a report had been brought forward by the Ministers of Health in consultation with various stakeholders on this strategy. I believe that report is due in the next ten days, and as of this date, none of us has seen that report. In talking to stakeholders, I don't know anyone who has been consulted.

As individuals with a tremendous amount of experience in research in this particular area, have you been consulted by Health Canada or any of the other individuals involved in putting that national pharmaceutical strategy draft report together?

Mr. Brett Skinner: I haven't been invited to speak to Health Canada, to my knowledge anyway.

Ms. Ruby Dhalla: Maybe in the next ten days...?

Mr. Brett Skinner: Maybe.

There are a few things I would like to say about the national pharmaceutical strategy. First, I believe it's unnecessary. The distribution of catastrophic drug expenses in the population is quite small. If we look at the data presented by Ken, for instance, there is a small percentage of people with catastrophic drug expenses. If we ask ourselves what percentage of that group lacks the income and insurance coverage to pay for those drugs when they reach a catastrophic level, it's an even smaller percentage.

Secondly, the national pharmaceutical strategy seems to be based on a desire by the provinces to escape responsibility for the rationing decisions they're making and upload it to the federal government, or at least to a quasi-national government agency like the CDR—common drug review—for instance.

So I believe it's unnecessary and a way for governments to avoid accountability for decisions they take on rationing. For those reasons, I would not be in favour of pushing forward with a national pharmaceutical strategy.

Ms. Ruby Dhalla: I can see that Barbara and Ingrid want to jump in.

Dr. Barbara Mintzes: I certainly haven't seen the final document or the final plans that are coming out. There was a broad consultation meeting that Health Canada held in September—or something of the sort.

● (1145)

Ms. Ruby Dhalla: No one has been consulted, apparently, since the last go-round.

Dr. Barbara Mintzes: I haven't been consulted more recently.

My understanding is that many of the issues that Ingrid Sketris has just raised in terms of needing to put many more resources into post-market surveillance and to ensure that there is a less piecemeal process in place in terms of supporting better quality use of medicines and better quality prescribing is something you'd expect out of a national pharmaceutical strategy. So I can say what I would hope would be in there.

I don't know if you have a....

Dr. Ingrid Sketris: I attended the Health Canada meeting in the fall around drug safety and effectiveness, and it's produced a report. I think it talks about the need for a system after the drugs come on the market, to monitor it. It had numerous stakeholders there, people from industry, a number of people from patient groups, and so on.

There were briefings on the national pharmaceutical strategy across the country. There was one in Atlantic Canada, in Newfoundland, that I was invited to attend, but I was unable to attend.

The co-chairs of the part that deals with drug safety and effectiveness have been trying to work with academics, and they have a number of consultation papers coming out. I haven't seen them, but I know they have been working hard in that area.

Ms. Ruby Dhalla: Aside from that particular area, no one else has been consulted?

Ken.

Mr. Ken Fraser: We've had inquiries from Health Canada regarding the capabilities of our research models, but that's the extent of it. We have not provided any input into Health Canada.

Ms. Ruby Dhalla: Brett, you mentioned something in your response to me, and I was taking a look at your report as well in regard to access to medications in terms of the involvement of the CDR, and the provinces basically utilizing it, I would say, perhaps as an excuse to avoiding the responsibility for their particular rationing choices.

Barbara touched upon having this piecemeal solution across the country: someone who lives in P.E.I. can't get access to a drug versus someone who lives in British Columbia who can, or if someone lives in Winnipeg, they may not get the best type of drug. We have to start creating equality regardless of where Canadians live. From your experience and the work you've done, how would you see, in terms of moving forward, that we can create some sort of equalization across the country in this respect?

Mr. Brett Skinner: The best way to do that I think is to incentivize interprovincial policy competition. When residents of P.E.I. see that their neighbours in a different province get better access to drugs than they do, they should pressure their governments to do something about it.

Health care is a jurisdiction of the provinces, and I believe it should remain this way, because there is a lot of value to that interprovincial policy competition.

I think what we're talking about here are governments that are attempting to hide behind the facade of sustainability when in fact health care finances are not sustainable. They're doing that by rationing access instead of reforming health care, by doing some of the things that are done in other countries, such as allowing user fees for publicly funded services, allowing the development of parallel private health insurance, for instance.

Drug insurance in this country is actually operating very well at the private sector level. The only problem is that some people do not have employment in order to obtain it, or they lack the income to obtain it.

Our public program should be identifying people who have catastrophic expenses and who also lack the income or insurance to cover those expenses, which is a very small percentage of the population, and it's a population that's amenable to sustainable insurance approaches.

So I would recommend something entirely different from a national program.

Ms. Ruby Dhalla: I have just one last question in regard to that. Quebec has set up a model that has worked very well for the individuals living in Quebec, which ensures, basically, that every single resident gets access to the pharmaceutical medications they require.

You mentioned individuals not having access—either the ones who are unemployed or the ones who don't have coverage—but there are also many women entrepreneurs, as an example, who don't have health insurance plans.

What are your thoughts, perhaps just generally to the whole panel here, with regard to the Quebec model?

Mr. Brett Skinner: I'd like to address that first. The Quebec model is very similar in many ways to the Swiss health insurance model, as it achieves universal coverage through a mandatory purchase requirement similar to, let's say, Ontario auto insurance. If you want to drive a car, you have to buy auto insurance. If you want to live in Switzerland, you have to buy health insurance. And in Quebec, you have to buy drug insurance.

For those people who lack the income to participate in a private market there is either a subsidy or a public insurer in which they are enrolled.

That's a way of achieving universal health insurance or drug insurance coverage that preserves all of the benefits of competition and private delivery of insurance products, and I think it's a much better model than what the other provinces are following.

In fact, it's very interesting to note that Quebec, among all the provinces, has approved far more drugs than have been submitted for review to the CDR than even the CDR itself, and than all other provinces as well. In fact, Quebec spends more on drugs as a percentage of its total public health expenditures than any other province, and yet health expenditures as a total are growing slower in Quebec than in all the other provinces.

That is consistent with research from Frank Lichtenberg, out of Columbia University, who has done significant work showing that medicines have a positive technological substitution value, so that more spent on medicines can lead to net cost savings on other health spending elsewhere. His figures show a dollar spent on new drugs, for instance, can save up to seven dollars on non-pharmaceutical health care spending.

● (1150)

The Chair: Madam Demers, you have five minutes.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): Thank you, Mr. Chairman.

Good morning, Mr. Skinner.

I was surprised to hear you talk about the difference between generic drug prices and research drug prices in the United States and in Canada. I don't quite understand.

Pharmaceutical companies engaged in research manufacture drugs that cost less in Canada than they do in the United States, whereas generic drugs, which only require companies to conduct bioequivalence tests, are far more expensive in Canada than in the United States, 78% more expensive in fact. I have a hard time understanding why that is so.

In your opinion, should minimum access standards be brought in for drugs required by clients served by the federal government?

As you yourself mentioned, Quebec has a very good drug insurance program in place.

Certain drugs are known to be truly beneficial in the treatment of certain conditions. For instance, Lantus, which is available in Ontario and Quebec and covered under private insurance schemes, is beneficial in the treatment of juvenile diabetes and type 2 diabetes. Why is it that certain drugs like Lantus are not available in all provinces under similar programs? As you noted, some drugs may be more expensive, but at the same time, they may be more effective. I just don't understand. Can you explain this to me?

[*English*]

Mr. Brett Skinner: The research indicates, for instance, that of all the silos in health spending, drugs or pharmaceutical products have made the largest contribution to improving human health outcomes, in extending life expectancies, and so on.

Beyond drugs, the other parts of the medical system actually have not insignificant but smaller impacts on the outcome of population health statistics, like life expectancy, which are influenced by things like general vaccination programs, treatment of sanitary sewage, general levels of economic development, and so on. So drugs are very important and should not be discounted.

In fact, if you look at the history of health spending, at some point governments began to view doctors as part of a cost problem, and then, on the basis of research published by Barer and Stoddart, they capped the supply of doctors and created what everybody believes now is the doctor shortage. Hospitals were also looked at as a cost problem, so mergers were forced and hospital beds were cut. Now we've run into problems with waiting times.

Now drugs are the third evil empire of health care spending and we're trying to do the same thing with drugs—ration access. I think this is the wrong way to go.

I guess I'm backing up here, going in reverse, by answering your second question first.

But with regard to your first question on the price of drugs in Canada versus the United States or the price of drugs in Canada versus international cases, evidence and research produced by Canada's own Patented Medicine Prices Review Board as well as the United States Food and Drug Administration have both shown that Canadian prices for brand-name drugs are at the international median of prices for the very same drugs, but they are far below U.S. prices, so it's far more affordable in Canada than it is in the United States.

For generic drugs, the prices are much higher in Canada than they are in other international jurisdictions. In fact, they are much higher than the lowest prices in the world, which are found in the United States. If you were to adjust those prices on the basis of currency equivalency, you would still find that for the top 100 selling generic products in 2003—a sample of data I found for myself—the average price difference is 78% higher in Canada, and three-quarters of the drugs that are common to both countries are priced higher in Canada than in the United States.

That's a significant inflation in generic prices, a price that is being obtained far above what a free market would produce using the proxy of the United States for their far more competitive drug market. In my opinion, that's where we should be focusing in terms of drug prices.

● (1155)

The Chair: Barbara Mintzes, did you want to add?

Dr. Barbara Mintzes: I just wanted to respond a bit on the so-called rationing question. I think there's an assumption here that a new drug is necessarily going to be better than what existed before, and that certainly does not hold up to the evidence. If you look at large series of evaluations of new drugs, only a very small minority are actually breakthroughs that make a significant difference to health. The large majority are what are called “me-toos”, where you have a small change to a molecule—another triptan for migraine, another beta blocker for blood pressure, and so on. Those are the majority of drugs that we have.

I work as a drug evaluator, so I'm involved in a lot of comparisons between drugs, basically carrying out the reports on safety and effectiveness that provincial governments or the common drug review might use as a basis for their decisions. The question we always looked at was, is there evidence of an advantage in terms of safety or effectiveness, or both, for a newer drug compared with other drugs that exist? If there isn't, and if the newer drug is costlier, why would it be a rational way to use public tax revenues to pay more money for something that's more expensive but is no better? If it's better, yes. Or you have these restrictions where some people can use certain things as a second line.

The idea that you simply pay whatever the asking price is because it's newer and that doing so will give you a better health system is certainly not something that has stood up to scrutiny.

The Chair: Thank you.

Mr. Fletcher.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Mr. Chair.

I'd just like to comment on Mr. Skinner's discussion of bulk exports. The Conservative Party, when we were in opposition, brought forward a motion banning bulk exports, which was passed. Certainly, that position has not changed, so rest assured that will not be allowed to happen. If the United States does pass legislation in that regard—which I understand has been stalled—that would probably be viewed by many as public policy folly on their part, if they were looking to Canada to solve their drug issues.

It wasn't in your speaking points, but did you say that the Internet pharmacies in Canada are exporting generic drugs?

Mr. Brett Skinner: Yes, in fact, what the data show is that over time, generic drugs are taking up an increasing proportion of the volume of prescription drugs being sold through Internet pharmacies to the United States.

Mr. Steven Fletcher: Why would that be the case? If generic drugs cost more here than in the United States, you would almost think that the Internet drug flow would be the other way.

Mr. Brett Skinner: Well, that's a very good question. It's a question I asked myself when I observed that too. I thought I should check the patent status of those drugs in both Canada and the United States. What I discovered was that 50% of the sales value of generic drugs going through the border to the United States was of products that were generically available here but still under active patent protection in the United States, with representative savings of sorts to consumers who were buying them. But this also represents an enormous rip-off of intellectual property that I think threatens our trading relationships.

Mr. Steven Fletcher: Are you aware that some data protection provisions were gazetted recently by the federal government?

Mr. Brett Skinner: I don't know if they would prevent the Internet pharmacies from profiting from the arbitrage of patent-protected drugs by selling generic versions of those drugs to U.S. consumers through Internet pharmacies, all of which is perfectly legal in Canada but very questionable on an international level.

Mr. Steven Fletcher: I'm just going to shift gears here a little bit. We've seen that there is a rationale for monitoring and evaluating real-world drug safety and effectiveness, and we've seen that that is compelling. Determining the best way to proceed is more complex. There are a variety of stakeholders, government health care professionals, patients, pharmaceuticals, researchers, and private insurers, and so on, with each stakeholder having a different perspective, but there could be common ground, and an integrated and comprehensive pharmaceutical surveillance system could be built.

In your opinion, is there a common understanding of the problem, and based on your analysis, what would be the best way to proceed in bringing everyone together?

● (1200)

Mr. Brett Skinner: The only reason to require drug evaluation is as an exercise in central planning. There are other ways to structure insurance programs to make them sustainable, to protect patient preference, and to protect the prescribing rights of physicians; that way is simply to make patients responsible for some of the costs at the point of service, through a deductible, which is normal insurance design, or through utilization-based premiums, for instance. Even with a community-based premium—one that is flat—everybody pays the same rate. It is a much different way of structuring a drug program than tax-based redistribution of financing. The only reason we have to engage in the central planning exercises of drug evaluation is because of the nature of our drug programs.

Secondly, I would say that those jurisdictions that have engaged in restricting access to drugs have not shown great achievements in cost constraints. In fact, B.C. introduced quite massive deductibles, twice changing the deductible by a range of $200 and dramatically reducing eligibility for benefits under their program in the process. That is where they achieved their cost savings. In fact, some of the prices of the drugs they were dealing with changed over that time, and even in the United States, they became lower. So all of the supposed cost savings in the B.C. model are really illusory. In fact, we've seen the same evidence from other jurisdictions, such as New Zealand, which has tried similar approaches.

I think the third and most important point is that restricting access has an impact on patient health outcomes. Let's face it, we're not all genetically the same; we don't all need the same drug product. We are trusting our physicians as our health care agents, and in conjunction with my physician, I would like to have my right to make those decisions for myself protected.

I just think if we go at this from a different angle and we look at a proper way to structure our insurance programs, we'll end up with a better result.

The Chair: Thank you, Mr. Fletcher.

Ms. Priddy, you have five minutes.

Ms. Penny Priddy (Surrey North, NDP): Thank you.

If I could, I'll ask for a short answer, at least for the first question, because I have a bit less time.

My first question—if you could each answer either with a yes or a no—is whether your work is funded by individual drug manufacturers or related companies or industries. Yes or no will be fine.

Mr. Brett Skinner: I'll answer the question first.

I don't think a yes or no answer in fact is adequate because of the implication of what you're saying.

Ms. Penny Priddy: Well, since I have five minutes—

Mr. Brett Skinner: I will say that less than 5% of the funding of the Fraser Institute comes from pharmaceutical companies, and that's declining over time. I will say that we have had members of the pharmaceutical industry on our board of trustees, and that includes both generic and brand-name companies.

Mr. Ken Fraser: It's less than 1% for the Fraser Group.

Dr. Barbara Mintzes: None.

Dr. Ingrid Sketris: None.

Ms. Penny Priddy: Thank you.

My next question would be to Ms. Mintzes.

You talked about Vioxx. I'm wondering if there's been any modelling done. I realize this must be very difficult to estimate, but on the cost of drugs from the U.S. direct-to-consumer advertising seen in Canada, I wonder whether there's been any modelling done on drug costs in Canada.

Dr. Barbara Mintzes: I haven't seen modelling on the effects of direct-to-consumer advertising in Canada. There certainly have been a number of studies in the U.S. The National Institute for Health Care Management, for instance, looked at annual increases in retail drug costs. They found that approximately half were due to the 50 drugs that were being advertised to the public—this was between 1999 and 2000—and the other half were due to the 10,000 additional other drugs. They certainly saw a large association between those two.

In the study I did in physicians' offices—in both a Canadian setting, in Vancouver, and in a U.S. setting, in Sacramento—I certainly saw an effect on volume of prescribing in individual consultations. If a person asked for a specific advertised drug, three-quarters of the time they walked out of that consultation with that specific prescription. They also almost always had at least one new prescribed product. Other patients, around one-third of the time, had a new prescription. So there certainly was an effect, in terms of volume.

I could go on about other research evidence.

Also, in terms of volume, say, of off-label prescribing of a drug, there was a study done in the U.S. that looked at off-label prescribing. It looked at whether physicians prescribed an anti-depressant that was being heavily advertised to patients who came in with a normal life situation versus clinical depression—whether they had asked for the drug or not. If they had asked for the advertised brand, they were much more likely, with a normal life situation, to end up with a prescription for an antidepressant.

● (1205)

Ms. Penny Priddy: Thank you very much.

Anybody who wishes to comment in the time we have left can do this one, but a couple of people have sort of indicated how they would like to go about this. But for those who have not, could you offer your thoughts on how the government should determine eligibility for catastrophic drug coverage?

Mr. Brett Skinner: I would be willing to answer that.

I think I've stated earlier that the way to do that is to identify those with catastrophic levels of drug expenses. Roy Romanow has offered $1,500 per person per year as a catastrophic level, and he identified 3% of the population with those expenses. We could look at a much smaller percentage of the population that has that level of expenditure and lacks the income or the insurance to pay for it on their own.

Surely, if you're a wealthy person, if you're a member of a wealthy family, if you're Conrad Black maybe, you don't need the federal government or the provincial governments to subsidize your drug purchases, even if they're at a catastrophic level. You have the means to pay for that yourself, so that's the way we should design our drug assistance from governments. We should focus on those who have catastrophic levels of expense and lack the income and the insurance to pay for it themselves.

Ms. Penny Priddy: So that it's means tested in some way.

Anybody else?

Dr. Ingrid Sketris: Related to your other question—I don't have drug company funding now, but I have in the past—I think one of the biggest questions is which drugs, so that when you have a certain amount, whether it's $1,500, $3,000 or $5,000, it's really critical to think about which drugs are funded within that. That makes a big difference.

The Chair: The time has gone, but I'll allow another answer. If there is none, we'll go to Mr. Batters.

Mr. Batters, you have five minutes.

Mr. Dave Batters (Palliser, CPC): Thank you very much, Mr. Chair. Thank you to the panel for being here today.

I have a number of comments and a few brief questions. I'd like to frame my comments by saying that I think, and perhaps all of us can agree, that patient access to medications that are most appropriate for them and their condition is of paramount importance. That's the overwhelming goal that I think we should be dealing with here. It's certainly the priority of Canadians. This does not seem to be the goal of the national pharmaceutical strategy, with the exception of catastrophic drug coverage. The NPS seems to focus on cost containment measures—and, Mr. Chair, I'd respectfully submit that the NPS is something that I think should be specifically studied by this committee.

Ms. Mintzes, I'd like to ask you and perhaps Mr. Skinner to comment on this very simple question. Should physicians have the right to prescribe the specific drug they believe is best for their patient? You mentioned COX-2 inhibitors. If a physician believes that a certain COX-2 inhibitor is best for their patient—they think a traditional NSAID is going to give them a GI bleed—that relationship, doctor-patient, in my mind, is sacrosanct. Should they have the right to prescribe the specific drug they believe is best for their patient, yes or no?

Dr. Barbara Mintzes: To go back to the COX-2 inhibitor story, for instance, you're also looking at a situation where part of the information was actually kept from doctors in terms of the outcomes of those drugs on their patients. What I would say is that if you are looking...I think both the doctor and the patient should have a right to access the full information on the safety and effectiveness of the products that are being prescribed and used, in order to make sure they can actually get the best health outcomes out of them.

● (1210)

Mr. Dave Batters: Absolutely.

I have very limited time, so I have to get to other questions. But provided they get the information and they're informed, does the physician have that right, the right as a clinician, to prescribe the specific drug they want for a patient?

Dr. Barbara Mintzes: In Canada currently, if it's on the market, the physician has the right to prescribe it. That does not mean, for instance, that as taxpayers we would necessarily say that we would reimburse that particular product.

Mr. Dave Batters: Thank you.

Mr. Skinner.

Mr. Brett Skinner: Emphatically, yes, doctors should be able to prescribe whatever they think is best for their patient. But I would agree with Barbara that as an insurer you have a responsibility to determine what you will pay for. I think under a public program that's financed by taxes in a redistributed fashion and that proposes virtually universal coverage, you will run into a problem of unsustainability that will lead you to rely on rationing and central planning exercises, like telling doctors what they can prescribe for patients.

I think a better way to approach this is through a private insurance model and mandatory purchase rule that would achieve better outcomes, including preserving a physician's right to prescribe what they see fit for their patient.

Mr. Dave Batters: In July of 2004, the premiers issued a communiqué, acknowledging the value of pharmaceuticals in that they

> reduce admissions to hospitals, help reduce wait times, prevent illness, allow individuals with mental illness to lead more productive lives, allow patients with chronic disease to regain a sense of health and independence, and improve end of life care through a robust palliative drug plan.

Despite the fact that numerous studies support this view, the NPS activity to date would not appear to take this into account. It seems to be a balance sheet exercise.

I would also point out that innovative patented medicines represent less than 8% of the total health care budget in Canada. Those are 2004 figures.

This is my final question, Mr. Chair.

Mr. Skinner, I would like to ask if you believe that prescription pharmaceuticals represent a net cost or a net savings to our health care system. From hearing your comments on the Quebec model, I can guess what your response is.

Considering medications, such as ACE inhibitors and statins, one has very good evidence to look at reductions in hospitalization, then quicker discharges from hospitals, and reductions in diagnostic procedures and surgery. So are prescription meds a net cost or a net savings? Of course, we're not even talking about the human costs, in terms of—

The Chair: Mr. Batters, that's your last question, so make it very fast.

Mr. Dave Batters: —drugs that help patients live happier, healthier lives. But in pure economics, is it a net cost or a net savings?

Mr. Brett Skinner: The evidence on this is very clear. There was a comment made earlier that new drugs don't have an impact. If you look at that impact over the entire range of new drugs, there is an impact. In fact, that's where it is most pronounced. As I mentioned earlier, Dr. Frank Lichtenberg of Columbia University has shown that a dollar spent on new pharmaceuticals saves up to $7 spent on non-pharmaceutical health spending elsewhere.

So you have to ask yourself the question, if we spent zero on pharmaceuticals, would we save money, or would we spend far more on other non-pharmaceutical health care goods and services to replace that? I think if you look at it from that perspective, you will see that there is a net savings. The research is clear on this. The Quebec example, among those in the other provinces, is also clear.

There is one other thing I want to address, which is the issue of distinctions being made between new products, such as biologic products, that are being hit harder in this rationing even than pharmaceutical products, which are being hit very hard.... So there are some distinctions the committee should be aware of.

The Chair: Thank you very much.

Now we'll go to Monsieur Laforest.

You have five minutes.

[*Translation*]

Mr. Jean-Yves Laforest (Saint-Maurice—Champlain, BQ): Good morning to the witnesses and to all committee members. I'm delighted to welcome you here.

My first question is for you, Mr. Skinner. You claim that governments ration the amount of new drugs available on the market because costs are out of control at this time and because they can't easily conceive of making new expenditures. You also said that governments are able to maintain this position because sick people make up only a small proportion of the electorate. That statement carries some political overtones.

I find it rather hard to believe your statement. We know, and various polls confirm this belief, that the primary concern of Canadians is health care. Since politicians are very mindful of polls, surely there must be some other explanation for this situation. And while sick people account for a small proportion of the electorate, they nonetheless have families and friends, all of whom are concerned about improvements to the health care systems and more affordable drugs.

There have to be some other reasons. Would you not agree with me? This can't be the only one.

● (1215)

[*English*]

Mr. Brett Skinner: Thank you for your comments.

I would argue that the number of people directly affected by waiting times—for hospital services, for physicians, for access to medicines—is in fact very small. The evidence is clear on that. So the general population, the bulk of the population, does not see in a direct way the failures of our health policy and the failures of our health care system. Because of that, there's not a lot of political momentum for change.

In fact, when you poll people on what they think of the health care system, they generally think it's pretty good. But then ask them how much they use the health care system: it's generally very little. So if you were to poll only those people who were very sick, I suspect they would have a very different opinion on how well the health care system is performing, including access to medicines.

That explains, I think, the lack of political momentum for change to make things better. It's not that we don't have high technology or advanced hospitals or well-trained physicians and nurses. Look, our medical staff can go anywhere in the world, and their skills translate very well. The problem is that our system is not allowing people timely access or appropriate access to an appropriate level of resources, and that's a function of its centrally planned design.

Dr. Ingrid Sketris: I think there can be an overuse of medicines. Antibiotics in particular can sometimes be overused, especially for viral infections. There can be an inappropriate use of medicines as well. We just looked at every single patient in our hospital who had a fall from their bed, and we found that 60% were on Valium-type drugs. So there's a quality issue there. There can also be an underuse of medicines—in heart disease, diabetes, and so on.

I think many issues around the quality of medicines need to be addressed more systematically across the country.

The Chair: Thank you.

Mr. Dykstra.

Mr. Rick Dykstra (St. Catharines, CPC): Thank you. I appreciate it, Mr. Chairman.

I have a couple of questions.

First, obviously the amount of research and development necessary is always on the cutting edge. Somebody wants to find, somebody wants to develop, the cure for cancer. How much money is actually spent on research and development in terms of the non-generic companies that are into it? Is there a number we bandy about, one that you're comfortable using?

Dr. Barbara Mintzes: There are some numbers bandied about that have been highly contested, and that keep going up, of about $1 billion. But that's based on a tiny proportion of drugs and on factoring in about 40% to 50% opportunity costs. So just the idea that at the top of the stock market bubble, the money could have been spent elsewhere....

Within the pharmaceutical industry, generally about twice as much is spent on marketing than on research and development. The whole rationality of research and development could be greatly improved if there was more of an incentive towards producing drugs that are real health benefits—

Mr. Rick Dykstra: I don't meant to cut you off, Barbara, but I have only five minutes; we have to rock to the answers here.

Brett, do you have something?

Mr. Brett Skinner: My understanding, and this is based on government data, is that the pharmaceutical industry is the most R-and-D-intensive industry in the country. That's the basis for comparison, I think.

I'd also say that governments spend some amounts of money supporting medical science research, but they spend heaping loads of money supporting public policy research that favours the status quo. Now, it's interesting to note that none of us were asked if we received any money for our research from governments; clearly our interests could be influenced by that as well.

If you were to compare government R and D spending in Canada with the R and D spending in the United States, I think you would see significant differences. That's something worth studying.

● (1220)

Mr. Rick Dykstra: How many jobs in Canada are in the industry?

Mr. Brett Skinner: Sorry, I'm not aware of the statistics on that. But it would be in the thousands, the tens of thousands.

Mr. Rick Dykstra: Madam Demers brought up the fact that there's a 78% difference in cost between generic drugs in Canada versus in the United States. Is that relationship because...?

Sorry, I'm totally new to this business. I'm learning as you speak, so I'm asking questions that may be somewhat rudimentary.

Is there a relationship between the fact that there are companies that do the research and development, that produce the product, and the fact that generics are 78% more expensive? Is there a relationship here, that generics are taking advantage of the fact that someone else does the work, and therefore keep the price up?

Mr. Brett Skinner: On the basis of that observation...which is true; generics do not spend as much developing their products. In fact, from the research I've seen, the average cost of developing a new drug is more than $800 million U.S. One in 10,000 molecules discovered actually makes it to the market as a successful drug product, and only 30% of the ones that do make it either match or exceed enough revenue to cover those R and D costs.

With that in mind, for generic drugs it's only a few million dollars, at best, to copy somebody else's invention. You would expect their prices to be lower, but in fact we find them to be much higher. Ontario reimburses these drugs at 70% of the price of a brand-name drug. Clearly their R and D costs are not 70% of the R and D costs of a brand-name product.

Mr. Rick Dykstra: So is a company like Apotex a generic, or is it a research and development company?

Mr. Brett Skinner: Apotex is a generic company.

Mr. Rick Dykstra: It is generic. Okay, thanks.

The Chair: Thank you.

We'll go to Ms. Dhalla.

Ms. Ruby Dhalla: To follow up on what Mr. Batters and Mr. Dykstra were saying with regard to pharmaceuticals and the differentiation in price, how do you think that not having data protection for the industry has harmed it in any way or has had any type of negative effect?

Mr. Brett Skinner: I'd be happy to answer that one. Patent protection is granted to a product in exchange for the release of its data. So that would not normally occur without patent protection.

Because that data is made public, that is the data set that is used by generic manufacturers to copy the inventions of brand-name companies. The argument behind it is that early access to that data allows the early development of those drugs, and in some cases, the early violation of patents, which are then challenged in the courts, and then there is some gaming in the courts that goes on.

That is the link with data protection. I think there are some good arguments to be made for extending data protection, but I'd like to study the question further before drawing any definitive conclusions.

Dr. Ingrid Sketris: Can I just comment on the way the metrics are coming out? Often what you hear about is the cost of a generic drug and the cost of the brand-name drug and so on, but I think what's really critical is how much it costs to treat a patient with hypertension or with diabetes. We've done some work looking at the cost to treat cholesterol in Nova Scotia compared with Australia. So as you explore this area further, think about how much it costs to treat the disease condition, as well as about the type of drug.

Dr. Barbara Mintzes: I would like to add a note on innovation and patent protection. What we're seeing more and more is the patenting of what are called isomers of existing molecules. The molecule has two orientations in space. The patent is due to expire and a new drug, which is one of the orientations in space of the same molecule, but with a very different brand name, is then produced by the same company. So it's really an evergreening of the patent.

Nexium is the *cause célèbre* of that. It's a lot like Lastium, but it's one of the leading drugs in terms of spending. So you have to ask—going back to how we are treating patients—whether this is actually meeting the needs of as many patients as possible for a specific sum of money.

Ms. Ruby Dhalla: I think it is not only in terms of meeting patient needs but also in terms of governments and ensuring that health expenditures.... As you mentioned in your report, Mr. Skinner, they are catching up and are going to make up over half of the total revenue sources by—what was it?—2022. So in the era of globalization, I think it's important that we invest in research and development and innovation for the pharmaceutical industry.

● (1225)

The Chair: If Ms. Keeper has a question, she should ask it now.

Ms. Tina Keeper (Churchill, Lib.): Yes, thank you.

I want to pick up on a term you used, Dr. Mintzes. You used the term "medicalization of life", and I think this is on the topic we're talking about. I would just like to know, in a quick, general way, what the impact has been in terms of pharmaceutical companies, in terms of what you're talking about—patents and development and this evergreening effect—on Canada.

Dr. Barbara Mintzes: In terms of medicalization, what I mean is the provision of medical care—and it plays out particularly in terms of drug treatment—for people who actually don't have an illness, or who are in a situation where they're dealing with normal life, and where there isn't evidence that giving what they have a diagnostic category, a diagnostic name, and then treating it with drugs is actually going to provide a health benefit.

Internationally, we're seeing an increase in the per population volume of prescription drug use. And one of the sides of the national pharmaceutical strategy—my understanding is that it is one of the key aspects—is to try to follow up on drug safety and effectiveness once drugs are on the market. That partly came out of the Vioxx scandal, because you had evidence from the clinical trials that thousands of people had had extra heart attacks, but nobody had noticed because they were mainly looking at elderly people and nobody had followed up. You've had specific follow-ups of stomach bleeding in Ontario and the rate going up after the COX-2 inhibitors came in, because so many more people started using those drugs who weren't using them beforehand.

So I think the concern is that we might be causing more harm than benefit in an individual patient, and that people are often very unaware of just how much benefit they can or cannot expect to get from drug treatment. I don't know if that answers your question.

Ms. Tina Keeper: Am I out of time?

The Chair: Yes, that's our time.

Our time for this segment is gone. I want to thank you for coming. It's always a balancing act between the testimony from Mr. Skinner, which says we save $7 for every $1 that's in pharmaceuticals—I think we all appreciate their benefits—and the testimony from the research from Ms. Sketris with regard to 60% of those who fall are on Valium or a like product, and the misuse of that. So it's that balancing act that we really have to discern in Canada and that the committee will have to take a serious look at.

I'll allow one more comment.

Dr. Barbara Mintzes: It's just that Lichtenberg's research is based on lousy methods. Nobody quotes it outside the pharmaceutical industry and pharmaceutical funding.

If somebody gets morphine near the end of life, that's considered an older drug and therefore more likely to kill them. If they get an allergy drug when they're not near the end of life, that's considered something that's life-saving. It's not defendable in terms of methods.

Mr. Brett Skinner: Actually, Lichtenberg's work has been replicated by others attempting to refute it, and they found exactly the same results.

The Chair: Therein lies the dilemma.

With that, I'll call the end of this segment.

I want to thank the witnesses again for coming forward. We will be able to ponder whether we continue with this study in the fall or not. Thank you very much.

Now we will move on to some of the other issues. Before we go into the in camera session, which will deal with the report, there are a couple of issues. First, we want to deal with a notice of motion that has been given to the committee.

But before that, we have the opportunity to nominate Weldon Newton as the president of the Hazardous Materials Information Review Commission. To proceed with that, if it is the will of the committee, we need a motion to make that appointment. We will entertain a motion and then we'll debate that motion.

Does anyone wish to make that motion?

Ms. Ruby Dhalla: I'll do it.

The Chair: We have a motion by Ms. Dhalla. Is there any discussion on the motion?

● (1230)

Mr. Dave Batters: With all the commotion of people leaving the room, can you just refresh...?

The Chair: This is a certificate of nomination for Weldon Newton with regard to....

I believe we've passed it around to you, so you have it in front of you.

The decision is to make the appointment at the present time and not necessarily call him before the committee.

It's moved by Ms. Dhalla.

Mr. Dave Batters: Is that seconded by Mr. Fletcher?

The Chair: Yes, that's right.

We want to make sure everybody is clear on the motion, prior to it....

Ms. Ruby Dhalla: Before the vote on that motion, can we get some information on the individual, to make an informed decision?

The Chair: You can.

How long has this individual been in the position?

Ms. Sonya Norris (Committee Researcher): How long has he been there?

The Chair: Do we know that?

Ms. Sonya Norris: Since 1998.

Ms. Ruby Dhalla: [*Inaudible—Editor]*...Mr. Merrifield.

The Chair: Actually it's your government that appointed him.

Ms. Ruby Dhalla: Then we'll definitely support him. It won't be a Gwyn Morgan....

The Chair: If you would like to challenge this appointment, feel free to do that.

Ms. Ruby Dhalla: We're doing due diligence on behalf of our constituents.

The Chair: So does your motion stand?

Ms. Ruby Dhalla: Yes.

The Chair: Okay.

We have a motion on the floor.

I understand this is a capable individual doing a job—

Ms. Ruby Dhalla: Right, Mr. Chair.

The Chair: But the committee can bring him forward as a witness and we can ask him these kinds of questions if we so wish. But I don't see the call for that by any committee members. So we have the motion to approve it.

(Motion agreed to)

[*Translation*]

Ms. Nicole Demers: Mr. Chairman, can you tell me what this means exactly? The French says something different, namely “Le comité prend acte du renvoi du certificat de nomination...”. That does not mean the same thing as

[*English*]

“The committee has taken note of the certificate of nomination....”

[*Translation*]

The scope is quite different.

[*English*]

Mrs. Nancy Miller Chenier (Committee Researcher): We don't have the motion.

The Chair: The clerk is telling me it's a motion that we have put forward approving this individual for appointment. That's really what it is.

[*Translation*]

Ms. Nicole Demers: He's been there since 1998. Have there ever been any complaints about the quality of the services provided?

[*English*]

The Chair: The motion is passed.

We'll now move on to the notice of motion put forward by Ms. Priddy.

Mr. Rick Dykstra: Mr. Chair, I have a question, and it's a follow-up to Madam Demers' point.

Under normal circumstances, so that I'm fully aware of how appointments work at the health committee, is it the normal procedure to put on the agenda that person X needs to be appointed to position Y and it's put before us?

The Chair: We can do it this way, if we're uncomfortable with that. In the time that I've been on the committee, we once had the individual come forward. I think Dr. Bernstein was the last one. We had him come forward, we sat around, we asked him questions about his appointment, and then we made a decision.

We could do that again here.

Mr. Rick Dykstra: I wasn't necessarily speaking to this appointment, but I would suggest that in the future it may not be a bad idea.

The Chair: This was one that the committee actually knew was coming forward. We heard no resistance from anyone, so that's why we thought we didn't need to bring him forward. I'm neutral on this, so whatever the committee wants to do....

On Bill S-2, he will be here before the committee, and he'll be able to thank us for the decision we made.

We're on to the motion. Well, I wish we could go on to the motion, because the other issue is actually over with.

Ms. Penny Priddy: I was only going to make a suggestion. We Googled him and that's why we knew what it looked like. But in the future, if we got his bio and background ahead of time, it would be easier to make the decision.

● (1235)

The Chair: Yes. As soon as it's referred to the committee, it's sent out to the committee so that you have the information.

On the notice of motion, would you like to present your motion, Ms. Priddy?

Ms. Penny Priddy: Thank you, Mr. Chair.

It seems to me that across the country people are very concerned about wait times, as is the government, and I think all opposition members. It was certainly one of the platforms of the Conservative Party and the Conservative government. Across the country we are seeing a lot of different kinds of examples of ways in which people have been able to reduce wait times.

Everybody has heard of the Alberta model, or most people have by now, and the Pan Am Clinic in Winnipeg. There are some very innovative models in Quebec. But we mostly hear about them by going to a conference or sitting around a table. There are big ones, but there are also small ones, like my own local hospital, which made quite a difference in wait times through some very simple things.

I'm concerned that we do this, because I think it will help a lot of hospitals that are looking for ways to do this. I am open to any kind of friendly amendment or an amendment to this:

> Be it resolved that the Standing Committee on Health call on the Minister of Health to establish within Health Canada a national publicly-accessible database of innovation around reducing wait times within the public system.

The Chair: There's the motion.

I believe we have a friendly amendment.

Mr. Steven Fletcher: Yes. By the way, I think this is a very good motion. The intent is certainly very good as well.

Would the mover be open to, after the word “to” after the “Minister of Health”, saying “work with Health Canada and the provinces to create a publicly-accessible database”, blah, blah, blah?

Ms. Penny Priddy: I certainly accept the “blah, blah, blah” part, and I consider the other part friendly too.

The Chair: You're basically asking for it to be in conjunction with Health Canada and the provinces.

Ms. Penny Priddy: Right. There may be some other friendly amendments. I don't know.

The Chair: Is there any discussion on the motion or the amendment? The amendment is part of the motion because it's friendly.

Is there any discussion over here?

[*Translation*]

Ms. Nicole Demers: Mr. Chairman, we intend to vote against the amendment and against the motion. We certainly have no desire to give more powers to Health Canada. We already have many reservations about Health Canada and its involvement in various matters. We also wouldn't want to see any undue pressure put on governments that already have innovative, forward-looking policies in place. Each provincial government has different health programs in place to address the specific needs of their populations, given different conditions and demographics. All of this must be taken into account, Mr. Chairman.

[*English*]

The Chair: I'm not sure. Just as a clarification, I don't believe it has anything to do with undue authority; it's just a database of excellent innovations, let's say, that have happened across Canada. That's my understanding of the motion or what the mover is asking for.

Is there any other discussion on the motion?

Okay, if it's necessary, Ms. Dhalla.

Ms. Ruby Dhalla: It's always necessary.

I just want to support the motion. I think having a national, publicly accessible database is important. I know Ms. Demers thinks it's going to put undue pressure on Health Canada, but I think we do need to have targets that are out in the open, and we need to have targets that are achievable. And I would hope that the current Minister of Health and the new Conservative government would make the investments required to ensure there is a wait times guarantee established in this country.

The Chair: Thank you very much.

Monsieur Laforest.

[*Translation*]

Mr. Jean-Yves Laforest: Like Ms. Demers, I too plan to oppose the motion which would only result in an increase in the number of officials at Health Canada. That's certainly not what the Bloc Québécois and the Government of Quebec want to see, since health care is a provincial responsibility.

Moreover, there's talk of a national data base. May I remind you that Quebec refers to itself as a nation, a fact that has been acknowledged by the Government of Quebec. Therefore, as far as Quebec is concerned, the word “national” is used to qualify something that applies to Quebec.

● (1240)

[*English*]

The Chair: We understand that.

Okay, very quickly—

Ms. Penny Priddy: Sorry, I thought that was protocol.

The Chair: It is.

Ms. Penny Priddy: The motion certainly isn't intended in any way whatsoever to put pressure on anybody; it's intended to take some pressure off, so they don't always have to figure it out for themselves. I don't know how important the word “national” is, or whether removing the word “national” would make any difference to your vote or not.

Secondly, perhaps we could have a word back at some further stage about how you intend to carry it out—if this carries—because if we had to have another level of bureaucracy to do this, my son will offer....

The Chair: So that closes debate on this.

Mr. Steven Fletcher: I have a beautiful statement I'd like to read, but—

The Chair: I'm sure you do, but I think the debate is closed.

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

The Chair: Thank you.

We have two quick housekeeping motions with regard to funding for witnesses again, and I believe Mr. Batters is going to move those.

Mr. Dave Batters: Thank you, Mr. Chair.

I'd like to move that the proposed budget in the amount of $10,300 for this study on prescription drugs be adopted.

(Motion agreed to)

The Chair: Okay, Mr. Batters.

Mr. Dave Batters: Secondly, Mr. Chair, in reference to our prior meeting on childhood obesity—the last meeting—I move that the proposed budget in the amount of $6,100 for the study on childhood obesity be adopted.

(Motion agreed to)

The Chair: Now we'll go in camera for the study.

[*Proceedings continue in camera*]

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