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Chair

Mr. Rob Merrifield

Standing Committee on Health

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● (1535)

[*English*]

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

I want to thank you for coming. We have enough of our members here and I know that others are going to be here very shortly, so we will start very soon.

Before I introduce the witnesses for today's session on the CDR, Ms. Priddy, with your smiling face, I know you have something very good to add.

Ms. Penny Priddy (Surrey North, NDP): Would it be anything else, Mr. Chair?

The Chair: I would expect nothing less.

Ms. Penny Priddy: Maybe we should talk about this later, but I think the executive committee was going to look at a whole work plan. Sometimes it's hard to look at the context of today without looking at that broader plan. I think we had a discussion about either the executive meeting—or bringing that back. Could you give me a bit of an update? It helps with the questioning of witnesses.

The Chair: We will discuss that in the in camera session during the last 20 minutes we have today. We'll go through a work plan and how we want to deal with what's laid out. We'll go through it at that time.

Is that fair?

Ms. Penny Priddy: Okay.

The Chair: With that, we'd like to start with our witnesses. As I said, we will be finished shortly after five o'clock so we can get to our in camera session in time.

Christiane.

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): Are we not studying the quarantine bill today?

[*English*]

The Chair: No. We will talk briefly about that in the in camera session. We had presenters at the last meeting on the quarantine bill and we decided to bring it back on May 2. We'll bring it back at that time.

I'd like to introduce our witnesses. We have, from the Department of Veterans Affairs, Verna Bruce. We'll start with you and introduce the other witnesses as we give them the floor.

The floor is yours. Proceed, please.

Ms. Verna Bruce (Associate Deputy Minister and Chair of the Federal Healthcare Partnership, Department of Veterans Affairs): Good afternoon, and thank you.

[*Translation*]

Thank you very much, Mr. Chairman, for inviting us here today to talk about the Common Drug Review.

[*English*]

I'm very pleased to have my colleagues from the Department of National Defence and Health Canada with me. You will be introducing them in a few moments.

You've asked that the federal health partners appear today to give our perspective on how effective the common drug review has been thus far. In my opinion it is working very well.

As you would be aware, in November 2004 the Auditor General's report highlighted some discrepancies between federally managed drug plans. The message was that those discrepancies shouldn't have occurred if all plans were following an evidence-based process in managing their respective formularies. As a result, the federal health partners agreed to a more rigorous, evidence-based process for reviewing and modifying their formularies. The common drug review, which became operational in 2003, has been key to helping us meet this commitment.

[*Translation*]

Before I go on, I'd like to give you a quick overview of the Federal Healthcare Partnership. The partnership was created in 1994, and was originally known as the Health Care Coordination Initiative. The six permanent members are the Department of National Defence, Health Canada, Veterans Affairs Canada, the RCMP, Correctional Service Canada and Citizenship and Immigration Canada.

[*English*]

The role of the FHP is to identify, promote, and implement more efficient and effective health care programs. Our mission is to achieve economies of scale while enhancing equality of health care services.

As a group, the Federal Healthcare Partnership represents the fifth largest publicly funded drug plan in Canada. Our goal is to provide access to medications that evidence indicates will be the most effective in treating our various clients' conditions. In doing so, we are also accountable to ensure that those medications represent the most cost-effective benefit. To do this, we need a strong, evidence-based review process, and we do feel that the common drug review fills this need.

My presentation will consist of our evaluation of the goals of the CDR and the results of an evaluation of the CDR conducted by EKOS Research Associates. This review is, in essence, an evaluation of the common drug review from the perspective of the Federal Healthcare Partnership.

As you know, the CDR has four goals: to provide a consistent and rigorous approach to drug reviews and evidence-based formulary listing recommendations; reduce duplication of effort by federal, provincial, and territorial drug plans; maximize the use of limited resources and expertise; and provide equal access to the same high level of evidence and expert advice.

Is the CDR meeting its first goal, to provide a consistent and rigorous approach? Yes, it is. The Canadian Expert Drug Advisory Committee is an independent advisory body, with leading Canadian experts in drug therapy and drug evaluation. As such, it's a critical part of the CDR. CEDAC provides drug listing recommendations to participating drug plans, following an approach that is evidence-based and reflects medical and scientific knowledge and current clinical practice.

The process also takes into account the economics of the new drug —that is, do the benefits of the drug warrant its cost? In many cases, new, more expensive drugs are developed to treat conditions for which there are already effective and proven pharmaceutical treatments. The CDR takes this into account when making its recommendations.

Based on this process, CDR is recommending approximately 50% of the drugs submitted to it, and we feel that this is fairly realistic. The Patented Medicine Prices Review Board itself says that only 6% of all drugs appraised between 1990 and 2003 were considered to be breakthrough drugs.

Speaking on behalf of the federal health partners, I can tell you that all partners now receive the same evidence-based recommendations for our formulary listings. As individual departments, we take those recommendations and use them as part of our decision-making process. Given our varied client groups, we do not all implement the recommendations in the same way. I believe this is a strength of the process rather than a weakness.

For example, some of the partners may authorize coverage of drugs, for an individual client, that may not have been recommended for inclusion in their formulary. In the case of the Department of Veterans Affairs, a non-formulary product might be authorized in the case of a client who has tried other available drug therapies for his or her medical condition and has not responded, or he or she may have had an adverse drug reaction. In this case, the non-formulary drug may provide some benefit, and it's done on a case-by-case basis.

This case-specific type of authorization is given to ensure that we are providing clients with the care that best meets their individual needs, when the less costly commonly used therapy is no longer effective. This flexibility allows the federal health partners to provide the most appropriate benefit that best meets the individual client's needs and, at the same time, achieve maximum benefit from the work of the CDR.

Is the CDR meeting its second goal, which is to reduce duplication of effort by drug plans? The CDR is definitely reducing duplication for the federal partners. From our perspective, it's also speeding up the process. The common drug review provides recommendations to our federal drug plans and all but one of the provincial and territorial drug plans. It has established one central body of expertise rather than each of the participants attempting to create its own review process.

Federal departments used to have to wait for decisions that were made on a quarterly basis by the Federal Pharmacy and Therapeutics Committee. As a result of CDR, the Canadian Expert Drug Advisory Committee meets and makes recommendations to us on a monthly basis. Those recommendations go directly to individual drug plans without further review. It allows us to authorize the use of new drugs much more quickly than we were previously able to. It saves time, effort, and money.

● (1540)

Is the CDR meeting its third goal, to maximize the use of limited resources and expertise? Again, having one body advising six federal drug plans gives all of the participants in the CDR access to leading Canadian experts in drug therapy and drug evaluation. Speaking for Veterans Affairs Canada, we would never have the means to achieve this level of advice on our own, and I don't believe many of our other partners around the table would be able to do that either. So by pooling our resources through the CDR, we're all able to provide a higher level of service to our clients. The process allows us to be more accountable with regard to the dollars spent through drug coverage.

As well, all participating drug plans are directly involved in the process. The Advisory Committee for Pharmaceuticals includes a representative from each participating province and territory, Veterans Affairs, the Department of National Defence, and Health Canada. The Federal Healthcare Partnership represents the remaining three smaller federal departments.

Finally, is the CDR meeting its fourth goal to provide all participants with equal access to the same high level of evidence and expert advice? I think we've mostly covered this point, but it bears repeating that all CDR participants receive the same high level of advice. Prince Edward Island receives the same quality of advice as larger participants like Ontario and National Defence. Without the CDR, this would not be the case.

I would now like to briefly mention an evaluation of the CDR conducted by EKOS Research Associates in 2005. It determined that federal, provincial, and territorial participants are pleased with the results of the CDR. They find it to be efficient, responsive, and timely. They believe it is providing quality reviews and recommendations.

The evaluation also raised some areas for improvement—and no process is perfect. If we aim for perfection, we will spend an awful lot of money trying to get there. But we believe the CDR is a very valuable tool that can use some tweaking, like anything else.

The areas for improvement include the need for public involvement, the need for increased transparency, the problem with delays in the uptake of CEDAC recommendations by the various drug plans, and the potential to tailor reviews to the complexity of a drug. I know that CDR is addressing these, and I'm sure they will be speaking to this either later this afternoon or later this week.

In conclusion, governments have a legitimate role in ensuring that public resources are appropriately used. For drugs that are publicly reimbursed, this includes verifying they are of good value relative to their benefits over existing therapies. Internationally, all OECD countries except the United States and France have adopted some type of post-licensure review of therapeutic benefits and cost-effectiveness.

So again, the common drug review is working very well. The federal health partners are pleased with it and look forward to continuing to contribute to, and benefit from, this invaluable process.

Thank you.

● (1545)

The Chair: Thank you very much for your comments. We will reserve questioning until all of the panel has had an opportunity to present.

We will now move to the Department of Health and Ian Potter, who has been here before. Ian, the floor is yours, and if you would introduce your colleagues, that would be great.

Mr. Ian Potter (Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health): Thank you, Mr. Chairman, and members.

[*Translation*]

Thank you on behalf of Health Canada for the opportunity to speak to the committee on the topic of the Common Drug Review.

[*English*]

I'm joined by my colleagues Abby Hoffman, the executive coordinator of pharmaceutical management strategies for Health Canada; and Scott Doidge, the manager of pharmacy for the non-insured health benefits program.

Committee members may recall that Health Canada's first nations and Inuit health branch operates a program for registered first nations and Inuit called the non-insured health benefits program, or NIHB. This program provides a limited range of medically necessary health benefits to approximately 790,000 eligible clients. These benefits include pharmacy and dental services, glasses and other vision care aids, and transportation to access medically required services. The NIHB program plays an important role in Health Canada's goal of closing the health gap between first nations and Inuit and other Canadians.

Approximately 80% of our clients are low-income earners. They experience a higher disease burden than the national average. For many of them, NIHB is the only available supplementary health benefit program they have.

[*Translation*]

NIHB is the largest federal non-employee drug benefit program with expenditures of $368 million in the year 2006-07.

[*English*]

Last year, NIHB processed over 13 million pharmaceutical benefit claims. In total, over 500,000 different first nations and Inuit clients claimed the benefit.

In managing this benefit, NIHB maintains a drug benefit list, or a formulary, to determine whether and how to fund pharmaceutical benefits. There are approximately 6,000 distinct products reimbursed under the program. Drug products on the NIHB drug benefit list are categorized as either open—that is, no restrictions if there is a valid prescription—or limited use. Other drugs are reimbursed on a case-by-case basis. The drug benefits list changes on a constant basis to reflect the availability of new drugs, new uses for old drug products, or generic versions of brand name products. Last year, the non-insured health benefits program made more than 600 changes to the drug benefit list.

Almost every day, new strengths or formulations of existing drug products are approved by Health Canada. Manufacturers often change, and generic versions of brand name medicines come to market. To provide advice on existing drugs in our formulary, NIHB looks to an independent expert advisory committee, the Federal Pharmacy and Therapeutics Committee. The committee provides clinical advice to all six federal plans and informs decisions related to delisting and to listing of new uses for drugs. The membership of this independent expert advisory committee includes practising physicians and pharmacists from the community and hospital setting, and it includes three first nations physicians.

The NIHB program also has a Drug Use Evaluation Advisory Committee to provide expert independent advice on appropriate utilization and client safety with respect to drugs listed in the NIHB formulary. This committee reviews utilization trends of certain drugs or classes of drugs and, where appropriate, refers issues of concern to the program. For instance, as a result of safety issues and concerns about potential misuse, NIHB changed the benefit status of Duragesic, a long-acting opioid patch, from open benefit to limited use.

For drug products that are new chemical entries on the Canadian market or for a new combination of existing products, the NIHB program follows the recommendations of the federal-provincial-territorial common drug review. Since 2003, the common drug review has reviewed 68 new prescription drugs. Of the 32 drugs recommended by the common drug review, NIHB has listed or will reimburse the cost of all these drugs for our clients. Twenty-five of these drugs are listed on our benefit list and seven are available on a case-by-case basis.

NIHB always assesses the recommendations made by the common drug review against the mandate of our plan and the unique needs of our first nations and Inuit clients. Given the unique needs of our clients, some exceptions are warranted. That is, they may not be reasonable in the general situation, but they make sense for our clients.

On rare occasions, the NIHB program will list a drug that is not recommended by the common drug review if a client-specific analysis warrants it. For example, to ensure access to oral contraceptives for a high proportion of clients in our program who are of child-bearing age—and our clients are mostly young—NIHB listed a birth control product in the formulary that was not recommended by the common drug review panel. In this case, our pharmaceutical committee reviewed it, looked at the specifics of our clientele, and said that there was a benefit to our clientele and that it should be available.

Through the work of the common drug review process, the NIHB program has been able to eliminate the backlog of new drugs awaiting review.

● (1550)

As a national program that delivers its benefits in ten provinces and three territories, the NIHB program has benefited from increased consistency in listing across jurisdictions, and clear objective standards.

We are also able to make faster decisions on new drug listing, reducing the amount of time to list a drug product by approximately 25%, from an average of 500 days from the day a product receives its marketing authorization to 334.

Because NIHB pharmacy professionals now spend less time reviewing drug submissions, the program has been able to concentrate on other key tasks that have led to important program enhancements, including measures to improve client safety.

Given the interest the committee has shown in the past about NIHB's work to improve safety, I have taken the liberty of circulating a publication called a “Report on Client Safety”, which highlights some of the improvements, for your information.

[*Translation*]

I have taken the liberty of circulating, in advance of this meeting, a publication called a Report on Client Safety which highlights some of these improvements for your information.

[*English*]

Thank you very much. *Merci.*

The Chair: Thank you very much for your presentation.

Now we'll hear from the Department of National Defence. We have Lieutenant-Colonel David Cecillon. I probably messed that name up, but you can correct that for me. Carry on with your presentation, please.

Lieutenant-Colonel Dave Cecillon (Pharmacy Policy and Standards, Department of National Defence): Thank you.

I am the senior clinic pharmacist in the Canadian Forces, and I am responsible for the administration and management of our drug acceptance centre, which is basically our drug plan. On behalf of the Chief of the Defence Staff and the director general of health services of the Canadian Forces, I would like to thank you for this opportunity to speak to you today on the common drug review.

As you may already know, the Constitution Act of 1867 assigns the sole responsibility for all military matters to the federal authority. Subsection 91(7) of the Constitution Act serves as the constitutional basis for the Canadian Forces health care mandate. In addition, the Canada Health Act specifically excludes Canadian Forces members from its definition of insured members, as do the public service health care and dental plans.

The director general of health services of the Canadian Forces is responsible for providing comprehensive health services to all regular and reserve members, as dictated by the conditions of employment, as well as anyone else, as determined by the minister. In all cases, despite this exclusion, the Canadian Forces health services must abide by the principles set forth in the 1984 Canada Health Act.

In April 2000, the Canadian Forces initiated an evidence-based medicine approach to managing its drug formulary, with the goal of improving health outcomes in Canadian Forces members. This program is based on three key principles: operational readiness, fairness, and equality.

With the creation of the common drug review process in 2003, the Canadian Forces and other federal health care partners determined that the common drug review offered significant benefits, and therefore we decided to willingly and actively participate in the common drug review process. At present, I am the Canadian Forces representative on the common drug review's Advisory Committee on Pharmaceuticals, and an observer at the Canadian Expert Drug Advisory Committee.

For the Canadian Forces, the common drug review has eliminated duplication, decreased time to review and make listing decisions on new chemical entities, and enabled the Canadian Forces and the Federal Pharmacy and Therapeutics Committee to address other pressing federal drug benefit plan issues. For the most part, the Canadian Forces has complied with the recommendations of the common drug review. However, as per the data you were previously provided with, there are variances, and many of these variances can be attributed to our vastly different patient population, as well as our mandate.

For instance, the membership within the Canadian Forces is approximately 85% male. They range in age from 17 to 60 years old, and they are relatively healthy compared to the Canadian population. Given the Canadian Forces health services group mandate to provide health care to its members in Canada and on operations, it is easy to see that our conditions of service have a direct effect on our drug benefit listing decisions. We must be able to overcome the limited load and resupply capabilities associated with deployed operations. We must also take into account product stability concerns based on each theatre of operations. Rest assured that careful consideration is given to every listing decision in order to ensure that we can maintain our operational capabilities.

At present we have four listing categories: list, list with criteria, do not list, and not a benefit. Should a member have tried all the benefit items and failed to demonstrate an improved outcome, a request for a non-benefit list item can be made to the Canadian Forces health services group directorate of health service delivery spectrum of care committee for adjudication on a case-by-case basis.

In conclusion, I hope I've been able to highlight the differences between the Canadian Forces membership and the rest of the Canadian population. In addition, like my colleagues before me, I must reiterate that the common drug review is working very well and has allowed us to reallocate many of our already scarce resources to other pressing drug benefit list matters.

Thank you.

● (1555)

The Chair: Thank you very much. That gives a perspective to the committee, from the witnesses before you, on the federal use of the common drug review.

We'll start questions with Ms. Bonnie Brown.

Ms. Bonnie Brown (Oakville, Lib.): Thank you, Mr. Chair.

Welcome to all the witnesses.

I believe Ms. Bruce said that all the participants in the CDR have access to leading Canadian experts in drug therapy and drug evaluation. Considering the plethora of agencies, groups, and committees that are part of it, I would ask Ms. Bruce this: which experts do you listen to out of those 14 groups? The committees listed in our report are CDR, CADTH, CDAC, ACP, FHP, FDVC, FPT, FDBC, not to mention the six plans, one of which is assigned to each federal department. I think that comes to about 14 different things.

● (1600)

Ms. Verna Bruce: I'll speak to it generally from a management perspective, and if you have technical questions, I'll defer to the people who have the technical expertise.

Simply put, for me, as a person responsible for delivering drug plans to veterans, and with my hat on the Federal Healthcare Partnership, there are three critical things. One, you need to know that a drug is safe, and that would be Health Canada.

Ms. Bonnie Brown: Excuse me, that's going around my question. My question is, considering there are competing committees of experts, which one do you listen to?

Ms. Verna Bruce: We listen to CDR in terms of getting the advice on whether or not a new drug is worth the money it's going to cost.

Ms. Bonnie Brown: Since the arrival of the CDR, to your knowledge has anything else been dismantled at Veterans Affairs? In other words, this is costing a lot of money, and I wonder what was there before and did any of that fold down to accommodate the CDR.

Ms. Verna Bruce: Speaking for Veterans Affairs, we have an internal committee—we still have it—but in the past it would have spent hours and hours trying to chase down medical reports and research reports. They don't have to do that anymore, because we take that information from CDR. Our committee can then take that information and make a decision about whether or not it's a benefit that would make sense to list for veterans.

Ms. Bonnie Brown: I can see that you're pretty happy with it and I can understand why. You may not think these numbers are accurate, but an outside report said that 27 drugs got positive formulary listing recommendations, and the government currently reimburses all 27 drugs under the veterans' drugs benefit plan.

I wonder what expert you're listening, because it said that 25 drugs got negative recommendations, and despite that, the federal government provides coverage for all 25 drugs to veterans. What it means is that regarding every drug that's submitted, somehow or other you have access to it for your client group.

Ms. Verna Bruce: There is an error in the listing in terms of the drugs that are not approved. We do not list them on our formulary, but we will, on a case-by-case basis, take a look at whether or not a veteran who's tried everything else without a positive result could benefit from the ones that aren't listed.

Ms. Bonnie Brown: They could get anything that got a negative recommendation if someone in your shop thinks they really need it?

Ms. Verna Bruce: It would have to have a very high level of rigour, and not just from people in our shop, but from the physicians involved as well. There would have to be documented evidence that existing medications are not working.

Ms. Bonnie Brown: The thing that concerns me about this, Mr. Chairman, is that for the first nations health branch, of the 27 drugs approved, apparently only 15 of them are available to first nations.

I think maybe that number was incorrect. What was the number?

Mr. Ian Potter: We reimburse them for all the drugs that have been approved by the common drug review.

Ms. Bonnie Brown: Do you ever fund the drugs that have had a negative recommendation?

Mr. Ian Potter: We have two drugs that had a negative recommendation. On both of them, as I said, our decision to fund was based on the unique needs of our clientele, which is sometimes different from that of the general public.

Ms. Bonnie Brown: My concern is this: the federal government pays 30% of the cost of the common drug review and the federal people here seem to be saying it's good for them, but if it's such expert advice, how come they're funding things that get negative recommendations?

Mr. Chairman, I understand the provinces are doing the same thing. In some cases, they are not listing the drugs that got a positive recommendation from the CDR and they are listing the drugs that got a negative recommendation. If this is all such highfalutin, perfect expert advice, how come nobody is obeying the recommendations? Everybody is doing it, both recommending and not recommending, totally opposite to what the CDR is saying.

What are we paying for here?

The Chair: Does anyone want to try that one?

Ms. Verna Bruce: I'd be happy to.

We can take a look at the CDR . My understanding is that they make decisions that are generally good for the highest proportion of people in the population. But as partner departments, we all have different clientele with different needs. So while the majority of recommendations—for example, a drug that's being listed for young women is probably not something we're going to list on our formulary, because we don't have a whole lot of young women as clients just yet. On the other hand, there may be a drug that is not recommended for dementia or a particular disease that we deal with in Veterans Affairs. If our veterans have gone through all of the other drugs without a positive result, our view is that they've served our country and we owe it to them to try to see if this will work. But we've only approved those drugs for 380 of our 132,000 clients.

● (1605)

Ms. Bonnie Brown: You don't have to justify what you're doing from the perspective of compassion. No one wants you to be compassionate more than we do. What I'm saying is that if the common drug review is so terrific, how come it hasn't taken those things into consideration?

The provinces would not agree that the general population is well served. They are rejecting the recommendations of the common drug review, listing things that have had a negative recommendation and not listing things that have a positive recommendation.

It isn't the population base. I think all the people who had decision-making power before the common drug review are simply hanging on to it. The only thing in your speech that seemed to be positive was that Prince Edward Island, which is the size of my county in population, is benefiting because they couldn't afford to do this themselves.

Ms. Verna Bruce: But I think that's also true of the federal partners. We couldn't afford to do it ourselves either.

Ms. Bonnie Brown: But what were you doing before?

Ms. Verna Bruce: We were not taking really evidence-based decisions. We were working with the research. Certainly in Veterans Affairs we don't have the expertise that's available from the CDR to make those kinds of decisions.

Ms. Bonnie Brown: Thank you, Mr. Chairman. I think that says everything.

The Chair: Thank you very much.

Madam Gagnon.

[*Translation*]

Ms. Christiane Gagnon: Good day. I'm somewhat surprised to hear all of you say that are you pleased with the Common Drug Review process. The industry's R&D sector is singing quite a different tune. We're hearing from sector representatives that wait times are too long. Mr. Potter, on the other hand, claims that it now takes less time than before to list and market a new drug.

We also have some figures showing that since the Common Drug Review was instituted, fewer drugs have been listed. In Quebec, where no such program exists, more pharmaceuticals are listed and qualify under drug benefit plans. The figures that I have are quite different from yours.

You stated that in any event, even is a drug was not approved for listing under the Common Drug Review, you would list it anyway and include it in a drug plan. I find your position somewhat contradictory. You seem to be satisfied with the current situation and have no recommendations to make, or concerns to voice about the listing process, about wait times and possible duplication at different levels. I'm a little surprised by this.

For example, I was expecting you to say that some drugs are not available, especially since you have some clients under federal government jurisdiction, and that people are not very happy with the existing process.

Are you saying then that veterans and First Nations are satisfied and that you're not being pressured in any way to make certain drug products available?

[*English*]

Ms. Verna Bruce: I can speak from the Veterans Affairs perspective.

We obviously have some clients who are not happy with the decisions we take, but again, we are a publicly funded program. We have to be able to make a decision about whether a drug should be provided to every veteran, or whether a drug should be provided to veterans who have a specific need because they've tried other things. To do this work ourselves would cost us a lot, so having the common drug review actually saves us the research work.

● (1610)

[*Translation*]

Ms. Christiane Gagnon: Mr. Potter, you maintained that you have reduced the amount of time it takes to list a drug product, as I recall, from 500 days to 300 days. Could a new drug product possibly be listed in less than 300 days? In the documents circulated, I noted that in Quebec, where many more products are approved and listed, the wait time is over 200 days.

[*English*]

Mr. Ian Potter: Yes, we would like to see wait times go down, and we are working to see that they are going down.

You must remember that the common drug review is only dealing with new chemical entities—

[*Translation*]

Ms. Christiane Gagnon: I understand.

[*English*]

Mr. Ian Potter: —and my understanding is that they've looked at around 68 since their inception. And that's against a backdrop of, as I said, a formulary of about 6,000 different drugs that are listed.

So in terms of the access to drugs, we feel our formulary does cover quite broadly the drugs that are available in the different therapeutic classes necessary for first nations and Inuit.

LCol Dave Cecillon: In addition, with respect to the common drug review, they'd be best to answer that question. However, my personal experience with them indicates that, for the most part, that timeline includes appeal process timing, so they may be better to address that.

From the time it receives a notice of compliance until the time they make their recommendation does also include an appeal process. If within that appeal process the manufacturer does not meet the timelines, then that further delays it.

But I'm sure they would be best suited to answer that question for you.

The Chair: Thank you very much.

Mr. Fletcher.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Good afternoon, Mr. Chair.

Thank you to the witnesses for joining us today.

Madam Bruce, I just want to concur in something that you said. Our veterans fought for our country and it's up to us to stand by our veterans once the fighting is done. So I hope that when there is doubt we err on the side of the veterans' health.

There is a frustration, I think, that either the committee has heard or that is behind the scenes. We have the CDR, and sometimes the CDR passes or approves a drug and some stakeholders don't include it, and in another case when drugs are denied, stakeholders do include it or cover it. There's no really clear mechanism or transparency on what makes a drug approvable or not.

I think there's a lot of frustration with stakeholders, be it drug manufacturers or individuals who are required to get these drugs. I wonder if you could talk about transparency with the CDR and about how you feel about the transparency of the organization.

You also referred to several other review committees in your opening remarks, the FPT and DUEAC. Does your program duplicate the work of the CDR by re-evaluating the recommendations through these other committees? This is similar to what I think Bonnie Brown was asking. There does seem to be a bit of a duplication, but perhaps not. Could you clarify?

Ms. Verna Bruce: Sure, I can try.

The questions around the common drug review are probably best answered by the common drug review, but from the perspective of the partner departments, it is really complicated, there's no question. But when you think about the amount of money we're spending on pharmaceuticals, you want to make sure that the drugs we're providing are, first of all, safe. You want to make sure that a really expensive drug is really going to be worth the extra investment of taxpayers' dollars and that it's not just a more expensive drug that does the same thing, or something not as good even as a drug that's already on the formulary.

So there are different groups that look at the drugs from different perspectives. Then among the six partner departments, we do try to learn from each other, to understand what one department is doing, how that applies to the other. So while it's extremely complicated, each committee has its own particular value that it adds.

The drug utilization evaluation is really important from the point of view of taking a look at people who are really high consumers of pharmaceuticals and trying to take a look at whether there are unintended consequences of so many drugs being consumed by one individual, and again making sure that we have experts who are looking at our data to highlight whether or not we have people who are having problems from drug interactions.

● (1615)

Mr. Steven Fletcher: And on the transparency issue?

Ms. Verna Bruce: I'd leave that to the common drug review. Again, we have a representative sitting on the common drug review, so for us as a department, we have access to the information. So it is a transparent process for us because we're part of it.

In terms of consumers, again, you would need to touch base with them.

Mr. Steven Fletcher: Does anyone else want to comment on transparency?

Abby.

Ms. Abby Hoffman (Executive Coordinator and Associate Assistant Deputy Minister, Pharmaceuticals Management Strategies, Health Policy Branch, Department of Health): I could comment briefly on this, although I think the CDR representatives will elaborate in more detail from their vantage point.

I think it's fair to say that if you look at the website where CDR information is posted, the website of the Canadian Agency for Drugs and Technology in Health, you will see there is a lot of information posted there documenting the progress and timelines and the conformity with time targets for review of drugs that CDR has been asked to review. And there are also quite good explanations of the reasons for decision when the CEDAC has provided its advice about whether or not a drug should be listed.

Now, I think there are always cases that can and should be made about whether or not the level of transparency corresponds with contemporary standards, and let's face it, those standards have changed a lot in recent times. But I think at this point, many of us would feel that CADTH and the CDR should be commended for the level of transparency surrounding their management of the CDR program. That's not to say they don't wish to do more—and you can ask them about their plans when their witnesses appear later on. But at the moment, if you want to know why a decision has been taken about a particular drug reviewed through the CDR process, you can get quite a good sense of what factors went into their recommendation just by consulting the CADTH and CDR website.

Mr. Steven Fletcher: Okay.

The Chair: Thank you very much.

Ms. Priddy.

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

I'm going to ask the people who answer to give fairly short answers, because sometimes I don't get to ask many questions, so short answers would be great.

The Federal Healthcare Partnership annual report for, I think, 2005-06 estimated that participating in the CDR saved about $21 million, or something to that effect. You have three different perspectives here, but could you tell me how you think that happened? How did these savings get achieved, because you're really the ones who are saving, because you're the clients in many ways, or your clients are.

So quickly—

Ms. Verna Bruce: On behalf of the partnership, the $21 million is not just from the common drug review, but a result of all the things we've been doing around pharmacy. We're doing some things like joint negotiations. So if we go into a province like British Columbia, the six partners, or many of us, will work together to try to have a similar negotiating agreement in that particular province so we will get the same prices.

So the common drug review would only be a part of it. The larger part would be from things like our negotiation strategies—and again, trying to get the best dollar for the drugs we do have listed.

Ms. Penny Priddy: Okay, thank you.

Does anybody else want to comment? No? Okay.

My second question, then, is about the common drug review currently expanding to cover, or thinking of expanding to cover, new indications for older or previous drugs, and eventually plans to cover all publicly covered drugs. Can you tell me the impact you think that will have on cost savings for the federal drug benefit plan?

LCol Dave Cecillon: I can comment on that.

If you look at what we're currently doing, we're doing that individually. Again, we would see economies of scale from that. If we're hiring one body to provide us with that information, it reduces our human resources and financial resources requirements by effecting that decision.

● (1620)

Ms. Penny Priddy: Okay, so it reduced your costs, because you're currently doing that on your own, right?

LCol Dave Cecillon: That's correct.

Ms. Penny Priddy: And you're suggesting that the $21 million saving is in part because of the drug review, but also in part because of other strategies you're putting in place, like negotiating drug costs, etc.

Okay, thank you.

Could you comment on whether you would see a benefit in moving to a national formulary?

Ms. Verna Bruce: One of the recommendations from the Auditor General was that we should do more on a common formulary. Through the departments, we have identified the common core formulary.

Again, each department is going to have different drugs. Birth control is one big thing for us right now, and a lot of dementia drugs are not a big thing for the Canadian Forces. We're always going to have different things, but we have identified a core of about 200 drugs that are common to all of our formularies. We can then use those core drugs as a basis for trying to negotiate better prices for all of us.

Ms. Penny Priddy: Do you think a national formulary is a benefit?

Ms. Verna Bruce: You'll never have one national formulary, but you can have a national core formulary. The cores will be absolutely beneficial.

Ms. Penny Priddy: Do you see the difference then only as it relates to the particular client groups that you serve?

Ms. Verna Bruce: Exactly.

Ms. Penny Priddy: That's wonderful. Everybody has the same opinion.

Ms. Abby Hoffman: Maybe I could comment, not because I have a different opinion but to mention this. Under the national pharmaceutical strategy, which is a joint enterprise of the provincial and territorial governments and the federal government, moving toward a national formulary is one of the objectives of that strategy. I think it's fair to mention that while not all drug plans will access all of the drugs, given the nature of the beneficiaries that might be on that formulary, it's one element.

A second element worth mentioning is that even in the environment of an agreed-on national formulary, I think there will still be decisions made about access on an exceptional rate basis to certain products. I think it's what you've heard a little about here today.

Even if in the majority of cases the recommendations of the CDR are accepted, there still will be exceptions that need to be made, and there are good therapeutic reasons and good efficiency reasons for doing that. There will need to be decision-making structures in place to allow for expert advice to be received on a case-by-case basis to allow for those exceptions. But they would not detract from the value of a core national formulary. We will continue to use CDR, particularly as CDR expands into new indications for old drugs. But even more importantly, class reviews, which we expect will come on stream over the next few years, will significantly assist the eventual goal of a common core formulary.

Ms. Penny Priddy: I believe there have already been some class reviews.

Am I done?

The Chair: You're finished.

Ms. Penny Priddy: In that case, I guess I am finished for now.

The Chair: Yes, you are finished. Thank you very much.

Ms. Penny Priddy: I'm never finished, but for now I am.

The Chair: I appreciate that.

Mr. Batters, you have five minutes.

Mr. Dave Batters (Palliser, CPC): Thank you very much, Mr. Chair.

Thanks to the witnesses for being here today.

Hopefully, we'll have time to get back to Ms. Priddy, because she's always very enlightening.

My first question is to Ms. Bruce.

First of all, I'd like to make a quick comment. Following the last meeting, we had a number of comments that the CDR represents a barrier to patient access. The avenue that I'm taking to this study is this. What's going to enhance patient access to pharmaceuticals?

There were comments made that the CDR represents a barrier to access. It provides unnecessary duplication as the provinces do their own reviews. There are significant delays. There's a lack of transparency, a real lack of accountability, and we're learning today that no consistency exists in the process.

Ms. Bruce, if the CDR is working as well as you say it is, why does it have so many critics?

Ms. Verna Bruce: From my perspective, I guess the CDR is really looking at bringing new drugs onto the market. It provides us with information on whether or not a particular drug is more cost-effective than anything else out there.

If I step back to where we were before 2003, it was taking a lot longer to get decisions made on whether or not a drug would be added to one of our drug plans, for example, because we didn't really have the expertise. Instead of it taking 300 days, it could've taken 600 days. I don't know the actual number, because we would have to try to get the information ourselves. The timeframes have actually come down dramatically. The benefit for the pharmaceutical companies is that they don't have to come to each one of us individually to try to make the case. They can make the case in front of a common drug review.

● (1625)

Mr. Dave Batters: Thank you.

The decisions are certainly not unanimous. A positive recommendation from the CDR doesn't necessary mean a positive recommendation from the provincial plan. There seems to be no consistency from level to level.

I want to pick up where Ms. Brown left off on the study conducted by Wyatt Health Management, commissioned by CARP. She covered the 73 drugs that were submitted in terms of the CDR's positive listings. Out of the 73 submissions, the CDR made 26 negative recommendations. One drug was withdrawn by the manufacturer, leaving participants with 25 negative recommendations.

Despite the negative recommendations, the federal government provides coverage for all 25 drugs to veterans, whom you represent through Veterans Affairs. In contrast, only three drugs are reimbursed under the drug plans available to first nations, the Inuit, and the Canadian Forces.

I have a couple of comments.

We have 73 drugs that are studied. This is supposed to be an evidence-based medicine approach with experts. We have 25 drugs that are recommended to not be covered, or negative recommendations, that are all covered for veterans. I don't understand that. I would be anxious to hear your explanation.

As well, if I were the gentlemen who sit to your right and to your left, I'd feel somewhat shortchanged by this whole process, although I guess the process seems to be working the way it should for them.

Can you explain to this committee the discrepancies in the listing decisions of federally funded drug insurance plans following CDR recommendations? More particularly, can you explain why the federal program for Veterans Affairs enjoys broader coverage than the other federal programs?

Last, can you explain why the Veterans Affairs plan would allow for reimbursement of drugs that were recommended by the CDR to not to be reimbursable? I'd like some examples of what those drugs might be.

Mr. Chair, it's a serious question. We have 25 negative recommendations, all of which are funded by Veterans Affairs. I'd like some examples of those drugs as well.

The Chair: Let's ask for an answer, because you took over four minutes in the question.

Ms. Verna Bruce: The information in the CARP article is actually wrong, so I'll start from that. In fact, of the 25 drugs that were not recommended to be listed, none of them have been listed by Veterans Affairs Canada. So as I was explaining earlier, the information is actually incorrect. They are not listed drugs. Similar to other people, though, if we have individuals who could benefit from the drugs, we will look at them on a case-by-case basis, but they are not listed on the formulary and they're not available to all.

Mr. Dave Batters: I have one last quick question, Mr. Chair, to anyone who wants to respond.

Have there been drugs turned down by the CDR that you really would have liked to see approved? This question is to all three of you.

LCol Dave Cecillon: On behalf of DND, no, there were no drugs that were not approved that I would have liked to see on the....

Mr. Dave Batters: Okay.

Mr. Potter.

Mr. Ian Potter: We're satisfied with the decisions of the CDR. As I said, in two cases where they had turned down a drug, we thought there was a reason that our particular clientele would benefit and that we would have a cost-effective situation where maybe generally it wouldn't exist.

Mr. Dave Batters: Were you able to seek redress on those two examples?

Mr. Ian Potter: No. The CDR is a recommendation, and we take the advice of the CDR fully. We see across the country much greater consistency in the drugs that are listed, but we do see that some plans have a unique clientele, and in those cases, there may be a reason.

Mr. Dave Batters: Ms. Bruce, do you want to comment?

Ms. Verna Bruce: Again, Veterans Affairs Canada lists all the ones that are recommended to be listed. We don't list the ones that aren't recommended to be listed. Like others, we have a case-by-case review mechanism.

Mr. Dave Batters: I'd like to state, Mr. Chair, before we move on, that there's a huge gap between the information that was supplied to us here from our very capable researchers and the information that was relayed to us by Ms. Bruce. I'd like to have some kind of explanation of why, on page 8 of the Library of Parliament's notes, the briefing notes that we received prior to this meeting, there's a huge discrepancy between the information given here and the testimony we've heard. I'd like to have some kind of explanation as to why that is.

● (1630)

The Chair: Okay. You can ask that question at, I believe, the Thursday meeting.

Mrs. Odette Madore (Committee Researcher): This is a study that was commissioned by CARP, and it was done by Wyatt Health Management. So if there is an issue of methodology, maybe we need to ask those people who have done the study. Or maybe we need to ask—

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

The Chair: Thank you.

Ms. Kadis.

Mrs. Susan Kadis (Thornhill, Lib.): Thank you, Mr. Chair.

On the question of whether there is duplication in terms of hopefully better health outcomes for clients and Canadians, I'm interested in knowing why, although the Federal Healthcare Partnership has representation on CDR, at least three of the federal drug plans do not? I'm not clear on that.

There also seems to be some discrepancy there as to why two organizations—I'm forgetting which two—I believe, have representation on behalf of the organization, but the others are all separate.

Ms. Verna Bruce: Sure. Through the Federal Healthcare Partnership, we as federal government departments are actually trying to work together and we try to support and help each other. There are three big players who want to represent themselves, and that's perfect. There are three other smaller players, from the drug perspective, who don't have the resources to dedicate to actually attending the committee meetings, so we have the pharmacists from the Federal Healthcare Partnership helping them by representing their interests at the committee.

Mrs. Susan Kadis: In terms of funding, because I believe we will be seeing the estimates soon, upcoming in a meeting shortly, how much was spent by the federal drug plans in reviewing new drugs prior to the creation of the CDR? In particular, where does the federal funding actually come from, and where will it appear in the estimate documents?

Mr. Ian Potter: I don't have the precise numbers. We could work to see if we could get an estimate. I think it may be difficult to go back in time and find out exactly what has happened, because it was part of some person's job and now they've moved. As I said, they're spending more time on safety issues, where they were spending more time on approval issues.

But if the committee would like, we could put some effort into trying to determine what we're spending now and what we were spending then.

Mrs. Susan Kadis: I think, in the name of transparency, the committee would appreciate that.

Where can we find the funding in the estimates?

Mr. Ian Potter: Excuse me, I didn't get that. Where in the estimates—?

Mrs. Susan Kadis: Where in the estimates can we find the funding for CDR?

Ms. Abby Hoffman: With respect to the federal share of costs for CDR, they will be found in a named grant that goes to the Canadian Agency for Drugs and Technology in Health, and the CDR is a relatively small proportion of that total annual contribution. You will find it in vote 5 of the Health Canada estimates.

What I'm sorry I can't tell you right off the top of my head is what the disaggregation of those vote 5 contributions is, but in any event you would see, among the organizations benefiting from vote 5 contributions, that the host organization and the amount that's directed to CDR in the current fiscal year is $1.55 million from the federal government. We are the second largest contributor after Ontario.

Mrs. Susan Kadis: Thank you, Mr. Chair.

If I still have a moment of two, I'm interested in this new establishment of the joint oncology drug review. In your opinion, what are the advantages of having a separate common drug review for cancer drugs, and what are possible drawbacks as well?

LCol Dave Cecillon: In that regard, I think you have to address that through to CDR. They would be best to answer that question.

Mrs. Susan Kadis: Thank you, Mr. Chair.

The Chair: Thank you very much.

Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Mr. Chairman.

Thanks to each of you for your presentations.

I want to go back and ask this. I think, Ms. Bruce, you had responded to the national drug formulary, but I'm interested to hear what the other two departments feel about that. Is it a good goal to be working towards, or is it something that would be beneficial to your departments?

LCol Dave Cecillon: As Ms. Bruce indicated, we have come together to have a core formulary, and based on our different needs, our patient population from 17 to 60, many disease states are not prevalent within our patient population and therefore we do not list those products for those disease states. So that means the difference between us.

I'll let my counterpart from NIHB respond.

● (1635)

Mr. Ian Potter: We've been seeing the advantage of a national or common core formulary, but as mentioned previously, there are very particular needs of different plans, and those needs show up in the formulary. And I think that was a strength of the system, not a weakness.

Mrs. Patricia Davidson: Thank you.

Ms. Bruce, the information that came out of the Wyatt health study that was commissioned by CARP has been quoted here a couple of times, and you have stated that those figures are incorrect. I believe the figure we have is that, despite negative recommendations, Veterans Affairs covers 25 drugs that got the negative one, and you're saying that's incorrect. What is the correct number?

Ms. Verna Bruce: As I understand it, and I'll verify this for the committee, of the 25 drugs that are recommended not to be listed, Veterans Affairs has not listed any of them. And again "listed" means that they're on the list and they're available for everybody to access without any questions being asked. We do have them, though. If a veteran has tried all of the listed drugs and it hasn't worked, then they can make a special request for case by case. So it's not listed on the formulary but it's available on a case-by-case basis.

Mrs. Patricia Davidson: In fact, maybe this information isn't incorrect, because it says the federal government provides coverage. So it could be providing coverage if in fact it's a specific incident, case by case?

Ms. Verna Bruce: But I think the information may not be consistent among the departments. I think for Veterans Affairs, they've taken that case-by-case and made it look like we're listed, whereas for the other departments they may have taken the listing.

Mrs. Patricia Davidson: Okay, and it says that for first nations, the Inuit, and the Canadian Forces, there are only three drugs reimbursed. Is that figure correct, or is that wrong too?

LCol Dave Cecillon: On behalf of DND, I can't comment on the exact number, because again it's a case-by-case basis, and at times you look at the economics between sending a person off to undergo a surgical procedure or putting them on a medication that may help them, and that's how you have to weigh it out. Our mandate is to provide health care to improve patient outcomes, and so that's what we attempt to do.

Mr. Ian Potter: For first nations and Inuit health non-insured benefits, there are two drugs that were not recommended. One is Lantus, which is a long-acting insulin drug that is on our exceptions list. It's been put there because it is sometimes useful instead of having to go to an insulin pump, which is often difficult given the location of our clients. The second is a drug control patch called Evra, and that's on a limited-use basis.

Mrs. Patricia Davidson: From a federal perspective, what changes, if any, should be made to the CDR?

Any or all of you could respond to that.

Ms. Verna Bruce: There are questions that have been raised, probably by other partners, around transparency. For us, we're really glad there are a couple of client people sitting on the committee. In terms of other things from the partnership, again, we've been working with the results of the EKOS Research.

I don't know if I can add anything, but someone at the table may want to.

There are always things you can do to improve.

Mrs. Patricia Davidson: Do you think it's time for another in-depth review? It's a young group and it has been an evolving process, from what I'm hearing. Is it time now after four years to do another in-depth review?

Ms. Verna Bruce: I guess you'd have to talk to other people who are partners in the CDR.

From the Federal Healthcare Partnership perspective, it has been four years and it is working well. Part of me would hate to think of all the resources required from the health care system if we were going to do another review of something that's working relatively well for us. Maybe it's not working as well for the provinces and territories; I can't speak to that. We have a member sitting there, so it's meeting our particular need at this point in time.

Mrs. Patricia Davidson: Thank you.

The Chair: Go ahead, Ms. Hoffman.

Ms. Abby Hoffman: Mr. Chair, if I may comment, I think there are a couple of things we might say about improvements. The first is about accelerating the further development of the CDR.

Earlier I mentioned the issue of class reviews. That would allow CDR to move from what it does now, which is to review new drugs, to actually doing some retrospective reviews of an entire array of drugs for a single condition. I think that would provide extremely useful information. That's a matter of building capacity in the CDR and permitting it to take that on, on behalf of all jurisdictions.

The other issue I think you'll undoubtedly hear about as other witnesses appear at this committee is the issue of drugs for relatively rare diseases. These are small populations where the drugs are extremely expensive. There has been criticism because using its normal analytical tools the CDR has tended to recommend against the listing of those drugs. That's an appropriate recommendation and advice that CDR is currently offering.

Whether governments ought to consider asking the CDR to open up a new stream of analytical capacity so that it could look at those drugs and provide a more nuanced recommendation about the circumstances under which some of those drugs ought to be reimbursed by public authorities, I think, is a very important question. I'm not going to prejudge what the answer is. It's that kind of sophistication and more complexity in what CDR could take on that I think would be of interest to this committee, and that is apropos of your question about further review or study of the CDR.

I think it would be more useful to look at new areas that the CDR could explore rather than once again going over the territory that I think CDR already quite capably undertakes.

● (1640)

Mrs. Patricia Davidson: Thank you.

The Chair: Thank you very much.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Mr. Chairman.

I'd like to thank the witnesses for joining us.

As you know, last week we met with industry officials as part of the review process. One sticking point seems to be the wait times under the program for recommending that certain pharmaceuticals be listed.

I listened closely to your opening remarks, Ms. Bruce, and I came to the conclusion that even if faster decisions were made on new listings under the program, your respective departments wouldn't be able to act any quicker on this and new drugs would not be available any faster.

Is my understanding of the situation correct?

[*English*]

Ms. Verna Bruce: That's one that I think we, and perhaps some of the other partners around the table, would need to think about. I know we only have a limited amount of capacity. If CDR were to all of a sudden really speed up, then we'd have to take a decision about trying to put more resources at the departmental level to evaluate that against our own drug plans.

I don't know if others have a view.

[*Translation*]

Mr. Luc Malo: Go ahead, Mr. Potter.

[*English*]

Mr. Ian Potter: I think that if they conclude their reviews in a shorter period, the total time between the drug's coming on the market and the drug's being listed in our program would be reduced.

As I said, we are trying to reduce the amount of time that we spend looking at our particular population and seeing if it is apropos or if there are some differences. Very minor changes are made between the recommendations in CDR and what we do in terms of listing. We build on after they approve, so if they reduce their amount of time, the total time will go down.

[*Translation*]

Mr. Luc Malo: How can you make that claim, Mr. Potter, when Ms. Bruce stated in her opening remarks that delays in the uptake of CEDAC recommendations by the drug plans was one area in which improvement was warranted?

If a problem already exists, how can you think that if the review process were accelerated, you would be better able to keep pace, when you're already having trouble doing that?

[*English*]

Mr. Ian Potter: I am not sure if I understood the difference between my position and Ms. Bruce's position. I think we're saying there is a period of time that the CDR does work and there's a period of time afterwards that each department looks at it and their drug plans to see if it's appropriate to list in their special circumstance.

I don't think the volume is so huge that it will make a big difference, but it may, depending on the size of your program. We have a fairly large program. I think we spend almost $370 million a year on drug benefits, so compared to others, we may have more capacity.

● (1645)

[*Translation*]

Mr. Luc Malo: Do you reassess each product submitted for review, whether it was recommended or not?

[*English*]

Mr. Ian Potter: We do not reassess the work that the common drug review has done. What we do look at is certain decisions they make based on parameters that they set out quite clearly. Some of them are things like the cost of the drug. Some of them are looking at alternatives.

For example, I talked about the situation in which we were looking at a long-term insulin drug, Lantus. It has the possibility of replacing the need for an insulin pump. Our program covers both. It is very expensive if a patient has to move to an insulin pump, and while it may not be of value in the general population, in our particular population, because of its isolation and the cost of servicing that clientele, it was deemed by our pharmacists and physicians to be a valuable drug for a few cases in which they may not need an insulin pump but do need a longer-acting insulin.

[*Translation*]

Mr. Luc Malo: In that case, do you really need the committee to make recommendations, or would a number of pharmacological analyses suffice, given that you do question whether or not the product is good for your own clients?

[*English*]

LCol Dave Cecillon: From DND's perspective, yes, we do need the analyses. It is a recommendation and it is based on a pharmaco-economic analysis that takes an uptake of the drug in each jurisdiction. Because we have various jurisdictions with quite a varying population, that uptake may not be the same as what CDR has looked at.

We're not a province. We don't have the population of a province, so it may not impact us financially as much as it would one of the provinces; therefore, given our individual mandates, we have to determine whether we can afford it within our resources.

[*Translation*]

Mr. Luc Malo: So then, you don't really need a recommendation, but rather more work on the process leading up to the recommendation.

[*English*]

LCol Dave Cecillon: No. We do need the recommendation, because the recommendation includes the pharmaco-economic analysis. What we need to do is individualize that for our program, bring it to our deputy minister or whoever, and let them make the decision on whether we will fund it.

[*Translation*]

Mr. Luc Malo: Thank you.

[*English*]

The Chair: Thank you very much for that.

Patrick Brown.

Mr. Patrick Brown (Barrie, CPC): Thank you, Mr. Chairman.

My concerns are similar to those of Mr. Batters about patient access. Since I wasn't here when the common drug review came about, was there a reason why some people felt that drugs were being approved prematurely? Are there any examples of mistakes that happened in the system without the CDR?

Second, what is the point of the CDR if the provinces are approving drugs that are not recommended by the CDR? Can you explain what benefits may arrive from having those conflicting positions?

Third is a local issue I had in my riding. A constituent came into my office to tell me that her mother was suffering from cancer. The physician said that Iressa would be helpful, and my constituent wanted to know why the CDR hadn't approved it. It's very difficult when a constituent is very upset, when dealing with a loved one, by what she believes is red tape and incredible slowness on behalf of the federal government.

I understand that some of the provinces approve that drug, so why would some provinces say it's good enough for their patients when the CDR is saying it isn't? It just seems we get so many mixed signals out of this system.

Could you provide some light on this?

● (1650)

Ms. Verna Bruce: I can take the first question, but the common drug review people should speak to the provincial matter. I have no knowledge there, and I don't think any of us do. Others can speak to the cancer drugs.

On why we got into the common drug review, previously each department tried to figure out, every time a new drug came on the market, even though it was a lot more expensive, whether it was actually going to provide that much greater benefit for the people to whom we were dispensing the drugs. So we were trying to do it ourselves.

There is not a bottomless pit of resources to do that. It requires a lot of professional expertise—doctors and pharmacists—and they're in high demand. So the view of the partner departments was that rather than each of us trying to build our own drug review process, if we went in it together we could end up getting something that would probably cost less in the long run, we wouldn't be duplicating the same work six times, and it would make it easier for everybody.

So from a user's perspective, that's basically why we got into the common drug review.

Mr. Ian Potter: We've seen improvement in the quality of work that's been done since the common drug review, and we've seen efficiencies in having one expert panel deal with it. We've reduced the amount of work we do on reviews of new drugs. We have seen the time period go down between when a drug enters the market or is approved by Health Canada for sale in Canada, and when it gets listed as a benefit on our program. We have seen benefits from it.

You'd have to ask the CDR about it, but my impression is that there is more commonality between drug plans now than there was in the past.

Mr. Patrick Brown: Is anyone able to comment on the case of the cancer drug being available in British Columbia but being turned down by CDR?

LCol Dave Cecillon: I can't comment on the individual provinces, but based on my attendance at CDR and the recommendations, each province has its own mandate and exercises it based on the recommendation. If one province feels it has the funding to pay for a drug that wasn't recommended based on cost alone—which some of them might be—it can do so.

Mr. Patrick Brown: So the explanation is that British Columbia decided it could pay for it, but CDR viewed that drug as being too expensive.

LCol Dave Cecillon: I'm not saying that. CDR makes its recommendation, and the provinces can determine whether or not they can fund the drug, based on their mandates. So it's not a matter of whether the decision is CDR's or not. Each provincial mandate allows the province to determine if it can pay for it or not.

Mr. Patrick Brown: Thank you.

The Chair: Thank you very much.

If the committee would allow me, I have a couple of questions just to clear it up for the committee.

It makes perfect sense. You want efficiency. You want to have one board examining these products so you don't have to duplicate it in each of your portfolios or areas. But we have before us three different departments of the federal government, all with three different formularies, all using the CDR and saying it's appropriate. The explanation you gave as to why they're not uniform is that the populations you're trying to accommodate are different. That sort of makes some sense. But it's physicians who prescribe the medication, and there are some in the Canadian armed forces who are female who might use the same birth control...whereas the first nations say they need a different product. Or there is even the insulin pump.

I guess where I'm coming from is that I have a difficult time understanding, even if it's not prescribed very often, why it would not be on a formulary as being acceptable, when it's a federal government department.

LCol Dave Cecillon: With respect to DND, the product that was alluded to by Mr. Potter is a regular benefit on our drug plan, and we do have that. That was the Evra patch.

The Chair: Okay. Then why is your formulary not identical to Mr. Potter's?

LCol Dave Cecillon: Again, based on our patient population, and I also alluded to it in my opening remarks with respect to our need to deploy, we have a limited list capability, which means that we can't take every single drug. We just don't have the capacity to move them. The other thing is that we have stability concerns in our operations. If you take a patch into a cold area compared to a very warm area, the kinetics of the drug, or the absorption of the drug, varies, and therefore we have to take that into account. So there are many factors that we look at.

The other thing is that we have primarily a healthy, younger population, and he has a varied population with pediatrics and geriatrics, which we don't have. So you wouldn't find many of the Alzheimer's drugs on our benefit list. You would not find drugs for some cardiovascular diseases, unless a patient has that condition, when we would do it on a case-by-case basis, as Bruce has said. We also look at the individuals and we tailor the therapy to them. It doesn't mean it's not a regular benefit; it means that not everyone can access it.

● (1655)

The Chair: I understand all of that. But it's not the formulary that prescribes it; it's physicians. It's specific, patient by patient. All the formulary does is allow you the ability to use it or not. So I guess that's where my problem is with three federal departments, all with different formularies, albeit, I understand, with different clientele. Nonetheless—

LCol Dave Cecillon: We also have jurisdictional issues across the country in that we are multi-jurisdictional across the various provinces and because our care can be provided after hours. Then there are also changes that you have to accommodate, because certain provinces may have certain drugs on their benefit lists that may not be on ours. We aren't able to facilitate care to all our individuals within our system, and sometimes we rely on the private system to do so.

Those are some of the differences, as well.

The Chair: Thank you very much.

I think we'll draw this to a close, then. We want to thank the witnesses very much for coming forward.

Mr. Batters put a late name on. I'm a little reluctant. We're into round two, but I'll allow Mr. Batters to go ahead.

Mr. Dave Batters: Did you not have anything, Bonnie?

The Chair: We have business afterwards.

Mr. Batters, I'll allow you to go ahead with a quick question, and we will promise a conclusion very quickly.

Mr. Dave Batters: Do I have five minutes, Mr. Chair?

The Chair: At most.

Mr. Dave Batters: I have two quick questions. Well, they're not that quick, but the second one is quick.

Mr. Potter, from NIHB, can you comment on your policy of forced switching to generic drugs? Isn't this a policy that's based purely on cost containment, without taking into account the health of aboriginal Canadians, which of course should be the priority? What happens if the drug the patient is switched to does not work for him or her? If it's, as I suspect, a policy based purely on cost containment, can you tell us how much money the department saves by switching these clients to generic drugs, when of course you have to factor in the extra costs incurred for transportation and doctor visits as a result of changing these prescriptions?

Finally, why does this policy of forced switching to generics only apply to NIHB and not to Veterans Affairs and the Canadian Forces?

Thank you.

Mr. Ian Potter: The issue you're asking about is whether or not there is therapeutic substitution available. We follow what provincial governments have enacted in their laws and regulations with respect to classes of medication that fit the same treatment profile. So they deal with the same diagnostic issue.

Mr. Dave Batters: How much money do you save? That's the rationale—

Mr. Ian Potter: No, the rationale is to provide effective care. The example perhaps you're looking at is our policy with respect to proton pump inhibitors, and when we introduced that, we looked carefully at the literature. We saw that based on the studies within that class of proton pump inhibitors, there were a variety of different products that had by and large the same therapeutic effect.

Mr. Dave Batters: Do you factor in, though, sir, the extra costs in terms of transportation and doctors visits as well? The only rationale for the forced switching would be cost containment. That would be it. I mean, sure, you're going to argue therapeutic substitution, that it's the same benefit from the drugs, but do you calculate in the extra cost of transportation and extra doctor visits as well?

Mr. Ian Potter: We try to pursue this on an efficiency basis. Our mandate is to use the resources that Parliament votes to us in the most efficient way we have, without compromising the therapeutic programs. We work with physicians and pharmacists to ensure that the program is therapeutically sound and that the services are, as well, delivered in an efficient way.

● (1700)

Mr. Dave Batters: Why is this a decision that you've undertaken, yet Veterans Affairs and the military have not seen fit to undertake the same decision?

Mr. Ian Potter: You'd have to ask them.

Mr. Dave Batters: I'm going to ask them now.

Ms. Verna Bruce: For Veterans Affairs, I know we do some generic substitution. I'm not sure how much, so I will get back to the committee with that.

LCol Dave Cecillon: At DND, we also do generic substitution. However, what we've also done, prior to the partners, is enter into agreements with manufacturers, and contracts with manufacturers would sometimes give us a preferred price. Sometimes it may be better than the generic price. So there are a number of ways that we do it.

Mr. Dave Batters: You don't have a policy of forced switching, though. Is that correct?

LCol Dave Cecillon: If we switch to a generic product, no, not forced switching.

Mr. Dave Batters: So if the patient wanted to stay on the brand name pharmaceutical, they'd certainly be allowed to do so.

LCol Dave Cecillon: Again, what we have is a therapeutic interchange. Where it's deemed to be interchangeable in two jurisdictions in Canada, then, yes, we would only pay for the generic.

Mr. Dave Batters: My last question of the day, Mr. Chair, is to all of the witnesses. If the CDR was eliminated through funding cuts, and here at this level we can only talk about the 30% that's funded federally, what would be the consequence, or would there be a consequence, given the tremendous duplication that seems to exist?

Ms. Verna Bruce: I can take it for the partners, and others can jump in.

It would slow down our ability to make decisions about whether or not drugs should be covered as part of our plans. We'd be into doing six times each, individually, what we're currently doing through CDR. With the partners working together, we'd try to share information, but we'd each be doing our own thing.

The Chair: Thank you very much.

With that, I will thank the witnesses for their presentations and thank the committee for their good questions. We will continue this study next time.

At this time we will take a quick pause and then we will move in camera.

[*Proceedings continue in camera*]

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