House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 050 • 1st SESSION • 39th PARLIAMENT

EVIDENCE

Wednesday, April 25, 2007

Chair

Mr. Rob Merrifield

Standing Committee on Health

Wednesday, April 25, 2007

● (1535)

[*English*]

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

I want to thank the committee members for being here, and the witnesses as well.

We have before us today, on the study of prescription drugs, the common drug review, a panel on federal-provincial-territorial perspectives.

We have with us the Conference of Deputy Ministers of Health. John Wright is the co-chair.

We'll follow the order that is here. We'll just start with you, right off the bat, Mr. Wright, if you want to start your presentation. Mr. Ed Hunt, I believe, is with you, and perhaps you will introduce the rest of the table as we give you the floor.

The floor is yours.

Mr. John Wright (Co-Chair and Deputy Minister, Saskatchewan Health, Government of Saskatchewan, Conference of Deputy Ministers of Health): Thank you, Mr. Chair.

On behalf of the Conference of Deputy Ministers of Health, I'm very happy to be here to speak with you about the Canadian Agency for Drugs and Technologies in Health, or CADTH, as it is known, and its common drug review program.

I'm John Wright, the deputy minister of Saskatchewan Health and co-chair of the Conference of Deputy Ministers of Health, which is also known at the CDM.

I'm joined today by Dr. Ed Hunt, assistant deputy minister, Department of Health and Community Services, Government of Newfoundland and Labrador, and chair of the CADTH board of directors. Dr. Hunt is here as the designate for Mr. John Abbott, deputy minister of health and community services, Government of Newfoundland and Labrador, and liaison deputy for CADTH.

We're very pleased to be here today to outline the governance and accountability structure of CADTH and the common drug review. As we are aware that this is an issue that has been raised with you in earlier hearings, we want to assure you that CADTH, which is owned and governed by the Conference of Deputy Ministers of Health, is fully accountable to the CDM. In fact, in our opinion, CADTH is one of the most accountable national agencies existing in Canada today.

By being here today, I also want to ensure that you have an understanding of the important role played by CADTH in Canada's health care system and to provide you with the opportunity to ask questions of either me or Dr. Hunt, relating to CADTH's governance and accountability.

I want to begin with a few words about the mandate of CADTH. CADTH is the national body that provides Canada's federal, provincial, and territorial health care decision-makers with credible, impartial advice and evidence-based information about the effectiveness and efficiency of drugs and other health technologies. Unlike regulators such as Health Canada, which determine which technologies can be marketed in this country, CADTH supports decision-makers in the determination of which technologies should be used to achieve the best outcomes for patients' health and which contribute to the sustainability of our health care system.

CADTH's mandate is to facilitate the appropriate and effective utilization of health technologies, from introduction through to optimal utilization and to replacement or obsolescence within health care systems across this country. CADTH delivers this mandate through three core programs.

First, the health technology assessment program conducts impartial, evidence-based reviews of the clinical effectiveness, cost-effectiveness, and broader impact of drugs, health technologies, devices, and health systems.

Second, the common drug review, as you are aware, undertakes rigorous clinical and economic reviews of new drugs and provides evidence-based formulary listing recommendations to publicly funded drug plans.

Third, CADTH'S newest program, the Canadian optimal medication and prescribing utilization service, COMPUS, provides evidence-based advice regarding optimal drug utilization.

Through the products and services delivered by these three programs and the direct support the agency provides within jurisdictions for the uptake and utilization of its work, CADTH is making a crucial contribution to the effectiveness and efficiency of Canada's health care system.

I'll now turn to governance and accountability.

We have handed out a slide today that depicts CADTH's governance structure. I'll try to give some context to this slide and explain what it means.

CADTH was conceived by Canada's federal-provincial ministers of health in 1989. It is legally incorporated as an independent not-for-profit corporation. The owners of a not-for-profit corporation are called members. CADTH's members are the deputy ministers of health of each participating province and territory in Canada and the federal deputy minister of health. All governments participate, with the exception of Quebec.

By definition, CADTH is owned by the Conference of Deputy Ministers of Health, and each member has an equal voice in overseeing the affairs of the corporation. The corporation is governed by a board of directors, which consists of directors who are appointed by a member deputy minister of health. The directors are accountable to the CDM for the effective management of CADTH.

The Conference of Deputy Ministers' oversight of CADTH is carried out at its regular meetings as well as at CADTH's annual general meeting, where it conducts its requisite business, including receiving the report of the board of directors, receiving the financial statements and report of the auditor, appointing the auditor for the next year, and conducting other business, as required. The Conference of Deputy Ministers must approve all changes to the agency, for example, mandate, amendments to the organization's bylaws, and approving changes to CADTH's budget.

● (1540)

On the topic of jurisdictional funding, I understand representatives from the pharmaceutical industry, in their presentation to you last week, may have suggested that CADTH is usurping the powers of this committee by unilaterally announcing the expansion of the CDR. Let me set the record straight since we, the deputies, are perplexed by this interpretation.

A staged expansion of the CDR was one of the highlights of the *National Pharmaceuticals Strategy: Progress Report*, released on September 21, 2006. That report states that expansion of the common drug review was a key recommendation made by the federal-provincial-territorial ministerial task force comprising Canada's ministers of health and co-chaired by the Honourable Tony Clement.

In February 2007, at the request of the CDM and based upon this recommendation from the national pharmaceuticals strategy, the expansion of the CDR to include new indications for all drugs was approved. Funding agreements to expand the program commencing April 2007 were recently finalized, hence the announcement from CADTH to its stakeholders.

We felt it was important for you to be aware of this information, Mr. Chair.

CADTH has a liaison deputy minister who is appointed by virtue of which jurisdiction the chair of the CADTH board comes from. The board of directors meets a minimum of three times a year, and the board chair reports to the CADTH liaison deputy minister after each of these meetings.

The role of the CADTH board of directors is to govern the affairs of CADTH; provide strategic direction and counsel; ensure the necessary resources are in place to meet CADTH's mandate; and provide oversight to financial management, risk identification, and evaluation. Through the governance structure I've just described, it is clear that CADTH is accountable to the Canadian governments that established it, and their continued support demonstrates their confidence in CADTH's ability to deliver on its mandate and meet the needs of Canada's health care decision-makers.

The final area I wish to speak about is expenditures and funding, specifically related to the CDR program you are studying. CDR was established in 2003 with a budget of $2 million per year. The volume of work CDR performs is determined by the number of drugs submitted to it by industry and by the participating drug plans. Its expenditures grew, on the basis of the volume of work related to these submissions, to $3.4 million for the last two years.

As I mentioned earlier, the CDM requested an expansion of the CDR to include new indications for old drugs and to implement further transparency initiatives. Accordingly, CADTH's annual budget for CDR is now $5.1 million. The funding formula for the CDR program is 70% provincial-territorial and 30% federal contributions.

The Conference of Deputy Ministers is very pleased with the progress made by the CDR over the last three years. The consolidation of the 18 separate drug plan processes into one process has reduced duplication of clinical and economic reviews, improved the quality and consistency of reviews and recommendations, and finally, contributed to improved standardization of drug coverage across the country. In doing so, the CDR has met the objectives set out by the CDM.

The CDR program is not only working, it is working well. Yes, there are challenges, and no doubt you'll hear about those challenges in just a few moments from Dr. Sanders; however, CADTH has shown us that they have evolved and continue to evolve to meet these challenges.

Thank you, Mr. Chair, for permitting me to speak to your committee today. I'll welcome your questions at the appropriate moment.

The Chair: Thank you very much.

To let the committee know, normally when we start into a study of this kind we have the agency, which you are, come forward and explain the situation. You have the opportunity to do that now. You couldn't make it at the beginning so you had the opportunity to address some of the questions that were brought up by previous individuals who testified before the committee. It's a bit of an advantage to you, which is fine, because we're not looking for anyone to get an advantage; we're looking for answers. So I appreciate your dealing with some of those.

With that, we'll move on to Jill Sanders, who is here with the Canadian Agency for Drugs and Technologies in Health, or CADTH. The floor is yours.

[*Translation*]

Dr. Jill Sanders (President and Chief Executive Officer, Canadian Agency for Drugs and Technologies in Health): Thank you, Mr. Chairman. I am delighted to be here.

[*English*]

Good afternoon, and thank you for inviting the Canadian Agency for Drugs and Technologies in Health to present our work to you within the context of the common drug review.

I am Jill Sanders, the president and CEO of CADTH. I'm joined today by Mike Tierney, who is our vice-president for the common drug review; and Dr. Braden Manns, who is a specialist in kidney diseases, an associate professor at the University of Calgary, and the chair of CEDAC, the expert advisory committee to the CDR.

Background information on the common drug review was provided to you in our written submission document, so I'm here today to expand further on some of the points therein.

In our publicly funded health systems in Canada, achieving the balance of optimized care, accessibility, equitability, affordability, and sustainability for all Canadians is, of course, what we all strive for. This means that difficult decisions must be made throughout the systems, and the role of the common drug review is to assist with the decision-making around pharmaceuticals.

As we all know, pharmaceuticals contribute to improved health outcomes for Canadians, but they're also the fastest-growing cost component of the system. This highlights the importance of rigorously reviewing the clinical and cost-effectiveness of drugs.

Let me begin by clarifying the role of the CDR in relation to Health Canada. Health Canada is responsible for ensuring that marketed drugs in Canada meet standards of safety, quality of manufacturing, and efficacy. In contrast, the CDR provides advice to public players about the clinical and cost-effectiveness of a given therapy against other therapies so that the public funds may be optimally used.

Health Canada's approval for the marketing of a drug does not automatically mean that the drug is the best option within the broader context of the health care system. So following the Health Canada approval for the sale of a drug, those providing health care services must decide whether to utilize the drug. These decisions, of course, are the responsibility of the provincial, territorial, and federal drug plans. These drug plans have operated processes for many years and make decisions based on exactly the same type of process that CDR uses.

The processes that have been used for decades include the assessment of both clinical and cost-effectiveness. So the CDR is not a new concept. In terms of its mandate, it processes, and its outputs, it performs assessments of clinical and cost-effectiveness just as the drug plans have always done. These assessments are considered by a committee of experts, CEDAC, who make the recommendations, just as the drug plans have done over the years.

So the newness of CDR relates to the fact that it was created by 18 publicly funded drug plans in Canada to perform exactly the work they had each been doing independently prior to its creation. Prior to CDR, a drug might undergo 18 reviews, and drug coverage was consequently not the same for all Canadians.

The CDR reduces duplication of effort across the provincial, territorial, and federal drug plans, and importantly, it makes significant contribution to equitable access to pharmaceuticals across Canada. Why is this the case? Because participating drug plans now have equal access to high-level evidence and expert advice from CDR, which leads to more consistent decisions. While CDR provides formulary recommendations for listing, of course the final decisions do rest with the drug plans, taking into consideration their jurisdictional needs, priorities, and resources.

I'd like to take a moment to talk about the importance of both clinical effectiveness and cost-effectiveness. Before the cost-effectiveness of a drug is considered, the drug must first be shown to be clinically effective and demonstrate improved health care outcomes. In other words, clinical effectiveness is the first consideration. The definition of cost-effectiveness can vary depending on your point of view, but the central concept is value for money. The internationally accepted standard for expressing cost-effectiveness is called the QALY, or the quality-adjusted life year, the cost per QALY.

The cost per QALY allows us to calculate the cost of a new drug relative to improvements in survival and quality of life. In fact, an expensive drug can still be cost-effective. For example, Prezista is a drug for the treatment of HIV infection, and that received a conditional listing from Health Canada in terms of being marketed in Canada. It costs approximately $10,000 a year per patient. The CDR recommended that it be listed for patients with HIV infection who had failed on other therapies.

On the other hand, a relatively inexpensive drug may not be cost-effective if it doesn't offer improvements in health outcomes compared to a less costly treatment. CDR has seen examples of these as well.

● (1545)

I'd now like to highlight some aspects of the CDR process, in addition to the information we provided in our submission.

CDR's aggressive timelines are based on the best practices of the provincial drug plans, and CDR has consistently met all these timelines. The average total time from the Health Canada approval of a drug to its listing on a formulary has changed from 471 days before CDR to 479 days. So CDR has not had an impact on this timeframe. In fact, CDR represents about one-third of this time, with 140 to 180 days. It's important to remember that once CDR has released a recommendation it is the drug plans that make the decisions as to whether to list the drug. The timeframe for this remains the responsibility of each drug plan, and CDR has no role in this process. Rigorous scientific and technical processes are important to ensure accuracy in the recommendations made and also to ensure fairness to the public served. Equally important is that the processes be as transparent as possible.

Prior to the CDR, provincial drug plans did not provide an opportunity for manufacturers to comment on the reviews upon which recommendations were based, and none of them publicly released reasons for their recommendations. Today, manufacturers review and provide feedback on CDR reports, and this time is built into the timeline for CDR to give manufacturers time to do this. Also, the status of all submissions, as well as the detailed CDR recommendations and the reasons for their recommendations, are posted on the CADTH website.

The CDR has set new standards of transparency for drug reimbursement in Canada and abroad, and it continues to make enhancements. In fact, based on the evaluation of CDR from 2005, there were recommendations that further steps be taken to improve transparency. Canada has responded by appointing two public representatives to CEDAC—voting members. Furthermore, as part of the budget expansion that Mr. Wright just mentioned, CADTH is implementing plans this year to publish lay versions of CDR recommendations, to publish the reviews upon which those recommendations are based, and to publish the minutes of the CEDAC meetings.

Given it's impact on public reimbursement, CDR attracts considerable attention and some criticism, particularly from the pharmaceutical industry. I'd like to address a few of these.

There have been claims that the drug plans do not follow CDR recommendations. As I said earlier, drug plans make their own decisions regarding reimbursement of drugs, and they're certainly not bound to follow CDR recommendations. However, to date, the drug plan decisions that have been made have followed the CDR recommendations in 90% of the cases. There are some exceptions, obviously, for the 10%, and what this shows is that drug plans take into account the local jurisdictional considerations.

There's also been some concern voiced that CDR is a barrier to access for new drugs. There isn't any evidence that CDR has created a new or more challenging threshold for drug access compared to what was in place before CDR existed. In fact, in the five years preceding CDR, the largest drug plan in Ontario listed 44% of the drugs that they reviewed. To date, the CDR rate for positive recommendations is approximately 50%.

It is also argued that CDR recommends fewer drugs than international comparatives. A study commissioned by Rx&D reported that CDR approved 52%, which I just reported, of the 50 drugs reviewed to date at the time of that review. But they also reported that this is significantly lower than for many other countries. The Rx&D study is based on very selectively chosen statistics for the other countries and it's intended to tell a particular story. In fact, the study shows that the positive recommendation rate for CDR is in the mid-range of all countries and in fact is higher than countries with similar health systems, such as Australia and New Zealand.

One must be very careful when doing such a comparative study. For instance, some countries may list a drug, but for only partial reimbursement, where the remainder is paid by the patient. For example, France has a three-level reimbursement model. Other countries undertake national price negotiations, which influence reimbursement decisions.

● (1550)

So the question is whether Canada is out of step globally in terms of access to drug therapies. In our opinion, this is not the case. Critics have claimed that CDR focuses on cost control and does not recommend innovative drugs. In fact, CDR has recommended expensive drugs that demonstrate improved drug outcomes, and it's clear that drug cost alone does not drive CDR recommendations. However, there are categories of drugs that do not fit well with the existing CDR process and for which another approach might well be an optimum approach. Such examples are expensive drugs for rare diseases, which I think you have heard about before today.

However, the national pharmaceutical strategy task group is working on this challenging issue and has been assigned to report to the Conference of Deputy Ministers this June 2007. So we await that report, and CADTH looks forward to continuing to work with NPS and the Conference of Deputy Ministers to implement its recommendations, which may include a specialized process at CDR for expensive drugs for rare diseases.

Finally, the pharmaceutical industry has cited concerns about the request for a reconsideration process. With the three years of experience we have with CDR now, a review of this process might well be appropriate at this point.

The challenges in the field of drug assessment and reimbursement, of course, are not unique to Canada. CADTH is very active internationally and is regarded as the gold standard in its field. We work closely with governments and agencies around the world on tackling the challenges we face.

There are many stakeholders in CDR: the public; health professionals; the pharmaceutical industry; and CADTH's owners, the federal, provincial, and territorial governments. While we recognize there will always be tension between the pharmaceutical industry and CDR, we will continue to engage the industry and stakeholders through regular meetings, liaison groups, and working groups.

The vision and mandate for CDR came first from the first ministers of health to establish a consistent and rigorous approach to drug reviews, to reduce duplication across publicly funded plans, to maximize limited resources and expertise, and to provide equal access to that expert advice.

In the three years since CDR was established, CADTH has fulfilled its mandate, and it's committed to a vision of a common national formulary that can be achieved through a staged expansion of CDR. CADTH continues to be well positioned to support the objective of the federal, provincial, and territorial governments to rigorously evaluate new technologies and to provide Canadians with equitable and affordable access to drug treatments.

The CDR continues to evolve in response to direction from its owners, the Conference of Deputy Ministers of Health.

Thank you for allowing us to present today. We welcome your questions.

● (1555)

The Chair: Thank you very much for your testimony. I see you have with you the vice-president of the common drug review, Mike Tierney, and Braden Manns, chair of the Canadian Expert Drug Advisory Committee, is with you as well.

Now we'll go to our final presenter from British Columbia, Robert Nakagawa.

Mr. Robert Nakagawa (Assistant Deputy Minister, Pharmaceutical Services, British Columbia Ministry of Health): Thank you very much, Mr. Chair.

The Chair: Thank you for being here. You're the assistant deputy minister of pharmaceutical services. The floor is yours.

Mr. Robert Nakagawa: Thank you very much, Mr. Chair. I really do appreciate the opportunity to appear before you and provide you with my perspectives and the perspectives of British Columbia on the common drug review and CADTH.

By way of background, I'm a pharmacist by training and have practised in hospital and government settings for the last 27 years. I'm currently, as you mentioned, the assistant deputy minister for pharmaceutical services within the Ministry of Health in British Columbia.

As part of that role, I am also serving as the co-chair of the task force for the national pharmaceutical strategy. British Columbia is co-leading that initiative, as requested by the first ministers, to advance issues of common concern in pharmaceuticals across this country. CADTH, the CDR process, plays a very important role in this.

I will not be reading my written submission; I trust you received it in both English and French. Rather than do that, I thought I would highlight some of my perspectives and allow the committee the opportunity to ask any questions they would like, for clarification or additional information from my perspective.

I bring the perspective of an individual who is responsible for the publicly funded drug program in British Columbia as well as for the drugs used in hospitals and otherwise publicly paid for. In British Columbia, that amounts to over $1 billion per year.

We view this as a very important investment in the health of British Columbians. Drug therapy is the cornerstone of modern therapy, and we feel we must invest wisely in drug therapy. We view the CDR, the common drug review, as a bit of insurance to make sure we invest wisely in therapies to advance the health of British Columbians. The CDR is truly federal-provincial-territorial initiative that works; it works well for all of the partners involved. We feel we get much value out of the investment we provide as a province.

As Doctor Sanders alluded to earlier, prior to the CDR process each jurisdiction undertook its own method of reviewing new drugs for consideration within its drug plans. To varying degrees there was more or less rigour applied to those processes. Different decisions were often arrived at between the jurisdictions because of different approaches to the drug review process. There were inconsistencies.

At the time, the jurisdictions felt this was not in the best interest of Canadians. We felt that by pooling our resources and working together we would be able to improve the rigour applied to the drug review process to provide some consistency of information that then could be viewed and interpreted by clinical experts, with advice being provided to jurisdictions to make their final decisions. Really, that was the reason we came together for the common drug review.

The other circumstance we were experiencing in those days was that in cases where different jurisdictions were coming to different decisions on drugs, the manufacturers whose products were being reviewed would take decisions in those provinces that had positive listing decisions and leverage them against the provinces that came to a different conclusion. There are significant discrepancies in the decisions across the country that resulted from the individual reviews.

With the common drug review, the intent was to try to create at least a common informational base for consideration across the country. We recognize that while the drugs are used in various jurisdictions, the information about those drugs is truly international literature.

So the literature is the same and can be viewed the same across all jurisdictions; the drugs are the same; the basic human conditions are the same. That all led us to believe that the common drug review would be the best way to move forward, and we believe it has attained those objectives.

● (1600)

British Columbia, as well as the other provinces I've spoken to, are extremely pleased with the current common drug review and we provide ongoing support for it, both in terms of input and feedback on an ongoing basis as well as through the governance that Deputy Minister Wright has advised you of.

Through the national pharmaceutical strategy, we've recognized that the common drug review is a key element of our pharmaceutical system in Canada. In our progress with the national pharmaceutical strategy, we have recommended the common drug review be strengthened and expanded beyond its original scope. Initially, the scope of the common drug review was for new drugs being brought into Canada for their initial purpose, or as we name it, their initial indication. Recently, deputy ministers have endorsed the expansion of the common drug review to include new indications for drugs already listed on the various formularies. That expansion is expected to happen this year.

With that, I'll conclude my remarks by saying that the common drug review is a process that was truly federal-provincial-territorial in nature, a true collaboration that has worked well for all partners across the country, and we wholeheartedly support its ongoing mandate.

Thank you.

The Chair: Thank you very much.

Now we will move on to the question part of our meeting. We will start off with Mrs. Bonnie Brown. The floor is yours. You have 10 minutes.

Ms. Bonnie Brown (Oakville, Lib.): Thank you, Mr. Chair. I'll carry on with Mr. Nakagawa for a minute, seeing he was the last speaker.

Mr. Nakagawa, do you have a figure that could tell us how much B.C. was spending on its own drug review process before the common drug review? What I'm really looking for is how much is B. C. saving now that the CDR is doing a certain amount of work for it?

● (1605)

Mr. Robert Nakagawa: I don't have that number at my fingertips, and it is hard to separate the cost of each component of the pharmaceutical system. The other complication in trying to do that sort of analysis is that the system has changed substantially since prior to the CDR. We've found an ever-increasing number and complexity of drugs, and at least in British Columbia, we have tried to use some of the resources that have been made available through the work being done by the common drug review for other initiatives within the province. So as we move forward, we have been looking at the issue of new indications for the old drugs and paying more attention to that. We've been enhancing our drug consideration for drug classes and those sorts of initiatives that we were not resourced for in the past.

So we don't have a clean number that I can provide you with at this point.

Ms. Bonnie Brown: Okay. You point out that approximately 50% of the recommendations from the common drug review have supported the reimbursement of the drug applied for. I'm wondering if you know what B.C.'s rate of recommendation for approval of reimbursement was prior to the CDR?

Mr. Robert Nakagawa: Again, I can't tell you that figure off the top. We have a rigorous process and we certainly have supported the recommendations coming from the common drug review, so I would say they are very consistent with our values and the type of information. In British Columbia, we also had a very similar approach in the way we appraised the literature and considered the evidence. So I would expect that the number would be somewhat similar.

Ms. Bonnie Brown: Can I ask you this? It seems to me that B.C. is leading the nation in cancer care. We've heard that in the past on other topics; people have said how well you're doing out there. Did you apply to get the joint oncology drug review program when it was being suggested at the CDR, or CADTH, or wherever it was being suggested?

Mr. Robert Nakagawa: I can start with that, and others may want to comment as well.

The joint oncology drug review process was initiated with many of the same principles as the common drug review. In fact, as that process moves along, the intention is for it to become part of the common drug review process.

It started with the western provinces identifying a need for some collaboration in the area of oncology. Saskatchewan and Manitoba both felt they had a need to advance in this area and were willing to spearhead the expansion. The common drug review had never included cancer drugs as part of its mandate because it was not within the mandate of the program.

Ms. Bonnie Brown: Yes, but excuse me, because you're going around the question.

Mr. Robert Nakagawa: Okay, I'm sorry.

Ms. Bonnie Brown: The question is, once they decided to have a joint oncology drug review, did B.C. apply to get it? We understand that it's now gone to the province of Ontario.

Mr. Robert Nakagawa: Okay, the way it worked was that the provinces agreed there would be a joint oncology review. Ontario offered to have their drug review serve as the basis for that joint initiative. Since that time, British Columbia has also joined the initiative, because we felt that the information coming from the joint oncology review could inform the process for the B.C. Cancer Agency as well as it would in other parts of the country.

I'm not sure if that answers your question sufficiently or if I've misinterpreted the question.

Ms. Bonnie Brown: We had planned to do this review, and we took a little bit longer on our obesity study than we meant to, but the word was out that we were going to study the CDR. And about one week before we began these hearings, the CDR announced an expansion, with a budget increase of more than 150%, from about $2 million a year to $5.1 million.

Knowing the committee was about to conduct a parliamentary review of the operation, why would you—I don't know who announced it, CADTH or the council, or whoever it was—announce this expansion before we'd had a chance even to evaluate the effectiveness of your process?

Mr. John Wright: Mr. Chair, if I may, that's an interesting question. In fact, as part of the release of the report of Federal/Provincial/Territorial Ministerial Task Force on the National Pharmaceuticals Strategy in September 2006, it was noted that we would be expanding the CDR to new indications for old drugs. The deputy ministers of the provinces, territories, and the federal government, who are the owners of this, reviewed the situation in December and directed that the expansion should occur. Preliminary budget estimates were considered.

The long and short of this is that it was significantly in advance of this committee giving consideration to the CDR process.

● (1610)

Ms. Bonnie Brown: Thank you.

I just have one more question for Mr. Wright. In his submission on page 3, it says, “The volume of work CDR performs is determined by the number of drugs that are submitted to it by industry—” We have heard in other meetings—not so much on this topic—that the volume of new drugs coming through the pipeline has diminished considerably in the last few years. So if in fact the number of new drugs coming forward is diminishing, how could the volume of work be going up and therefore require this increase in the budget from $2 million to $3.4 million for the last two years?

Mr. John Wright: If I may, I can provide a preliminary indication and then turn it over to my colleague.

As I mentioned, the budget has been increased predominantly to deal with new indications for old drugs that were not previously considered by the CDR; hence, the increase to the $5.1 million budget. That's incremental or new work—old drugs, new indications.

Ms. Bonnie Brown: Okay. Thank you very much, Mr. Chair.

Does anybody else want to comment?

The Chair: We have another answer.

Mr. Tierney.

Mr. Mike Tierney (Vice-President, Common Drug Review, Canadian Agency for Drugs and Technologies in Health): As a supplementary on that, the initial business plan for the CDR projected that we would be reviewing 25 new drugs per year. In the first two years of the CDR, that's what happened. In the past year, we received 40 submissions.

Why? I'm not quite sure. It could have been that Health Canada has now caught up on their backlog and those drugs have flowed downstream to us and CDR. So additional resources were applied in the past year to accommodate that increased workload.

Ms. Bonnie Brown: Thank you very much.

Thank you, Mr. Chair.

The Chair: Thank you very much.

Now we'll move on to Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): I have two questions, Mr. Chairman. The first is for Ms. Sanders and the other is for Mr. Nakagawa.

Ms. Sanders, you said that the Common Drug Review makes decision-making with regard to pharmaceutical products easier. You questioned the figures obtained by research and development witnesses who came before this committee. You feel that the Common Drug Review facilitates and speeds up decision-making. However, the number of drugs that fall under the Common Drug Review is lower than that in Quebec, that does not adhere to this program, and as a consequence provinces are accepting lower numbers of drugs on their markets.

You stated that 90% of the recommendations are accepted by the provinces. Those aren't necessarily meaningful results and don't necessarily back up your comments. Does this mean that there are provinces that choose to turn those drugs down? According to the numbers provided by the research and development experts, you also turn several down.

[*English*]

Dr. Jill Sanders: I'm not entirely sure I understand which figures you're referring to. The 50% recommendations from CDR that go to the provinces and then turn into 90% of the provincial decisions are the figures that we are certain of. The 90% is 90% of the decisions made within provinces.

In some cases, decisions haven't been made, and so this is where it can get a little confusing, if the decision hasn't been made yet. So that could contribute to some of—I'm not sure exactly.

[*Translation*]

Ms. Christiane Gagnon: In British Columbia the number is lower, 15%. In Quebec, 62% of new drugs are approved and are on the market. Numbers like 15% or 21%, depending on the province, are lower than the numbers approved in Quebec, in terms of new drugs available to patients. One of your goals is to make these drugs more accessible to the public. That is why I am asking you this question.

Do you deny these numbers? Do you think they are realistic? You have not improved the process for approving and marketing some drugs for patients. You defend your role, but the effectiveness of your role is somewhat questionable.

● (1615)

[*English*]

Dr. Jill Sanders: Of course, as you know, the Quebec process is separate from the common drug review and therefore their decisions are based on their own recommendations.

The range of the provincial decisions made averages 50%, and it's plus or minus about 3% to 5%. The range between the other drug plans that are members of the common drug review is fairly tight around that average of 50%. It's 50% plus or minus about 3% to 5%.

For Quebec, of course, we have to be careful because we're not comparing apples with apples. It's a different process. It operates under a different structure, and in Quebec, as with comparing to any other jurisdiction, whether it be abroad or within this country, we have to be careful that we understand what we mean by reimbursement. My understanding is—and I'm not sure whether I'm accurate on this—that there may be co-payment in the Quebec system. I'm not sure of that.

But these kinds of things can influence the reimbursement decisions. If we were to look at one jurisdiction to another, we do have to very carefully look at whether we're talking about exactly the same decisions that have been made. The 62% of Quebec versus the 50% average for the membership of CDR, I think, is the centre point of your question.

[*Translation*]

Ms. Christiane Gagnon: Yes.

[*English*]

Dr. Jill Sanders: As I said, we really can't compare separate processes, because Quebec is not part of CDR.

[*Translation*]

Ms. Christiane Gagnon: I realize that. In Quebec, there are more drugs that are covered by drug plans. I wonder where the problem lies. Is it because of the way you work? Health Canada can decide to approve a drug, but the opposite can happen when there is an assessment of the effectiveness of a drug compared to its cost. The opposite sometimes happens. Quebec does not have to go through those types of steps, and more drugs and products are approved.

Does the problem lie with Health Canada or with your organization? There appears to be some confusion. I'm trying to understand how the effectiveness of the Common Drug Review process compares to the amount of money being dedicated to improving its procedures.

[*English*]

Dr. Jill Sanders: We're going to have Mr. Nakagawa answer your question, and he may be able to offer a more conclusive answer.

The Chair: Go ahead.

Mr. Robert Nakagawa: Thank you very much.

I hope I'm understanding the question properly as well, but let me try, and you can advise me as to whether I'm answering your question.

When Health Canada does their reviews of drugs to provide market access to Canada, they do a comparison of the impact of the drug on health and safety and they compare it relative to a placebo. So they'll say, does this drug provide a therapeutic benefit more so than a placebo or does it provide more danger than a placebo? That's their test. If it passes those tests, they can provide market access to the country.

As payers, the federal, provincial, and territorial governments have a different test, because we recognize that for most diseases or for many diseases that are experienced within Canada there are already existing therapies. So if we have effective therapies for the treatment of asthma, then our comparator isn't no treatment at all; it may well be what the standard of care is for asthma. Then we will consider whether the additional amount that we would pay for a new drug is worth the additional benefit that we receive from it.

Quebec is not part of the common drug review process, and so what we see is that they have taken a look at the evidence in perhaps a different way, have interpreted things in perhaps a different way, and have come to a decision that makes sense for Quebec. But it's using a different informational base than the common drug review uses. It really is what we were experiencing before the inception of the common drug review process for the rest of the country. People would come to different decisions despite the same drug being reviewed.

Does that help to answer your question?

● (1620)

The Chair: Okay—

[*Translation*]

Ms. Christiane Gagnon: The chairman said yes. That's life.

[*English*]

The Chair: —her time is gone now. Thank you very much.

Mr. Fletcher, you have five minutes.

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

I have two questions for the committee, and I'll allow the witnesses to self-identify who will answer.

First, the CDR was established to inform government about which drugs to publicly reimburse. What do you see as the major challenges or barriers to carrying out the CDR mandate, and how are they being addressed?

Second, how have the results of previous CDR evaluations been addressed—for example, the recommendation to increase transparency in the CDR processes? Are there any other challenges to implementing change?

Thank you.

The Chair: Go ahead, Jill.

Dr. Jill Sanders: I referred to some of the challenges. In particular, I mentioned the expensive drugs for rare diseases, and I probably should have said drugs for rare diseases, because frankly, the challenge around drugs for rare diseases doesn't entirely relate to their cost; it relates equally to the methodologies that are used for the assessment and evaluation of drugs that require data. The data sets for rarer diseases are based on smaller populations, and therefore there are challenges around methodologies, and I mentioned that in my presentation.

This is an area that the national pharmaceutical strategy task group is looking at, and the likelihood is that a different specialized approached should be taken for drugs for rare diseases, based on that, irrespective of the cost. Data sets are different, and we need to look at that.

However, what has happened to date, of course, is that the 13 owners and operators on common drug review agreed, in the establishment of the program, that all new drugs would go through the common drug review. There is not a bypass at this point in the system. The members of the common drug review agreed that all new drugs would go through common drug review before a reimbursement decision. Therefore, that is what happens currently.

This is a challenge, and therefore, as we move along with the national pharmaceutical strategy, looking at some of these challenges, we may see changes in the future.

Mr. Steven Fletcher: Mr. Wright or Mr. Tierney, do you want to address the first or second question?

Mr. Mike Tierney: I can address question number two, if you wish.

There was an agreement when CDR was established to do an evaluation of the program after one year, and EKOS Research carried out that evaluation. Out of that evaluation, which included input from drug plan stakeholders, from academics and health professionals, from the pharmaceutical industry, and from patient and consumer groups, there were four key recommendations. The first was to increase public involvement in the process; another one was to increase transparency; the third was to publish lay versions of our recommendations and reasons for our recommendations; and the fourth, to look at ways of tailoring our drug reviews for drugs of different complexity.

On the issue of public involvement, as Dr. Sanders indicated in her remarks, we've added two members from the public on our Canadian Expert Drug Advisory Committee. They were trained and oriented to the committee in November 2006.

On the transparency initiatives, in the coming year we've been given funding and support to move ahead with publication of minutes of CEDAC meetings and to publish summaries of the full drug reviews on both the clinical effectiveness and health economics of the drugs. We'll also be publishing lay versions of our recommendations and reasons for recommendations in the coming year.

On the issue of tailored reviews, we have encountered that some drugs are new and very complex and represent new innovations in a therapeutic area. Others are so-called “me-too” drugs or may just be combinations of drugs that are already on the market. We've now moved forward with different ways of evaluating those drugs, based on the level of complexity, both on the clinical side and on the economic side.

● (1625)

Mr. Steven Fletcher: That's fine, Mr. Chair.

The Chair: Okay, thank you very much.

We'll move on now to Ms. Priddy. The floor is yours. Just speak.

Ms. Penny Priddy (Surrey North, NDP): Thank you, Mr. Chair. I always thought that would be my role, anyway, but thank you for that.

The Chair: Everything in moderation.

Ms. Penny Priddy: Well, not always.

I'd like to ask this question particularly of Mr. Nakagawa. Because British Columbia appears, anyway, throughout the country to be a standard that's often held up as having one of the best formularies, etc.—whether that's accurate or not, I'm not sure—and having been the minister of health there, I'll just take it that's true. I heard the statistics Dr. Sanders talked about in terms of how many recommendations are actually followed by the provinces once you've made the recommendation. I'd be curious if that is consistent in British Columbia, or whether that's higher in terms of recommendations that you accept.

Mr. Robert Nakagawa: We have a high degree of concordance. In fact, what I was told is that in all cases but one we had accepted the recommendation of the common drug review, and when I asked what that one was and the reasons for it, I was told the original recommendation was to not list. British Columbia looked at it and thought there might be some specific criteria that could be applied for a patient to receive the drug. Subsequently, the common drug review relooked at it and identified specific criteria.

So I feel that we have in fact followed the recommendations in 100% of the cases.

Ms. Penny Priddy: Okay, thank you.

Dr. Manns—or it doesn't matter to me, whoever can best speak to this around transparency.

I did hear, Mr. Tierney, what you said around the plan to publish a lay version of your decision and the reasons for your decision. If I were a drug company, or if I were a patient group, I might say the recommendations may be something like “We didn't recommend it because we didn't think it was safe”, or “It might have side effects on your kidney”, or whatever, without really getting into the transparency of the data. I understand intellectual property and all of that, but I want to know how far you're going to be able to go with the transparency that really gives people an understanding of the reason that a drug may have been either rejected or approved, but beyond what we might read on a prescription label that we get from the pharmacy.

Mr. Mike Tierney: There have been situations, certainly, when, in trying to explain our recommendations, we have not been able to refer to unpublished and commercially confidential information. We have confidentiality guidelines in place that manufacturers agree to and we agree to. They have the opportunity to review our recommendations in an embargoed form before they're publicly released, and they can request that certain sections of that be removed.

We have stuck to that agreement, both in terms of talking about confidential price information that's submitted to us or confidential clinical data that are submitted. As we move forward, we would like to continually try to release more information so that our decisions are more transparent.

Ms. Penny Priddy: How many, among the drugs that are submitted to you, would come with unpublished data?

Mr. Mike Tierney: That's quite variable. There is always some form of published information. I don't think there's ever been a situation when we've not been able to refer to some published information. But with many of the drugs—I would say the majority of the drugs—some of the information we're looking at is unpublished and has been submitted to us in confidence by the manufacturer.

Ms. Penny Priddy: But your recommendations could certainly include the published information and would reference it?

Mr. Mike Tierney: Yes, and we do that.

Ms. Penny Priddy: Okay.

I guess I'll go back to Mr. Nakagawa, if I may. I know people have explained this in different ways. Dr. Sanders has talked about it in her report.

The fact that there are seemingly two reviews—the one you do, and then the province does another one—that's the perception. I wonder whether anybody might like to comment for me on why CDR does the review and then you do another piece when you receive it—other than for reasons of your own budget.

● (1630)

Mr. Robert Nakagawa: Actually, most of our review does not redo the work that the common drug review has done. They do a very thorough and wonderful job of reviewing and critically appraising the literature and then providing that information for the province. We do not redo that.

Ms. Penny Priddy: So you do no work that's done by CDR?

Mr. Robert Nakagawa: We do not redo that work.

What we do is look at the drug within the context of other drugs we currently fund for the same purpose within British Columbia—how it fits within that therapeutic group. We'll take a look at what the budget impact of implementation will be for the province and make a determination as to whether we feel it is affordable for British Columbia and whether there are any other overriding policies that we have adopted, within pharmaceutical services or within the province, that would have an impact on our being able to implement the recommendation of CADTH. But we do not redo the evidential, critical appraisal process.

The Chair: Okay. Thank you very much.

We'll now move on to Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): I'd like to thank the presenters for being here today.

Mr. Nakagawa, I have a question for you. On the bottom of page two of your presentation, you talk about CDR having "successfully fulfilled its initial mandate" and say this is "evident in the approval given by the Conference of Deputy Ministers to begin a staged expansion of the program" and that "in the future, another possible area of expansion" could be drug class reviews, and so on.

My question is, can the mandate be enhanced at any time, and how does that process happen?

Mr. Robert Nakagawa: First, thank you very much for your question. I think it really speaks to the degree of comfort and the confidence we have in the common drug review that we do feel it's appropriate to expand and do more work of the same level and importance for us.

The process for that expansion is largely held within CADTH to determine, first getting direction from the provinces. When we recommended things from the national pharmaceutical strategy, our process was to make those recommendations through the deputy ministers, for the deputy ministers to give due consideration to the recommendations we were suggesting, and for us to make sure there was adequate information to justify the value of those changes, as well as get a good idea for both what it would ultimately end up costing CADTH as an organization and, as we as jurisdictions pay for it, what the cost for each of the jurisdictions would be to meet those objectives.

So we work through the deputy ministers of health as well as the CADTH board in coming to an understanding of where the priorities are and in what direction the CDR would be expanded.

Dr. Sanders or Dr. Hunt may wish to expand on that.

Mrs. Patricia Davidson: I think that fairly well answers it.

Then the recommendation goes forward to the funding bodies, and they then approve the funding for the enhanced recommendation. Is that correct?

Mr. Robert Nakagawa: Yes, that's essentially the process.

Mr. John Wright: Yes, it will flow through, and the deputy ministers, who are the owners of the corporation, will consider it and go from there. That's exactly what happened with the recent expansion to include new indications for old drugs and an increase in the budget to $5.1 million for 2007.

Mrs. Patricia Davidson: So then the federal portion comes to us —

Mr. John Wright: Yes, the 30% that the federal government contributes to this exercise.

Mrs. Patricia Davidson: —in the Department of Health budget for approval?

● (1635)

Mr. John Wright: That's correct.

Mrs. Patricia Davidson: Okay. I have another question, if I have some more time. I guess I do.

I don't know who to ask this of, but when assessing the cost-effectiveness of a drug for which there's no comparison, a first-in-class drug, what criteria do you use for that?

Dr. Braden Manns (Chair, Canadian Expert Drug Advisory Committee, Canadian Agency for Drugs and Technologies in Health): That's difficult. We should just say at the start that when we're looking at a new first-in-class, they're often recommended by Health Canada on the basis that their potential benefits outweigh any safety issues. When we're looking at it, just to give you an example, often these first-in-class agents are approved based on their evidence of effectiveness on non-clinical end points.

For instance, concerning a medication that we looked at for patients with kidney failure on dialysis who had elevated parathyroid hormones, we knew from studies that patients who had elevated parathyroid hormone levels had a higher risk of breaking their bones and dying. This new medication was released that showed it could lower that level of parathyroid hormone.

Actually, as a physician, I know that patients don't care about their parathyroid hormone level. They want to feel better, they want to live longer, and they want to prevent complications from happening.

But the evidence, when it's brought to Health Canada, is at a relatively early stage. So we have this information that it makes a reduction in this laboratory test, but no information as to whether it makes people feel better or live longer. Some of these medications, this one in particular, came with a price tag of about $4,000 to $23,000 per year. So there's a tremendous amount of uncertainty in trying to determine whether a reduction in a laboratory test will produce clinical benefits.

We've seen in people with acute heart attacks that if they have lots of ventricular premature beats, that says they're at higher risk of dying. We have a class of—

Mrs. Patricia Davidson: So how many of these would have been approved that have come before you?

Dr. Braden Manns: In 2004-05, we had 11 or 15, I believe.

Mrs. Patricia Davidson: Is that the number that have come before you?

Dr. Braden Manns: I think we had 14, actually, and about nine of those were based on data just around non-clinical end points. Some were approved. Two of the ones that came with just data on non-clinical end points were approved, and of the remaining five that had clinical end-point data, I'm not actually sure what the statistic is.

Mrs. Patricia Davidson: If they're not approved, would these patients then have alternative pharmaceutical treatments available to them, or what do they do then?

Dr. Braden Manns: For instance, for some of these things, standard of care would include other potential medications as well or, in that particular situation, lowering phosphorus in the diet and that sort of thing.

I should say that in some of these examples, if they're not able to get regulatory approval, they will move on to do studies that look at clinical end points. They have started a big study that will give us that data over the next three to four years. Investing in these drugs before that may not be a wise investment if we don't know that it actually improves the health of Canadians, which is what we're trying to promote.

Mrs. Patricia Davidson: Thank you.

The Chair: Thank you very much.

Ms. Kadis.

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

Welcome, and thank you for your presentations.

We are investing significant money in research and development, as you know. My concern is, are other patients in other countries getting increased access to our innovative therapies and discoveries, more so than Canadians?

We did hear some reference to that and some concern that was raised. I know you also referenced that in your remarks. In other words, we're making the discoveries, and others are having increased access to those innovative therapies, more so than Canadians. That was the concern that had been raised.

Mr. Mike Tierney: The study that Dr. Sanders referred to that was done on behalf of Rx&D Canada reported a range from a low of 16% of a basket of 50 drugs being recommended for approval to a high of 82%. The common drug review is at 50%. So we're pretty much in the mid-range of that access continuum, recognizing that there are limits with that. If we had different processes in place in terms of different levels of reimbursement, or if we had a process for national price negotiation, there's a chance that there would be more similarities if the processes were similar across countries.

Mrs. Susan Kadis: Perhaps it would benefit the committee, Mr. Chair, to have this range laid out for us. We think it's a very substantial issue for Canadians. We would do the investments here in R and D, again very significant, and others in other countries may potentially benefit more so. If that is a fact, I think we need to know, and why if that is so. I think we would benefit from that information, if the committee could receive that.

● (1640)

The Chair: Yes, they could provide that.

Mrs. Susan Kadis: Just to hear the range I don't think really pins it down enough. I guess probably all of us would want to feel we are facilitating innovative therapies as best we can, so Canadians can benefit in terms of increased access.

The Chair: So you're asking for information?

Mrs. Susan Kadis: Yes, exactly.

Mr. Robert Nakagawa: Not necessarily speaking directly, but I think it's important for the committee to recognize that the common drug review process doesn't differentiate drugs based on their country of origin. In fact, that information is sometimes very difficult for us to know.

Recently, I found out that Vioxx was a drug that was discovered in Canada. But I would have been quite disheartened if it were treated differently from the rest of the drugs because it was discovered in Canada.

So we take a very objective view. Our feeling is that if drugs are discovered in Canada, they still need to meet the same standards of evidence to ensure that they are still safe and effective and are competitive and are worthwhile investments for taxpayers, not from an R and D perspective but from a health perspective.

Mrs. Susan Kadis: You made reference to a national pharmaceuticals strategy task force or task group. Just to ask you a little more about that, when was that struck or appointed, and who's on that?

Mr. Robert Nakagawa: The national pharmaceuticals strategy was identified as part of the 2004 first ministers health accord, and the Premier of British Columbia committed to co-lead the provincial jurisdiction. Subsequent to that, the health ministers undertook to move forward with the national pharmaceuticals strategy. The task force is the group that's been delegated with the task of doing the work and making recommendations to the deputy ministers for moving that agenda forward.

I don't know if that's direct enough.

Mrs. Susan Kadis: Can you tell us who serves on that?

Mr. Robert Nakagawa: Every province except Quebec is a participant as well as the federal government and the territories.

Mrs. Susan Kadis: There was a drug that last week, I believe we heard, was turned down by CDR, but in B.C. I believe you had approved it. Are you familiar with that? That was raised, I think.

Mr. Robert Nakagawa: No, I'm not.

Mrs. Susan Kadis: I'm not sure what it was for, but this is the type of disconnect we're trying to understand: why, and what rationale there is.

Mr. Robert Nakagawa: I don't know what example was being put forward. If that information were to become available, I'd be happy to respond.

Mrs. Susan Kadis: Okay.

Thank you, Mr. Chair.

The Chair: Thank you very much.

I will now move on to Mr. Batters. You have five minutes.

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

Thank you to the witnesses for appearing before us today.

Dr. Saunders or Mr. Tierney, you've heard the criticisms of CDR. Some people will claim it's a barrier to patient access to new drugs; that it's an exercise in cost containment, and not what is best for patient health; that there's a lack of accountability and transparency. I'd like to ask whichever one of you wants to respond, and I've relatively short questions. If you could give me relatively short answers, that would be wonderful, because I only have five minutes.

Wouldn't open door meetings increase the transparency of the CDR, and what would be the disadvantages of having open door meetings?

Dr. Jill Sanders: The first step toward the transparency with regard to the content of meetings will be the publishing of the minutes of the CEDAC meetings, which is going to happen this year, and that's part of this year's initiatives.

As for opening the doors, there's a cost to that. Opening the doors entirely may be a good idea. We need to discuss that with the owners of the process. They need to make that decision, because there will be some cost and process implications.

Mr. Dave Batters: Is that something you'd commit to discussing among yourselves in the future? That is one of the big criticisms of CDR, and perhaps this could make it go away, but let the public come. Let those who are critical come, and maybe it'll alleviate a lot of the concerns.

Dr. Jill Sanders: In my presentation I spoke to some aspects—that we may look at the conduct of the meetings. In that, I mentioned a couple of examples: one might be attendance at the meetings, one might be presentations to CEDAC by certain groups. It may go beyond attendance is what I'm saying.

Mr. Dave Batters: You know what I'm talking about, though.

Dr. Jill Sanders: Yes, I know exactly what you're talking about. We need to look at it with our owners and with respect to the costs associated.

● (1645)

Mr. Dave Batters: Thank you.

This is to Mr. Nakagawa.

The CDR touts evidence-based decision-making. Why is it that other countries, such as Sweden, Switzerland, and the U.K., are approving much greater access—more than 50% more—to innovative medicines for their citizens? Given that they are reviewing the same drugs, the same science, the same evidence base, why is the CDR blocking access to these same innovative therapies for Canadians?

I'm going to go a little further. Why are patients in Quebec provided with greater access to more innovative medicines in less time than those on a CDR-participating plan? And if I may say so, sir, you're explanation that somehow the science may be viewed differently in Quebec is baffling, at best.

I'll give you a chance to respond to all that.

Mr. Robert Nakagawa: First, I really don't have a thorough understanding of the processes, of the way that other countries—I think you mentioned Sweden and perhaps others?

Mr. Dave Batters: Switzerland and the U.K.

Mr. Robert Nakagawa: I don't know what their process is for reviewing the evidence and the rigour that they apply. I can tell you, though, that I am extremely comfortable with the process that the common drug review applies. It is very similar to the process that British Columbia has applied and continues to apply for the new indications for old drugs, and it's one that meets the standards internationally that are applied by the Cochrane Collaboration.

It's hard for me to know why there are differences that exist when I don't have a good understanding of the details of how those countries go about doing their process. If they did things in the same way as we used to do them before we undertook critical appraisal, I can understand that they would come to different conclusions.

Mr. Dave Batters: What about the difference, though, within this great country? Why do Quebeckers have more access to innovative medicines in less time? I'll give you an opportunity to explain your previous comment that maybe the science has been viewed differently in the province of Quebec.

Mr. Robert Nakagawa: I will actually say that part of it is similar to my response for other countries. I don't know the detail of how they go about their process, so in comparison I can't give you the answer. I can tell you that when experts look at the same literature there often are different views that come to the fore and decisions that are made, based on those perspectives.

If they applied the same rules of evidence that the common drug review uses and those that are applied by the Cochrane group and by British Columbia, I expect they would come to the same conclusions. I just don't know that they have done that.

Mr. Dave Batters: That's very dicey ground, sir. We have excellent scientists in the province of Quebec—fantastic medical professionals.

Mr. Robert Nakagawa: They have extremely good scientists. What I don't know is that they've applied the same rules of evidence as others have, and in particular ours.

Mr. Dave Batters: Sir, you know a lot more about this than I do, but either you have morbidity data or you don't.

I'm going to move on, Mr. Chair, if I have a little more time.

The Chair: Your time is pretty well gone.

Mr. Dave Batters: Pretty well, but it's not gone, right?

The Chair: It actually is over. I'll let you come into another round, because I think you're going to ask for that at any rate.

Mr. Dave Batters: Thank you, sir.

The Chair: Let's go on to Mr. Malo.

The floor is yours.

[*Translation*]

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

You are probably aware of the fact that last Monday we met with officials from various federal departments responsible for carrying out the recommendations. The impression I get is that of a buffet. Some drugs are recommended and others not. On the other hand, some are covered across the board. In other cases, some are and some aren't. From what we've been told it appears that those choices depend on the clientele in question.

Mr. Potter, the assistant deputy minister responsible for first nations and Inuit health, told me, when I asked him about Lantus, a drug for diabetes, that this particular drug was eligible. However, it isn't under other programs.

I would like to ask Mr. Nakagawa about this, because he deals directly with British Columbians.

Do people in your province know that if they were Inuit, if they lived in another province, they might have access to a drug that could improve their health? Or, are they, rather, kept in the dark about these drugs? Why would these drugs be available to some people and not others, for example those in your province?

● (1650)

[*English*]

Mr. Robert Nakagawa: In answer to your question about whether British Columbians are aware of the different drugs that are available within each of the jurisdictions and whether, if I were in British Columbia, British Columbians are aware that a drug might be not available in British Columbia and would be available in Alberta, as an example, I don't know whether the average British Columbian is acutely aware. I think they would only become aware of this if the circumstance were that they went to their physician, received a prescription for a drug, found out that it was not funded, and had a subsequent discussion with their physician and found out that there was nothing else available.

What I think happens most commonly is that they might find that a drug would not be provided, then would have a discussion with their physician, who would then say the choice was theirs whether to pay for this drug as an individual or through their third-party payer or another insurance plan; or that they could use another drug, perhaps within that same class, that is covered by the province.

In British Columbia, as we look across the different drugs that are covered, we have a very broad range of drugs, so that within each of the therapeutic categories there's always something available that's publicly funded.

So I think the patient may not be aware of differences. That being said, what the common drug review does is provide for more consistency across the country in drug listing decisions.

As we look at the recent decisions and see this high degree of correlation between what the common drug review is recommending and what provinces are actually accepting and implementing, we're seeing that there are more commonalities now than there ever have been; there are fewer differences between provinces.

For the most part, the drugs that are coming onto the market now are not all wonderful therapeutic innovations. I wish they were, but fully two-thirds of them are not significant advances in therapy.

So we see there's consistency across the country now more than ever.

[*Translation*]

Mr. Luc Malo: Thank you, Mr. Nakagawa.

Ms. Sanders, in your presentation, you said something that is very serious in my opinion. It pertains to the following:

> While we recognize that there will always be tension between the pharmaceutical industry and CDR, [...]

So that means that there will always be a completely irreconcilable difference between what the industry wants and what the various legislatures or CDR partners want. Your opinion on the matter is very harsh. Could you explain why this is irreconcilable?

[*English*]

Dr. Jill Sanders: I think I used the word “tension”, and the word “tension” is the one I would still apply to the situation. There will always be a tension, because the mandate of private industry is to gather return on investment and profits. Our mandate is to perform scientific, rigorous work based on the data, and the data is often provided by the industry, but not in its entirety.

As I said earlier, the cost-effectiveness work is done following clinical effectiveness. Sometimes the data are insufficient, and sometimes we draw conclusions, as is clear in our recommendations, that are not satisfying to the industry.

[*Translation*]

Mr. Luc Malo: Do you think, as our chair was suggesting—

Mr. Chairman, I'm talking about you.

[*English*]

The Chair: Okay, go ahead.

[*Translation*]

Mr. Luc Malo: Last Monday our chair said that one solution may be to come up with one form. Do you think that that may help us bring the two parties together?

[*English*]

Mr. John Wright: Mr. Chair, Saskatchewan is actually taking the lead on the development of a common formulary for a national basis. This is part of the national pharmaceutical strategy, one of the five key priorities, and work is well under way.

● (1655)

The Chair: Thank you.

Mr. Brown, the floor is yours.

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

When the CDR was set up and the decision-makers decided that it was an appropriate route to take, were there any drugs being approved that shouldn't have been approved? When this extra layer of review was put in, were there cases that sparked the decision? Was there a case where a provincial body was approving a drug prematurely? Was giving the best possible drug to those patients in need somehow inhibited? Are there any cases like these that merited the creation of this body?

I just want to know whether there were any actual errors that might have sparked this extra layer of review.

Mr. Robert Nakagawa: I could respond.

As somebody who was involved in that process, I can say there was no specific triggering event. Our current drug regulation process is based on the experience that came out of thalidomide. The latest round looking at post-marketing surveillance is from Vioxx. There was no such triggering event for the common drug review. There was, I guess, just the experience of all of us doing exactly the same thing in trying to review the same medical literature for the same drug. The larger provinces had very rigorous, evidence-based, critical appraisal systems similar to the CDR. The smaller provinces didn't have that capacity, and so we were looking at ways to share that and to be able to improve the quality of the drug reviews in those provinces that didn't have the capacity.

But to answer your question directly, no, there was no precipitating event to lead us down this path.

Mr. Patrick Brown: Just to play the devil's advocate, one thing I get in my riding is the general belief, I guess among some Canadians, that government is too big. What do you say to people with concerns that there are overlapping jurisdictions here, in the sense of relevancy, where you might have a provincial body deciding to approve a drug that has been rejected federally, and you're at cross purposes and have duplication? What explanation is there that we're not duplicating government resources in these instances?

Mr. Robert Nakagawa: Well, I would respond that the common drug review is doing the opposite. It's allowing us to share resources across the country. I think Dr. Sanders referred to the 18 different reviews that would have been undertaken prior to this, and now the resources are pooled, the experts are pooled, and we can do one review, which is then shared across the country. So there's a lot of efficiency being generated by this across the country, rather than additional redundancy, because it could have happened 16 or 18 times before and now it happens once.

Mr. Patrick Brown: Is there any evidence on that front that we've actually expedited timelines? From a patient access perspective, I have concerns from constituents that the CDR has actually delayed their access to needed drugs. Is there any evidence that we've actually made it faster?

Mr. Mike Tierney: There was an independent study published in the *Provincial Reimbursement Advisor* in November that looked at the time taken from Health Canada approval to decision-making by drug plans: pre-CDR it was 471 days, post-CDR it's 479 days. So there really hasn't been any change.

Along the way, we've added opportunities for the manufacturers to receive and comment on our reviews, which they did not have prior to the CDR.

The Chair: Is it possible that you could provide the committee with that study?

Thanks.

Mr. Patrick Brown: Two other areas where I've had concerns brought to me in my riding are, one, on the front of rare diseases, where the delays are perceived to be excessive; and two, on drugs relating to cancer. Is there any information you can share with us on how the CDR handles these two areas? Is there any concern that because of the smaller patient samples, CDR isn't currently best able to handle the approval or disapproval of drugs for rare diseases? And could you comment on the cancer front as well?

● (1700)

Mr. Mike Tierney: I'll take the cancer one first.

In the first three and some years of the CDR, we've received over 90 submissions, and six of those drugs were for the treatment of cancer. The reason that's relatively low is that most cancer drugs are given by injection, and they're given in cancer centres or hospital settings. That's outside the mandate of the CDR. So the joint oncology drug review process was an opportunity for the provinces. And we are collaborating with that process to work together to provide a review of not just the oral drugs, but also the injectable drugs—not just the drugs given in the community, but also those given in hospitals and cancer centres.

Mr. John Wright: With respect to rare diseases, again, this is another element and another priority of the national pharmaceutical strategy. As I mentioned, Saskatchewan leads the common formulary. Alberta is leading work on how we can address expensive drugs for rare diseases. So work continues on that.

The deputies just met these last several days in Montreal, and this was an issue that came up. A friend of mine and Bob and I were talking earlier about the need to expedite our review processes on that.

The Chair: Thank you very much.

Mrs. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thank you very much.

I think I'm still having trouble with the context of where the national pharmaceutical strategy is. Maybe you could update me, from what the deputy ministers have agreed to.

The EU has a common formulary, and we heard from the five formularies that are in the federal government. Where does the CDR fit, in moving towards a common formulary? And what timeframe are we looking at in terms of generics and the other pieces? I know about the budget and the mandate you have, but where do you, as deputy ministers, see this in the process, and how long will it take for us to actually not have these little bits and be able to get on to an actual national pharmaceutical strategy that includes an approach to expensive drugs for rare diseases, catastrophic drug coverage, and our moving as a country beyond what was there in the Canada Health Act, when everything happened by doctors and in hospitals and drugs weren't as important?

Mr. John Wright: Very quickly and briefly, Mr. Chair, there are five elements to the national pharmaceutical strategy that the provinces are currently working on: catastrophic coverage, a common formulary, pricing and purchasing, real world effectiveness and safety, and expensive drugs for rare diseases. Again, the deputies just met for the last couple of days in Montreal.

Hon. Carolyn Bennett: Is post-market surveillance on that list?

Mr. John Wright: That would be real world effectiveness. In fact, that was another major topic for discussion, as to how to expedite it. Ontario is responsible for that area.

We look forward to meeting again, and with ministers in June of this year in sunny Saskatchewan. At that time we expect that officials will have presented to the deputies, and through the deputies to the ministers, a solid update on the national pharmaceutical strategy.

Hon. Carolyn Bennett: I understand that in other countries people look at international evidence with stakeholders, particularly around cancer. Patient groups and provider groups have a sort of green light committee that will green-light stuff based on an international—whether it's Japan or the EU or the FDA—standards, so that if those stakeholders are comfortable that the science has been done properly, the drug could be fast-tracked. Then they move to whether you pay for it or not in terms of whether it is effective and then whether it is worth paying for in that sort of way.

I think all of us as parliamentarians are concerned as to where the choke points are in all of this in terms of the science. If it resides with Health Canada, then the 491 days that it takes in your shop to actually get drugs to market—And then, I think the far more important thing that Canada should be doing is finding out what happens when it gets out in practice.

In our looking at safety and efficacy and tax dollars—there's a huge spectrum there—is there something that you see? In how many cases of the drugs you look at do you also look at what international groups have done? And just from your gut—and maybe it's not fair to ask the agency, but rather any of the deputy ministers—how many drugs would we be sitting waiting for Health Canada to approve when internationally you knew they were going to be fine? It seems a rather odd thing for us to do here in Canada, when other people are taking other scientists' points of view on this and you could just get to work.

● (1705)

Mr. Mike Tierney: One of the things we have initiated in collaboration with Health Canada is the capacity for a CDR to start our review process in the latter stages of the Health Canada review process, so that for those drugs that offer the potential for treatment of life-threatening or very serious conditions, we could expedite the CDR review process and also bring forward the learnings from the Health Canada review into the CDR. We've completed one such drug review and were able to reach a recommendation within two months of the market approval by Health Canada.

Hon. Carolyn Bennett: Let me change the way I'm asking this. What is the value added—I mean in terms of you people who do this every day—if you look at the international evidence? We as a committee are supposed to look at how we get Canadians what they need. How often would you be surprised to find the Health Canada review different from the FDA review or the EU review or the Japan review? What would be your gut instinct of the value added by doing this domestically in Canada for drugs that have been in the marketplace in other countries?

Mr. Mike Tierney: I'm not sure I can comment. I believe what you're asking is, are there—

Hon. Carolyn Bennett: Was value added?

Mr. Mike Tierney: —efficiencies in having Health Canada repeat the review that other regulatory agencies have done internationally?

Hon. Carolyn Bennett: Yes.

Mr. Mike Tierney: I can't speak to that.

The Chair: I believe it's probably beyond the scope, unless somebody else wants to take a shot at it.

Hon. Carolyn Bennett: Well, somebody has to have an opinion on this. We spend buckets of money. This is half the staff of Health Canada that do this. So where would you suggest I find that information?

The Chair: Okay, we have two who would like to quickly answer that. I'll allow the two quick answers, and then your time is actually well over.

Dr. Jill Sanders: I think, Dr. Bennett, really it's Health Canada that would answer that question. The question you're asking is around the regulatory process, if I'm not mistaken. In that case—

Hon. Carolyn Bennett: Yes, I'm asking the provincial guys whether they can help us decide whether they think this is value-added.

The Chair: We're going to allow a quick answer from Mr. Nakagawa; then we will move on.

Hon. Carolyn Bennett: That would be great.

Mr. Robert Nakagawa: My gut response is that I would be very surprised if there were a substantial difference between the Health Canada review and the decisions of other jurisdictions.

The timing sometimes is due to the time the manufacturer applies. The manufacturer doesn't apply to Canada at exactly the same time as to other jurisdictions. Then it just becomes the capacity of those individual systems to process within their mandates.

But I think it really is a Health Canada question, to be honest.

The Chair: Thank you very much.

Now we're going to go to round two, and we have Mr. Batters. You have five minutes.

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

The CDR makes decisions that impact upon patients, so patients deserve to know to whom the CDR is publicly accountable. My question is very simple: to which elected person or persons are you, or is the CDR, directly accountable?

Mr. John Wright: The CDR is directly accountable to the deputy ministers of health, who in turn are directly accountable to the ministers of health, who are in turn directly accountable to their legislative bodies.

Mr. Dave Batters: What about the 30% of federal dollars that pay for the CDR? What's the accountability on a federal level, Mr. Wright?

Mr. John Wright: I can't speak to the federal government. I can speak to the provincial and territorial governments .

Mr. Dave Batters: Can anyone speak to the accountability at the federal level for the 30% of federal funding that funds CDR?

Mr. John Wright: I'm assuming, Mr. Chair, that's why we're here, for the 30% that the federal government does. I expect that the federal—

Mr. Dave Batters: I'm asking at a federal level.

● (1710)

The Chair: I think the question is about—and I'm just looking for it—the accountability on the federal side, just as information.

Mr. Dave Batters: Is there any accountability at the federal level?

Mr. John Wright: The accountability mechanism would still be the same, in my opinion, Mr. Chair, which would be through the deputy minister, Mr. Morris Rosenberg, through to the minister, Mr. Tony Clement, through him to cabinet, and through cabinet into the legislative body.

The Chair: Okay. Does that answer the question?

Mr. Dave Batters: Did you say Minister Clement?

Mr. John Wright: Yes, that's right.

Mr. Dave Batters: Which government auditors review CDR and evaluate whether there's value for money for Canadian taxpayers?

Dr. Ed Hunt (Chair of the Board of Directors, Canadian Agency for Drugs and Technologies in Health, and Assistant Deputy Minister, Department of Health and Community Services, Government of Newfoundland and Labrador, Conference of Deputy Ministers of Health): The Conference of Deputy Ministers actually appoint auditors at their annual meeting each year. This past February, in fact, they appointed the auditors. The auditors are accountable to the Conference of Deputy Ministers. I'm not sure who it is this year, but—

Mr. Dave Batters: Okay, thank you.

Dr. Sanders, on the bottom of page two of your submission you note that formulary listing decisions are "entirely within the authority of the jurisdictions, and the CDR has no role in, or influence on, the nature...of [these] decisions by drug plans". Why, then, are Canadian taxpayers paying so many hard-earned dollars to support a body that admits it has no influence or role at the end of the day?

Dr. Jill Sanders: Perhaps that was worded in a way that was misleading, and I apologize for that. The intention of that statement was to inform the committee that the CDR makes recommendations and not decisions. Those recommendations inform decisions, but the decisions are entirely the responsibility of the jurisdictions that make them.

I apologize if the wording of that statement is misleading.

Mr. Dave Batters: It's maybe not misleading, because in the last meeting we had regarding this topic, we noted multiple negative recommendations that were covered by some public plans and multiple positive recommendations that were not covered. So it is puzzling, to say the least.

I want to pick up a little bit on the comments of my colleague Mr. Malo, specifically regarding Lantus. Health Canada has provided access to Lantus for federal drug plans, as have Ontario and Quebec. Lantus costs between $63 and $70 per month. According to Health Canada's Mr. Potter, who was here last meeting, Lantus can be a substitute for much more expensive insulin pumps, which cost around $5,000 for the equipment and $200 per month for the insulin.

If you're a patient in Ontario or Quebec, you have access to Lantus. Why does the CDR deny access to Lantus for other Canadian patients? It seems to be that we're going down a road of two-tier health care, where it really depends upon which province you live in. Can you explain to me why the CDR has not approved Lantus?

The Chair: Go ahead.

Dr. Braden Manns: I can talk about the CDR due process that Lantus went through.

When that medication was reviewed, one of the advantages of the CDR reviews, which we did not have when we reviewed these medications in Alberta and I am not sure whether Quebec has—Quebec could answer that—is that companies are compelled to send unpublished information to us. The majority of the information we reviewed around Lantus, whose comparator was another NPH insulin, was actually unpublished. We were not able to state that in our recommendations, because of proprietary issues. But the body of evidence available to physicians and to the makers of clinical practice guidelines is not the same body of evidence as we reviewed.

Ontario has made a recommendation that—Ontario has different policies in place by which they can fund pharmaceuticals. Ontario does not list Lantus on their formulary but has it available under individual clinical review.

We make recommendations to the provinces. All of the provinces have different policy options available for restricting the use of medications, and they've taken their right to restrict this very aggressively, with an individual clinical review mechanism.

The Chair: Thank you very much.

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

The Chair: We'll now move on to Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon: I would like to go back to the table on research and development. Dr. Sanders, you said that this was not a rigorous study and that we had to consider variables in other provinces or countries, variables such as the national price. New Zealand has another approach when negotiating the price of drugs. In addition, some of these costs are reimbursed by insurance policies.

We may criticize the statistics that have been presented, but the fact remains that they are somewhat troubling. For example, in British Columbia, only 15% of the drugs are recommended for reimbursement whereas in Quebec the percentage is 62%.

With respect to new products, you said that this was about effectiveness and cost. Does that mean that Quebec allegedly reimburses expensive medication which does not necessarily provide greater effectiveness? If that's the case, you're better off using a product already available on the market. I believe one of you said that the new medications offered to patients were hardly more effective. I would like to know what you do not like about the research and development statistics. You have certainly read them, given that you criticize them in your statement, Ms. Sanders.

As for the list of approved drugs, I would like to know, in particular, whether those who have the highest acceptance rate—and that would be Quebec—pay much too much, given the effectiveness of these products. Is that what you meant?

● (1715)

[*English*]

The Chair: Madam Gagnon, what study are you referring to from which you're getting your information?

[*Translation*]

Ms. Christiane Gagnon: I was referring to the study distributed to us when we heard the testimony of the industry and research and development representatives. They submitted some tables.

For example, we could also criticize the number of days it takes to assess a product. If we consider the number of products that are assessed, the average is very high when it comes from you—

[*English*]

The Chair: Do we have that information, or is this information you have? We don't have it?

[*Translation*]

Ms. Christiane Gagnon: No, I'm not the only one who has it; you have it. They came here and submitted it to us. Unless I'm the only one who received it, but that would surprise me. No, you have it, Mr. Chairman. It was the day when I chaired the meeting, I believe.

[*English*]

The Chair: Okay, that's fine. As long as our researchers have the information, we'll look after that later.

Go ahead with the answer.

[*Translation*]

Ms. Christiane Gagnon: We are not here to take sides. We are here to examine the documents and hear the various testimonies, in order to try to understand how things work.

We have statistics, averages regarding the number of days it takes, for instance, to approve medication, to analyze it, and there are some disturbing gaps.

[*English*]

The Chair: Fair enough.

Dr. Jill Sanders: I'll give part of the answer, and then I'm going to turn to Dr. Manns.

Part of the answer with respect to my concerns with that study has to do with comparing apples and oranges. Aside from the science, the decisions are often based around other factors. Some of those factors have to do with affordability, and in that factor we have to consider co-payment made by patients.

Where we see a drug listed, we need to fully understand—and it is confusing, quite frankly—because on the face of it, if we look at the tables, and we're not given that information, we wouldn't know that there are differences within the plans being compared, where listing a drug doesn't tell you the whole story.

In some countries there is co-payment by the patient. In other countries you must pay an additional health insurance dollar to get coverage for drugs, and then you get into that drug plan. Those are the decisions being made. It is complex. We're trying to help as well.

What I am trying to say is that the study doesn't highlight these differences between the plans, and therefore it doesn't highlight the differences around those reimbursement decisions. That is where I have trouble with the statistics as they are presented.

[*Translation*]

Ms. Christiane Gagnon: I would just like to have some clarification.

Regardless of whether it's paid by insurance, an individual or the state, in the final analysis, this is about the cost of a particular drug. For instance, in British Columbia, 15% of the products are included on the list of drugs that are refundable whereas in Quebec, the figure is 62%. That means that Quebec is paying too much for drugs that are not very effective. We don't have labels indicating who pays for what, but that is not what I see when I read the table. I think it's perhaps the individual or private insurance that pays, or both.

Finally, if I understand the logic, regardless of whether or not you are recommending a product for approval, on the whole, someone is paying too much for medication that is really not effective. That is what I am interested in. Regardless of who pays, in the final analysis, someone is paying too much for medication that is not very effective when in fact he or she could have had another medication that is just as effective but less costly.

In New Zealand, that's how things work.

● (1720)

[*English*]

Dr. Jill Sanders: I'm sorry, are you referring to the price of the drugs or the number of drugs listed? Is it the price of the listed drugs or the individual drug prices in the study?

[*Translation*]

Ms. Christiane Gagnon: I'm saying that when you make your recommendations, you always consider the effectiveness in terms of what it provides in addition. But when you do your analysis, you also take the cost into account.

Consequently, there is a tremendous gap if 62% of the products are approved in Quebec for reimbursement whereas British Columbia approves only 15%. That means that Quebec is reimbursing too much money for drugs, especially since you are saying that there may be other medications that are just as effective but less costly.

[*English*]

The Chair: Okay, I think we have the gist of it.

Dr. Jill Sanders: May I have one more stab at this?

I can't fully answer the question, but that study was based on a snapshot in time.

The Chair: Go ahead.

Dr. Jill Sanders: I don't know what snapshot in time, I don't know what basket of drugs was being studied, so we have to be careful.

This is what we're saying about looking at any statistics. We have to look at the baskets being compared. It may not be the same basket that goes through the common drug review. To be frank, I don't know what the basket is in the 62% and the 15%, because what we heard from Mr. Nakagawa was that they are following all the recommendations.

So it is confusing.

The Chair: We'll allow a quick answer from Mr. Manns and Mr. Nakagawa.

Dr. Braden Manns: Given that the focus today seems to be on the common drug review, I would ask this question. I think the provinces have already shown statistics saying that the proportion of drugs approved prior to CDR was similar to the proportion that are approved now with CDR. So the difference isn't because of CDR. There may be other factors to be considered. The evidence may be the same, but departments of health make decisions about whether they want to send more money towards waiting lists or pharmaceuticals. Those types of decisions may factor into this as well.

The Chair: Mr. Nakagawa, very quickly.

Mr. Robert Nakagawa: You're right that a difference of 62% in one province and 15% in another seems horrific. It would be of great concern to me. I don't know that study; I do not have a copy. But I can tell you that in the past when we saw big discrepancies, we found that the numbers weren't counted the same way. We'll find out why there is that difference.

What happened in the past in British Columbia is that people went to the Internet to look at what drugs were publicly available within the drug plans. Within British Columbia, none of the cancer, HIV/AIDS, or transplant drugs, or renal agents are included in the Internet listing for B.C. PharmaCare. That doesn't mean that we don't pay for them for the public; we pay for them through different agencies.

So perhaps the cancer drugs weren't counted, even though we provide them, but through the B.C. Cancer Agency, rather than through B.C. PharmaCare. This might not have been obvious to the people who were counting the drugs.

As I said, I don't know if that's the case in this example. But when we saw big differences like this before, we found this sort of discrepancy.

The Chair: Thank you very much.

Now we have two more questioners. We have about six minutes left, so I'll allow three minutes each.

Mr. Fletcher, and then Ms. Kadis.

Mr. Steven Fletcher: Mr. Chair, listening to the testimony today, I have the impression that one way or another, all roads lead to Quebec. I look at the witness list, and we don't seem to have any witnesses from Quebec who can share the Quebec experience with us.

I'd like to suggest to the committee that we ask the chair and the clerk to get some witnesses from Quebec who can help us discern what is actually going on here.

● (1725)

The Chair: Yes, that's not a question then. It's something that we will deal with. I believe we have a steering committee meeting, and we'll deal with it.

Mr. Steven Fletcher: No, it's not a question for the committee; it's more of a statement.

The Chair: That's a fair comment, but we'll deal with it next Tuesday.

Ms. Kadis.

Mrs. Susan Kadis: Thank you, Chair.

I was interested in knowing, where is the CDR in terms of approved formulary coverage for biologics? Are we on a par with other countries, or are we behind?

Mr. Mike Tierney: When we looked just at drugs, and defining biologics as those drugs that go through the bureau of biologics at Health Canada, setting aside the expensive drugs for rare diseases, seven out of seventeen biologics were approved through the CDR.

Another way of looking at this is to look at drugs that come to us where the manufacturers have indicated a request for a priority review on the basis that the drug offers a significant benefit to a life-threatening or very serious disease. We looked at those drugs as well. In the first three years, eleven such drugs were reviewed. Five of them had recommendations to be listed, and six did not. So again, the percentage for that basket of drugs did not differ very much from the other drugs.

Mrs. Susan Kadis: In terms of a comparative with other countries, where do we stand? Are we similar or are we less, in terms of approving those particular drugs?

Mr. Mike Tierney: I'm sorry. I don't have information on approval of other countries and their guidelines.

Mrs. Susan Kadis: Mr. Chair, could we please get some information on that? The committee would benefit.

The Chair: Certainly.

We have one more late-entry question from Ms. Brown, and I'll allow it.

Ms. Bonnie Brown: Do you do vaccines as well?

Mr. Mike Tierney: No.

Ms. Bonnie Brown: Thank you.

The Chair: That was easy.

Thank you very much for coming in. I appreciate the opportunity to be able to question you on CDR. We didn't expect you to say how terrible it was, and you defended the position well, although you did show some of the concerns you had and how to make it better. We take that into consideration.

I want to thank you for coming. I want to thank the committee for their good questions.

The meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

Also available on the Parliament of Canada Web Site at the following address:
Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante :
http://www.parl.gc.ca
