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Chair

Mr. Bill Casey

Standing Committee on Health

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● (0845)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): We'll call our meeting to order. We're continuing our study on the national pharmacare program. We have some interesting witnesses today, as we always do.

From the Department of Health, we have Sony Perron, senior assistant deputy minister, first nations and Inuit health branch; and Mr. Scott Doidge, director general, non-insured health benefits, first nations and Inuit health branch. We have from the Office of the Auditor General of Canada, Mr. Michael Ferguson, Auditor General of Canada, and we have Dawn Campbell, director from the Office of the Auditor General. From the Department of Veterans Affairs, by videoconference, we have Michel Doiron, assistant deputy minister, service delivery branch; Elizabeth Douglas, director general, service delivery and program management; and Fiona Jones, in addition.

We're going to start with the witnesses from the Department of Health. Mr. Perron, would you like to start? We have 10 minutes for opening statements and then we have a round of seven-minute questions, and then a round of five-minute questions.

Would you like to start your presentation, if you have an opening statement?

Mr. Sony Perron (Senior Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health): Good morning, Mr. Chair, and members of the committee. I'm pleased to address the Standing Committee on Health as the senior assistant deputy minister of the first nations and Inuit health branch at Health Canada.

[*Translation*]

This is my first appearance before your committee. I am thrilled to have this very productive discussion with you, and I look forward to building a good working relationship with all of you.

Before I continue, let me introduce Scott Doidge, the director general of the non-insured health benefits program.

[*English*]

Today I will provide you with a general overview of our mandate and programming followed by more specific information related to the non-insured health benefit program. Health Canada, through the first nations and Inuit health branch, is committed to ensuring that first nations and Inuit communities and individuals receive a range of health programs and services that are responsive to their needs. The overall objective is to improve their health status.

[*Translation*]

As you know, First Nations people and Inuit face significant health challenges. When compared to the general Canadian population, they have a shorter life expectancy, a higher rate of chronic diseases, such as diabetes, and of communicable diseases, including tuberculosis and HIV, as well as higher mortality and suicide rates.

They also face greater challenges when it comes to social determinants of health, such as high unemployment, lower levels of education and higher rates of overcrowded housing.

[*English*]

In addition, first nations and Inuit face historical legacies such as colonialism, the disconnection of culture, and the intergenerational impacts of Indian residential schools. The health care system for first nations and Inuit is complex. Provinces and territories deliver hospital, physician, and public health programs to all Canadians, including first nations and Inuit, but do not operate health systems on reserve. In order to support first nations and Inuit in reaching an overall level of health that is comparable to other Canadians, Health Canada funds or provides a range of health programs and services in first nations and Inuit communities.

[*Translation*]

In this context, Health Canada works with First Nations, Inuit, and provincial and territorial partners to deliver effective, sustainable and culturally appropriate health services and programs, with a view to improving health outcomes and to giving them more control over the health system.

[*English*]

There are five elements funded by Health Canada to support first nations and Inuit health: health promotion and disease prevention, public health protection, primary care services, supplemental health benefits, and health infrastructure support.

Today I'm going to focus my presentation on the non-insured health benefits, and drug and pharmacy components.

The NIHB program is one of the largest health benefit programs in the country. It is national in scope and provides medically necessary health benefits to over 839,000 first nations and Inuit living on and off reserve.

In addition to pharmacy benefits, the NIHB program also provides coverage for medical supplies and equipment, dental benefits, vision care, mental health counselling, as well as medical transportation to help clients access medically necessary health services that are not available in their community.

NIHB's mandate is to cover items that are medically necessary based on clinical and scientific evidence. The NIHB program does not require deductibles, premiums, copayments, or user fees. There are no annual limits for medically necessary coverage. Providers are encouraged to bill the program directly so that clients do not face out-of-pocket expenses.

Last year, total NIHB expenditures were over $1.1 billion, with pharmacy benefits accounting for the largest proportion of these expenditures at $427 million. Approximately 514,000 NIHB clients used their pharmacy benefits at least once in 2015-16, resulting in a utilization rate of 61%. This utilization rate has been constant over the last five years.

I would like to speak to you about the NIHB program's formulary management approach, which is aligned with that of other public drug plans in Canada. Whereas a private payer may provide coverage for a drug once it has been approved for use in Canada, NIHB and most other public plans take a formulary management approach whereby the coverage provided is based on clinical effectiveness, cost-effectiveness, and safety.

The NIHB program's pharmacy benefits are outlined in the program's drug benefit list, called DBL. Medications are divided into three categories. Open benefits are listed in the DBL and have no established criteria, gender, or age limitations, or prior approval requirements. Limited use benefits are also listed in the DBL with coverage criteria. Coverage is provided when the established criteria, the prior approval requirements, are met.

Exceptions are not listed on the DBL. These are drugs that may be approved for coverage on a case-by-case basis when an exceptional need is demonstrated. NIHB coverage ranges from very low to very high-cost pharmacy items. For example, low-cost blood pressure medications may cost about $150 a year per client. Biologics for diseases, such as rheumatoid arthritis or psoriasis may cost in the range of $20,000 to $50,000 per year per client, and oral chemotherapies and high-dose biologic therapies for ulcerative colitis or Crohn's disease may cost in the range of $50,000 to $150,000 per year. At the very high end of the spectrum, enzyme therapies such as Adagen, Vimizim, or Aldurazyme may cost as much as $1 million per client per year.

● (0850)

[*Translation*]

The non-insured health benefits program also covers selected non-prescription drugs that are not normally covered under other public plans. These include therapeutic vitamins such as vitamin B12 and folic acid, prenatal vitamins, smoking cessation products, antihistamines, topical antibiotics, non-hormonal contraceptive methods and over-the-counter pain medication.

[*English*]

All efforts are made to process non-insured health benefits pharmacy claims as efficiently as possible. Approximately 96% of the non-insured health benefits pharmacy claims, amounting to around 16 million claims annually, are automatically approved at the point of service through an electronic system that does not require any paper forms. Only 4% of claims require the NIHB program to seek further information to ensure that requests are aligned with coverage criteria, just like other plans in Canada. Most of these NIHB claims are processed within half a day.

Evidence-based decision-making is the guiding principle. Once Health Canada has approved a drug for use in Canada, the NIHB program must decide if the drug will be eligible for reimbursement. Like most other public drug plans in Canada, the NIHB program participates in the common drug review, CDR, process and the pan-Canadian oncology drug review process, pCODR, which provide listing recommendations to participating public plans.

Common drug review recommendations are made by the Canadian drug expert committee, and pCODR recommendations are made by the pCODR expert review committee. These committees, made up of independent experts, synthesize the best available evidence by using rigorous peer-review processes. They assess the cost of the drug in relation to its clinical effectiveness; therapeutical advantages and disadvantages; availability of comparable drugs; shorter- and longer-term medical benefits; potential costs for the health system; and input from patients, drug manufacturers, and clinicians.

Though the NIHB program does not require a CDR recommendation to cover a drug, the program typically follows CDR recommendations.

In addition to the recommendations made through the CDR process, the NIHB program relies on its own drug therapeutics advisory committee, DTAC, to seek expert recommendations specific to drugs related to the therapeutic issues of its clients. Most Canadian public plans have a similar dedicated expert advisory committee to supplement the advice provided through the CDR.

The DTAC is an advisory body of highly qualified health professionals who bring impartial and practical expert medical and pharmaceutical advice to the NIHB program to promote improvement in the health status of first nations and Inuit clients through effective use of pharmaceuticals. Like the CDR process, the approach is evidence-based and the advice reflects medical and scientific knowledge, utilization trends, current clinical practice, health care delivery, and specific departmental client health care needs.

● (0855)

[*Translation*]

The NIHB drug coverage is generally aligned with that of the provinces and territories, given that most public drug plans in Canada follow the advice of the Common Drug Review.

[*English*]

The program has conducted a listing comparison of NIHB versus other public plans, based on available Canadian Institute for Health Information data. According to this analysis, approximately 75% of NIHB pharmacy claims in 2015-16 were for medications that had the same listing status as other provincial and territorial formularies. Approximately 16% had a less restricted listing status than provincial and territorial formularies, including medications such as antiretrovirals and hepatitis C medications. The remaining 9% of NIHB claims were medications that had a more restricted listing status under NIHB than provincial-territorial formularies. This includes claims for methadone and long-term opioids.

In July 2010, the NIHB program secured a ministerial mandate to enter into product listing agreements, confidential agreements between drug plans and drug manufacturers to list medications in exchange for rebates. The program entered into its first PLA in October 2010, and had negotiated 42 agreements by December 2015. These agreements allowed the program to provide its clients with more open access to newer and higher-cost medications.

Joint work through the pan-Canadian pharmaceutical alliance is expected to bring greater alignment by providing participating plans with access to the same price reductions through joint PLAs. The NIHB program has entered into 24 new PLAs since joining the pCPA in January 2016.

[*Translation*]

I would also like to take this opportunity to tell you about the NIHB prescription drug abuse strategy.

The NIHB program has taken a broad range of measures to ensure that eligible First Nations and Inuit clients receive the medications they need. This important work is grounded in the design of the plan under the program, which conscientiously follows an evidence-based list of insured drugs, to ensure that medications are reimbursed based on clinical evidence.

[*English*]

The formularies management approach to PDA has included delisting drugs of concern such as OxyContin, Tylenol 4, brand-name Ritalin, Demerol, and other drugs. The program has also restricted the listing status of other drugs of concern, moving them from open benefit to limited use, and introducing enhanced coverage criteria.

[*Translation*]

The NIHB program—

[*English*]

The Chair: I'm sorry. I have to ask you to wind down now.

Mr. Sony Perron: One minute...?

The Chair: You're a couple of minutes over now.

Mr. Sony Perron: I apologize.

The Chair: No problem. We appreciate it. I'm sorry that we can't let you carry on.

Mr. Sony Perron: It's all right.

The Chair: We have to hear from everybody and we have to be fair.

Now we're going to hear from the Office of the Auditor General.

Mr. Ferguson.

Mr. Michael Ferguson (Auditor General of Canada, Office of the Auditor General of Canada): Mr. Chair, thank you for this opportunity to join representatives of Health Canada and Veterans Affairs Canada to assist you in your study on the development of a national pharmacare program. My comments will be based on our 2016 spring report on drug benefits for veterans.

Joining me today is Dawn Campbell, the director responsible for the audit.

Our audit examined three areas that pertain to any drug program. First, we examined veterans' access to drug benefits. Second, we looked at the department's cost-effectiveness strategies. Finally, we examined how the department monitored the veterans' use of drugs covered by the program.

[*Translation*]

Decisions about which drugs to cover need to be well documented and clearly based on evidence such as clinical research and the needs of beneficiaries. Timelines need to be established for the implementation of decisions.

In one case we examined, a decision by Veterans Affairs Canada's Formulary Review Committee to limit access to a narcotic was still not implemented two years after the decision had been made.

Pharmacare programs need to have a framework that specifies the type of evidence required and how the evidence should be considered in deciding what drugs to cover. The framework would be used to decide which drugs to pay for and how much to pay for them. The framework should require that the drug benefits be kept up to date.

● (0900)

[*English*]

Some cost-effectiveness strategies will always be necessary. These can include substituting generics for brand-name drugs and negotiating reduced dispensing fees with pharmacies. These strategies will need to be assessed regularly to determine if they have achieved the expected results, if they are up to date, and if they have led to reduced costs for drugs and pharmacy services. Particular attention should be paid to implementing strategies related to expensive new drugs entering the market.

[*Translation*]

A well-defined approach to monitoring drug utilization is also important. The approach should serve the needs of the beneficiaries and help the program sponsor manage its drug benefits program. Particular attention should be paid to the utilization of some high-risk drugs that need to be adequately monitored in order to understand the trends and their use.

Our findings on the Veterans Affairs Canada's management of drug benefits for veterans underscores the importance of the points I have outlined above.

[*English*]

In conclusion, as you may know, my 2016 fall reports were presented to Parliament earlier this week. I noted recurrent problems with government programs that are not designed to help those who have to navigate them and that focus more on what civil servants are doing than on what citizens are getting. It's critical for the government to understand that its services need to be built around citizens, not process. As such, I encourage the government to think at the design stage about how a pharmacare program could deliver services that work for Canadians.

[*Translation*]

Mr. Chair, this concludes my opening remarks.

We would be pleased to answer any questions the committee may have.

Thank you.

[*English*]

The Chair: Thank you very much.

By video conference, we'll move now to Prince Edward Island.

Mr. Doiron, will you be making the presentation?

Mr. Michel Doiron (Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs): Yes, I will, sir.

Good morning, Mr. Chair, vice-chairs, members of the committee, and ladies and gentlemen. I'm pleased to be here today on behalf of Veterans Affairs Canada to discuss the drug component of the department's health care benefits program. As the chair mentioned, my name is Michel Doiron. I am the assistant deputy minister for Veterans Affairs in the service delivery branch. With me today are my two colleagues, Libby Douglas, director general of the service delivery and program management branch, and Fiona Jones, manager of strategic priorities.

Honourable members, as you know, Veterans Affairs Canada focuses on the health and well-being of our veterans, and we provide many services and benefits to those veterans. While those benefits include covering the cost of prescription drugs, it should be noted that VAC plays a limited role in the provision of drug coverage in Canada. Of the total Canadian population. VAC estimates the total veteran population to be approximately 670,000 veterans. Of these, approximately 48,000 of our veterans received prescriptions in 2015-16. This is approximately 0.1% of the Canadian population. The total expenditures for the drug component of the VAC treatment program for fiscal year 2015-16 were approximately $92 million.

The authority for VAC drug benefits comes from the Department of Veterans Affairs Act and the veterans health care regulations. The treatment benefits authorized under these regulations are provided into groups called “programs of choice”. We call them POCs for short. POC 10 is the prescription drug program, and it refers to the drug products and other pharmaceutical benefits that are available to our veterans who have a medical need and who have a prescription from a health professional authorized to write a prescription in that province.

[*Translation*]

The eligibility of veterans for this program depends on factors such as their military service, income status or disability. Some veterans are eligible for coverage for drugs prescribed to treat their medical problems. Other veterans are eligible for prescription drug coverage for any illness as long as the benefits are not available as an insured service under a provincial health care system.

● (0905)

[*English*]

It is very important to note that VAC does not prescribe or dispense drugs. Veterans obtain the prescription drugs in the same manner as other Canadians. When a drug has been prescribed, the veteran presents the prescription and the VAC health identification card to a pharmacist, who will dispense the product. If the product is on VAC's formulary and all the criteria are met, then VAC pays the cost of the drug directly to the pharmacy, or in some cases it reimburses the eligible veteran who chooses to pay out of pocket.

[*Translation*]

Veterans Affairs Canada's drug coverage relies on a formulary developed and maintained through ongoing assessment of drug effectiveness, safety and cost-effectiveness.

[*English*]

The department operates a formulary review committee that makes decisions regarding drugs on the formulary. New drugs are added based primarily on recommendations from the common drug review process of the Canadian drug expert committee. This committee is an advisory body to the Canadian Agency for Drugs and Technologies in Health, and it is composed of individuals with expertise in drug therapy. I think my colleague from Health Canada described that quite well, so I will save you that component. This committee makes recommendations to participate in federal, provincial, and territorial publicly funded drug plans, and our VAC formulary categorizes drugs as standard benefits, specialized authorization benefits, or non-formulary products, based on their recommendations.

[*Translation*]

Standard benefits include many over-the-counter drugs and prescription drugs that Veterans Affairs Canada considers essential therapies. Approximately 80% of all drug benefits included on the Veterans Affairs Canada formulary fall under this category. All standard benefits are readily available to eligible veterans with a valid prescription.

[*English*]

Special authorization benefits are listed on the formulary with clinical criteria or with conditions that must be met before the drug is approved. They are higher-level or higher-cost therapies. To be approved for payment of these benefits, veterans have to demonstrate that the clinical criteria, or conditions established for the drugs, have been met. For example, a trial with a less expensive drug may be required before a more expensive drug would be approved. Non-formulary products are products that are considered not to provide therapeutic value or to provide insufficient additional therapeutic value, as compared with the cost of a comparable product.

Even so, VAC may approve these items on an exceptional basis. To be alert to potential issues with drug components of the treatment benefit program, VAC uses a drug utilization evaluation process to identify veterans who may be at risk through inappropriate use of drugs.

[*Translation*]

For example, pharmacists receive warning messages through a computer system to alert them to the potential of duplicate drugs, duplicate therapies, drug interactions, overuse or abuse.

[*English*]

VAC is committed to ensuring that our programs continue to meet the needs of our veterans. We were pleased that the Office of the Auditor General carried out a comprehensive review of our drug benefits in 2015 and 2016. The Auditor General's report, which was tabled in May of 2016, included recommendations to improve the program.

The Standing Committee on Public Accounts also reviewed the Auditor General's report and tabled its own report with additional recommendations on October 17, 2016.

This deep examination of VAC's drug benefits has provided the department with an opportunity to introduce changes that will result in positive outcomes for the department, Canadians, and more importantly, for our veterans.

[*Translation*]

Both reports provided recommendations on the process, management and monitoring of the Veterans Affairs Canada's prescription drug program.

As indicated in both reports, Veterans Affairs Canada has accepted all the Auditor General's recommendations and we have taken immediate steps to begin implementation.

Specifically, in response to the recommendations, Veterans Affairs Canada relies on its partnerships with other federal departments and other jurisdictions to ensure that it is effective and that it provides cost-effective solutions for veterans. This could include working with our federal partners to participate in price negotiations with drug manufacturers, and reaching agreements on selling products at lower prices.

● (0910)

[*English*]

Additionally, the department has taken advantage of this opportunity to revise and refine the operation and composition of the formulary review committee, including standard operating procedures, which formalize the decision-making process and how evidence is considered. We are also developing a framework to enhance the drug utilization evaluation monitoring.

In closing, Mr. Chair, I would like to reiterate that VAC's role in national pharmacare is limited to that of a payer for the drug benefits for a small, specialized portion of the Canadian population, our veterans. While we have experience with benefits as a result of working with partners, Veterans Affairs top priority is the provision of services for the health and well-being of our Canadian veterans.

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

[*Translation*]

Thank you.

[*English*]

The Chair: Thank you very much. I'm sure we're going to have lots of questions.

We are going to start our first round of questions with seven-minute questions, and then we'll go to five minutes.

We're going to start with Mr. Kang.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Thank you, Mr. Chair.

Thank you all for your testimony, ladies and gentlemen. Good morning, everybody.

I have a general question, so Health Canada, AG, Veterans Affairs, anybody can answer this.

We have heard from previous witnesses from different areas of federal government about pharmaceutical coverage, for example, for first nations, veterans, and others. To what extent do the federal departments currently collaborate and coordinate in their provision of drug benefits to all these federal client populations. Is there any coordination between...?

Mr. Sony Perron: There are a number of places where there is collaboration. I think my colleague from Veterans Affairs was mentioning, just a couple of minutes ago, the work around negotiating a product listing agreement. In fact, we also do that now with provincial and territorial partners. This is a horizontal process. Health Canada is the lead federal department and supports the other federal departments in this process.

Also, in some cases, we work together to negotiate agreements with service providers. We were talking about the dispensing fee before. Sometimes between federal departments, we work together to enter into negotiations with pharmacy associations to negotiate better dispensing fees.

Yes, there is a certain level of collaboration. There is also collaboration on the technical side. We keep each other aware of listing decisions and criteria that are being used. There is some difference in the formularies, but usually it's because there is something that is specific to our population.

I mentioned before that we are covering some over-the-counter drugs in the first nation and Inuit health program. The reason for this is that there's a need to support prenatal and postnatal health and the development of kids, and these kinds of products are very important from a public health perspective. There are small deviations because of the different populations we serve.

Mr. Darshan Singh Kang: My second question is this. In your view, how could a national pharmacare strategy provide better collaboration and coordination among the departments to achieve cost savings in this area?

Mr. Sony Perron: I have to say that the listing decisions that are being made by various plans, whether they are private or public in Canada, create pressure on other plans to move. Greater alignment and collaboration among the plans has already proven to be more effective. I think it helps to improve the service to clients, because they can anticipate what service will be available and get some alignment between coverage. Second, it creates an opportunity for negotiating rebates and cost-saving measures. We already do that, and we see the benefit of having this kind of collaborative approach and of having something that is synchronized.

Often public plans are under pressure to cover some products, because private plans will start to pay for these products right after Health Canada has approved them in the Canadian market. However —as we and our colleagues from VAC mentioned—we normally follow this common drug review process, so we come after. But when a large portion of Canadians have received coverage from their private plan for a drug, you have the physicians starting to prescribe it because it's covered by some, and some plans will start to cover it, as well.

Better alignment there helps to create economy, for sure, and there is already work under way to try to get some alignment into the coverage.

● (0915)

Mr. Darshan Singh Kang: Do you think we will succeed in having a one-stop shop?

Mr. Sony Perron: I cannot tell about one-stop shop, as you suggest, but what I can say is that we have seen the benefit of greater alignment when it comes to formulary management.

Mr. Darshan Singh Kang: Thank you.

My other question is for Veterans Affairs. Do the veterans have a uniform kind of coverage, all the veterans, or is it just steered according to the rank? How is that coverage provided?

Mr. Michel Doiron: Thank you for the question, Mr. Chair.

We have a common formulary that applies to all veterans. However, the fact that we would pay is based on the injury and service relationship or the ability of the veteran to pay. If somebody is frail or cannot pay, then Veterans Affairs will take care of that veteran. However, it is based on the injury and the relationship to service as a first premise. That said, the formulary is uniform for our veterans from coast to coast to coast.

Mr. Darshan Singh Kang: You mentioned the frail veterans or those who can't afford it. How hard do they have to fight with the department to get their coverage?

Mr. Michel Doiron: It's not always a very simple process. The Auditor General commented to that effect in his report in 2015.

We are working very hard. We have this initiative called the service delivery review, to modernize and make our services veteran-centric as opposed to program-centric. We're working on that.

If a veteran is frail or it's an end-of-life situation, we have expedited matters to get the programs done. However, the moment you come to us and we deem your injury to be service-related, you are then eligible for medications related to that injury. You do not have to reapply for that. Once we adjudicate the case and say that your hearing loss is service-related, then hearing aids, batteries, or any specialized medication are automatically given to you. You receive your card for medication, and you are in the club immediately.

Mr. Darshan Singh Kang: When we get old, we are going to have different diseases. I don't think the coverage should be just service-related, because those ladies and gentlemen in uniform have put their lives on the line for us. I think they should be treated better than what I hear out there in some stories from veterans.

Mr. Michel Doiron: Sir, I agree with you, but we have to remember that in Canada medication is not paid for everywhere, The provinces do have programs. If they are not covered by the provinces, etc., then Veterans Affairs will take care of our veterans. That is our primary mandate, and we work very hard to do that.

Mr. Darshan Singh Kang: My only concern is that they don't have to go in circles to get their coverage. That's what really bothers me. Even in my constituency I hear some veterans, and they are in tears. They say that sometimes they are running into a brick wall. That's why I'm passionate about this, and that's why I'm bringing this up.

Mr. Michel Doiron: Thank you.

Mr. Darshan Singh Kang: Am I done?

The Chair: Mr. Webber, you're up.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair.

I appreciate everyone's being here today and presenting to us. Thank you.

I read here a paragraph from the Office of the Auditor General. He said, “A well-defined approach to monitoring drug utilization is also important.” He went on to say:

> Particular attention should be paid to the utilization of some high-risk drugs which need to be adequately monitored in order to understand the trends and their use.

My question to the Department of Veterans Affairs is about a concern I have with the reported high use of medicinal marijuana within the Veterans Affairs department. First of all, to be covered, medicinal marijuana obviously must be on your drug formulary.

Can you give us some specifics on that particular drug—the stats, perhaps, on the increase from the years before? Also, are other drugs being less utilized because of the high increase of medicinal marijuana? If you can answer those, that would be great.

Mr. Michel Doiron: Thank you for the question.

First, cannabis or marijuana for medical purposes is not on the formulary because it is not a prescription drug. It's not considered a drug, and it doesn't have a PIN. It doesn't have those criteria, so it's not on our formulary.

The OAG rightly identified the fact that we were paying a lot of money for marijuana and that the department should look into it, and Minister Hehr came out very clearly saying that we need a reimbursement policy for this. I think the committee will be happy to know that the reimbursement policy was announced and is being implemented now, as of November 22, whereby we will limit the amount to three grams per day, down from 10 grams, which was the limit before. In addition, we will cap the amount that we pay per gram to $8.50 per gram.

Now, I want to stress that it is not a prescription for marijuana, but a script, and Veterans Affairs does not provide scripts. We will pay, but it's the professional health care professionals or the doctors who work with the veterans who make the determination whether marijuana for medical purposes is the right substance to use.

The department in 2007 decided to pay for palliative clients based on compassionate grounds. Over the years, that use has gone up. In 2013-14, we had 112 clients, which is not very many. Then the courts made certain decisions, and some of the regulations surrounding the distribution or the availability of medical marijuana were changed.

We finished 2015-16 with just over 1,700 veterans using marijuana for medical purposes. This year, in the first six months there are just over 3,000. As you can see, there's been a pretty significant increase, and it is not due to Veterans Affairs providing the scripts. I want to be very clear. It is more and more doctors and health professionals deciding that our veterans could have some use for it. Now, we are very concerned with the health and well-being of our veterans, and hence the minister came in with the new requirements.

To answer your questions about a decrease in other areas, we did a review about six months ago, following the OAG's visit, of whether there was—because we were hearing anecdotal evidence that there was—a decrease in opioids, or benzanines, or such medications. The review at the time did not demonstrate that. It demonstrated that our numbers are staying pretty consistent in that area, but that the use of marijuana was going up.

Now, if you look at our public reports, you will say, “Well, sir, your numbers are going down for opioids”. That is not because of the people using marijuana. We compared people using marijuana and people using opioids. Our veteran population is decreasing; we now have 670,000 veterans. Therefore, the use of opioids, benzanines, and other medications is decreasing because of the decrease in the number of veterans.

We actually did a correlation between veterans using marijuana and veterans using other drugs to see whether, in that population, there was a decrease, and at that moment there was nothing of any significance.

I hope I've answered all your questions, sir.

● (0920)

Mr. Len Webber: Yes. Thank you so much.

I don't know how much time I have left, but I quickly want to ask the first nations and Inuit health branch a question.

Do you see a significant increase in the use of medicinal marijuana in your department?

Mr. Sony Perron: As my colleague from Veterans Affairs mentioned, medical marijuana is not a prescription drug in Canada. The policy of the program is to cover only prescription drugs, so as a result we've had no coverage for medical marijuana in past years.

Mr. Len Webber: Thank you.

The Chair: You still have some time.

Mr. Len Webber: I still have time? Oh boy. Okay. I'm not used to having seven minutes, Mr. Chair. Maybe we'll just sit and look at each other.

The Chair: No, we won't do that. We'll move to Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you.

Can I have some of those minutes? Thanks.

Thank you to all the witnesses for being here today.

My first question is for the Auditor General. I apologize if you've covered this. Are the six departments that provide coverage participating in a common bulk-buying program for all of their drugs? Do we know that?

● (0925)

Mr. Michael Ferguson: Actually, probably the department would be in a better position to answer that.

Again, the audit that we're presenting to you today was just on Veterans Affairs, so I think the departments could give you a better idea of what they're doing in terms of bulk purchasing.

Mr. Don Davies: Okay.

Do either of the officials from Health Canada or Veterans Affairs know if the six departments are coordinating bulk buying of their drugs?

Mr. Sony Perron: I will ask Scott to talk about our participation in the pharmaceutical procurement alliance.

Mr. Scott Doidge (Director General, Non-Insured Health Benefits, First Nations and Inuit Health Branch, Department of Health): For about the past year we've been participating with our provincial and territorial counterparts through the pan-Canadian pharmaceutical alliance. We are representing the other federal departments at that alliance, so when agreements are negotiated through that consortium, we do provide those agreements through our federal counterparts. Then it's up to the departments to choose whether or not to enter into those product-listing agreements.

Mr. Don Davies: As all the witnesses know, this committee is studying the potential for a universal national pharmacare program of some type. What I'd like to know is whether it is a fair comment—if I'm understanding this properly—to say, with Veterans Affairs and with Health Canada, with respect to first nations and Inuit peoples, you effectively have a universal pharmacare program for veterans, and there's a universal pharmacare program for first nations and Inuit people. Is that a correct description of what is presently the case within those cohorts?

Mr. Sony Perron: I think what I can say for the first nations and Inuit is that the program is universal for all first nations and Inuit in Canada, with the exception of first nations living in British Columbia, because this portion of our activity has been devolved to a first nation institution.

There are small pockets in Canada where first nations under self-government or Inuit under self-government have taken on this program, but generally speaking, you're right to say that it's universal coverage for drugs for all first nations and Inuit. In particular, the program, because of the economic conditions of the populations we serve, has no copayment, no deductible, and no income testing. It's for all of them as status.... There are some rules in terms of the formulary that I mentioned in my introductory remarks, which we are applying, but otherwise, this program can cover really high-cost products, and there is no maximum limit if this is medically required.

Mr. Don Davies: Thank you.

Mr. Doiron.

Mr. Michel Doiron: We don't usually say that it's a universal program. I want to be careful. Ours is based on the needs of the veteran. However, once the need has been identified and they meet the eligibility criteria, then every veteran has access to the same formulary. In that sense, that would be universal, but it has to be service-related, or you have to be in a certain category. Once we deem it to be service-related or you're in that category, then we use the same formulary, and again, there is no cap, as my colleague said, no top. We ensure that you get the medication you're entitled to.

Mr. Don Davies: Okay. The reason I ask that question is that we're not reinventing the wheel here at this committee. Many countries have universal hospital and physician coverage and also have some form of universal drug coverage. We also have, of course, the U.S. veterans association, and I think your two departments are examples of where we already are providing some form of universal coverage for a defined group of people. What I'm trying to delve into now is what lessons or advice you might give this committee, from your experience, about how we might be able to set up such a system that covers all Canadians.

Maybe I'll start with you, Mr. Perron, focusing particularly on the formulary. Is the formulary broad enough, in your experience, in covering your cohort? Is the administration of the program efficient and effective, in your view?

Mr. Sony Perron: Thank you for the question.

I think some of the principles that the Auditor General of Canada mentioned in terms of what we should look at when we look at formulary management are principles that we try to adhere to. It needs rigour. Evidence is changing all the time. It needs to rely on expert advice. This is why we are looking at the common drug review process, and the expert group that supports that is giving us the first input about what we should do when a new drug comes on the market, or when new theoretical value is identified for a drug and we need to take that into consideration. I think the rigour in formulary management is essential.

Alignment with other plans is also very important, so that you don't get into a situation where patients going to see a physician receive a certain type of prescription from one physician, and because another kind is covered by someone else, they will receive a different kind of prescription. In fact, it's really difficult for the prescriber to know what is covered in one plan and in the others, so a certain alignment is good.

I think we have made progress. When I say we, it's not necessarily Health Canada only. I think, generally speaking, in Canada we have made progress in the last few years in some alignment that makes it easier for the prescriber, for the pharmacists who deliver, and for the client, of course, to access what they need. There is more progress that can be done. I would think rigour in this is important.

There are also specialized drugs that emerge. Cancer therapy that used to be delivered in hospitals now is often dispensed at the pharmacy desk, and people leave with this for home. These are new areas where we have to refine our process all the time because it's not static. The pharmaceutical offer is changing all the time. We need to have the capacity to adapt to these new realities and changes in the health system because the patients are also facing that. Therefore, the plans always need to be evolving.

● (0930)

Mr. Don Davies: Thank you for that. I think that's jibing with a lot of evidence we're receiving from many of the witnesses.

On a very general question, do you feel that the program you're administering is able to provide a broad enough formulary to cover the cohort that you're covering in a reasonably efficient way?

Mr. Sony Perron: Yes. This is our objective. I would say it never ends. We need always to refine and re-evaluate and assess the trends. I think we mentioned opioids before. For a number of years we were closing our eyes to this problem and we were just paying for the drugs that were prescribed because we relied on the physicians to do the prescriptions, but it caused a public health problem in Canada. We have a role to play in trying to curb that going forward.

Mr. Don Davies: Thank you.

Mr. Doiron, are veterans generally happy with the coverage they get? Again, in your experience, do you feel that Veterans Affairs Canada is providing a broad enough formulary to cover the needs of veterans, and providing that service to them in a reasonably efficient way?

Mr. Michel Doiron: I would echo my colleague's comment, and the answer is yes. I think our formulary is very wide. We have made some changes following the OAG.... We've brought in more professionals to manage our formulary. We've hired a pharmacist, and our committee is now chaired by a doctor, so we understand more about the complexity of the drugs than we did before, because it's not only now an administrative.... We've actually brought the health professionals to the table—the pharmacists, in particular—to provide us with in-depth knowledge of one drug versus another.

Yes, our formulary is quite wide. Our biggest challenge is often the provinces, because each province has a different formulary, or doctors may prescribe a different drug for different things. It's keeping up with their changes in prescriptions. I have exactly the same comments as Mr. Perron when it comes to that, but I think we do have a pretty large formulary.

Mr. Don Davies: I'm done.

The Chair: Thank you very much.

Mr. Oliver, you have seven minutes.

Mr. John Oliver (Oakville, Lib.): Thank you very much. Thanks for the various testimony that we've heard.

To begin, I heard both from Veterans Affairs and Health Canada that you work with CADTH. You take the Canadian Agency for Drugs and Technologies in Health and their common drug review, but then you put it through your own sort of drug benefit review lens, which would change it.

I'm thinking about a national program. We'd heard from CADTH that they felt they were in a position to help to define a formulary. You feel that you need to redefine what they're doing. Could you help me understand what kind of criteria you would apply that CADTH doesn't apply?

Mr. Sony Perron: I think we are not redefining. I would qualify that we refine what is being given to us by CADTH. For example, a large portion of the population we serve lives in remote, rural, and isolated locations. Sometimes the criteria that have been designed by CADTH will apply to Canada, in general, and mostly urban or suburban areas.

When it comes to populations that live at a distance, we sometimes have to change and decide to do coverage differently, because the likelihood that this patient can come back the week after to see the physician to try a second therapy might not work. Sometimes we have to change the rules a bit to accommodate the reality of the population we try to serve and the geographic distribution of the population.

Maybe Scott can give a partial example because I think this could be better illustrated.

Mr. Scott Doidge: I think the route of the administration of a drug sometimes becomes important, so to Sony's example, if a drug is administered intravenously and there's an alternative product that can be self-injected, that's something that we might take into consideration in looking at a category.

● (0935)

Mr. John Oliver: Going from an open benefit to a limited-use benefit, do you have other criteria that you're applying in addition to only the clinical application of the pharmaceutical? In your DBL you said there was an open benefit, a limited-use benefit, and then there's an exception, so for the limited-use benefit, is someone applying some kind of criteria in addition to the clinical performance of the drug?

Mr. Scott Doidge: The limited use and exception criteria for coverage are actually built around what CADTH says a drug's place in therapy is. We don't add net new criteria to those kinds of products. If CADTH says pay—

Mr. John Oliver: So CADTH does that. Other than the geographical issues, the CADTH recommendations on formulary are what you accept.

Mr. Scott Doidge: Except for a very limited handful of circumstances.

Mr. John Oliver: Is that true for Veterans Affairs as well?

Mr. Michel Doiron: Yes, it is. It's not so much the remote locations of our veterans, it's more that the injuries suffered by the veterans sometimes need us to veer a bit. As an example, we know that veterans have a lot of issues with mental health. PTSD is what everybody says, but we should actually call it mental health because it's a full spectrum. Sometimes we will make a drug more available, or treatment benefits more available to help, because we have a full suite of services in mental health for our veterans that not many Canadians may have, and that includes certain medications.

Typically, the recommendations we get from the committee is what we follow, as my colleague—

Mr. John Oliver: Just on that, recommendation 4.12 from the Auditor General said that other than following CADTH there were 17 committee decisions that he couldn't find adequate evidence for, for clinical review, so you must be applying other criteria besides CADTH.

Mr. Michel Doiron: Yes, we look at the need of the veteran outside of what CADTH has provided us. In those 17 cases, it's because we did not track the decision-making, but the committee had met and had discussed. That's why, as I mentioned earlier, we brought the health professionals to the table, the pharmacists and the doctors that we have internally, to help us refine those requests, or refine those...I won't say exceptions, but those categories.

Mr. John Oliver: It sounds a bit like your drug benefit process is related more to the adjudication process than it is to...because you're not really providing a universal coverage. You're providing for veterans from certain classes, categories, or service-related injuries.

Mr. Michel Doiron: Yes, but I would not say it's based on adjudications only. It is based on the needs of the veterans and the injuries they have suffered. That is determined by adjudications often, but not always. In the case of PTSD, we provide a lot of services to our operational stress injury clinics, where we have psychiatrists and psychologists who provide help, and that is outside the adjudication process.

Mr. John Oliver: Thank you.

I'm going to keep us moving along here. I only have seven minutes.

I'm also looking at the cost of administration. I think Veterans Affairs uses Blue Cross to administer. I don't know whether Health Canada uses a third party to administer their funds. What is the admin fee associated with that? There's the cost of the actual medication and then there's a percentage that Blue Cross or others would charge for the administration of that. What's your percentage?

Mr. Michel Doiron: I will have to get back to you with the answer to that. I don't know it right off the top of my head and I'd rather not give you a wrong answer. They administer all our POCs. There is an administration fee, but it states on the contract—

Mr. John Oliver: Mr. Doiron, if you went to a single-payer versus multiple third-party payers, that's a savings that we'd see across the system for private insurers and public people who are using third-party insurers. In Health Canada, do you have an administration arm for that?

Mr. Scott Doidge: We have one for the program, including all the benefits that Sony described at the start of the testimony, so for all of our benefits our admin cost ratio is 5%. That includes all the salaries of Health Canada employees, plus the contract payments, and our contract is with Express Scripts Canada.

Mr. John Oliver: Thank you.

If we could get the cost of your Blue Cross administration fee for veterans, that would be worthwhile receiving.

Mr. Michel Doiron: Yes, sir. We will follow up on that. Thank you.

Mr. John Oliver: I have less than a minute left.

The adjudication must cost something as well. If there were a national formulary, a national pharmacare program, veterans wouldn't need to be adjudicated. They would receive drug benefits as required, as any other Canadian would, regardless of the class of veteran or whether it was injury-related, so the whole cost of adjudication, the whole cost of.... I would potentially say the same thing about indigenous people, that they would fall under the same category.

Do we have any guesstimate of the cost of administration of these separate programs that would fall under a universal benefit?

● (0940)

Mr. Michel Doiron: Sir, there would be no savings on adjudications because, we have to be clear, when they do the adjudication process to determine if the injury was related to service —

Mr. John Oliver: It wouldn't matter. If there were a universal pharmacare program, it wouldn't matter where they had the injury from.

Mr. Michel Doiron: It would, because the pharmaceutical part is a very small component. There are disability awards, disability pensions, and other treatments that are not medication, which all fall under that area.

Mr. John Oliver: Thank you. I understand that.

The Chair: Okay, time is up.

We're going to five-minute rounds now, but the chair has to leave. I'm going to table our fifth report on Bill C-233, and I think that's quite an accomplishment for us. I'm tabling that this morning. When I table it, I'm going to say that every party had amendments that we think strengthened Bill C-233.

I'm going to turn the chair over to Mr. Webber, and I'll go to table Bill C-233.

I want to thank our guests. I'm sorry I'm going to miss the rest of this. It's very interesting, and you're bringing new perspectives that we hadn't heard. Anyway, I have to go.

The Vice-Chair (Mr. Len Webber): Dr. Carrie is up now.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, and we'll miss you.

First of all, I'd like to thank our witnesses today.

I actually have a whole bunch of questions. I'd love to have more than five minutes, but the reality is that if we're going to be moving to a national pharmacare program, the rationale behind that is to decrease costs and have better coverage, but some of the evidence—even Mr. Ferguson's point 9—is that when government runs things, sometimes that's not exactly what we end up getting.

We've defined pharmacare. Some of the activists, unions, and groups that have come in front of us say it's a government-run, single-payer monopoly that would entirely replace Canada's current pluralistic system of federal-provincial-territorial publicly funded, government-run drug plans, and the employment-based private drug plans. One of the problems with setting this up is that a lot of the data we have is extremely old. What I'm concerned about is the cost to the taxpayers in the immediate costs, if you're moving toward this.

Mr. Ferguson, in your point number nine today, you said that you "noted recurrent problems with government programs that are not designed to help those who have to navigate them and that focus more on what civil servants are doing than on what citizens are getting", that it is "critical for the government to understand that its services need to be built around citizens, not process" and that you "encourage the government to think at the design stage of how a pharmacare program could deliver services that work for Canadians."

You gave an example, I think in point number four, about inefficiencies and it being two years before things are actually looked at.

I'm really concerned. We don't really know at this stage of the game how many Canadians are insured, uninsured, or under-insured. We don't know how access to newer treatments and drugs would be affected. We've seen in other countries that have national pharmacare that innovative drugs can be restricted. Under realistic assumptions, we don't even know how much cost is going to be shifted to the taxpayers under pharmacare, and we don't know indirect economic costs, for example, job losses, private sector job losses, or takeover of the private sector. We don't know what the NAFTA implications would be, how other countries are really doing this, and what we have in the pipe right now that's working very well.

My first question for you, Mr. Ferguson, would be this. The federal government only covers 2.1% of total prescription drug expenditures in Canada. How is it being done? Is it being done efficiently by the government right now? If we extrapolated that 2% to 100%, do you think the costs would be huge?

What are your thoughts on this? Maybe you can't even answer that question.

Mr. Michael Ferguson: Perhaps I can provide a bit of perspective.

I think we heard in the opening statement from the Department of Health that some drugs can be extremely expensive for individuals. If you look at the opening statement from Veterans Affairs they commented on the fact that in 2015-16 they covered 48,000 veterans at a cost of $91.6 million. It's a very small program in terms of the overall coverage of prescription drugs. When we did the audit in 2014-15 they were covering 51,000, so the number of veterans they were paying for has decreased from 51,000 to 48,000, a decrease of 3,000, but the costs have gone from $80 million to $91.6 million.

A lot of that, as we have seen, has been the increase in the use of marijuana for medicinal purposes. Nevertheless, if you pull that out I think you can see that the incremental inflationary cost of prescription drugs can often be much higher than just normal inflation. Again, if you look at 2014-15 at the information we have in the audit, again, the average cost per person to Veterans Affairs was almost $1,600. The numbers we heard from Health Canada would probably put their average somewhere around $800 or something like that per individual. I may be wrong on that. That was my quick math.

When you take that number and multiply it by the number of people who would be covered you get a very large number. Some offsets to that would have to be figured in. What are the other programs that would no longer have to exist, what are they paying for, and where are they getting their money? Understanding the costs of this type of program and the offset costs that could go toward it would be prudent, as well as understanding the cost pressures.

I think in the audit that we have here that's something we said is very important in these types of programs: being able to monitor those cost pressures and being able to put in place cost-effectiveness strategies. Also, these would be strategies to know up front how the program is going to react when a new, expensive drug comes on the market and there's a lot of demand.

● (0945)

Mr. Colin Carrie: You mentioned prudence—

The Vice-Chair (Mr. Len Webber): I'm sorry, Dr. Carrie, your time is up.

I hate to cut you off, being a colleague. Unless we have unanimous consent around the table to allow you to continue—

Mr. Colin Carrie: I wanted to know if we need good data before we do this because it's a huge cost. Can we afford it?

The Vice-Chair (Mr. Len Webber): Perhaps Mr. Ferguson could answer those questions in writing.

We'll have to move on to Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Mr. Chair. Even though we are not colleagues, it is nice of you to give me the floor.

Let's talk about first nations. We have not talked a lot about them, but there are significant concerns.

It appears that the non-insured health benefits program is the responsibility of some first nations, such as the Mohawk community of Akwesasne in Ontario and the Bigstone Cree Nation in Alberta. They must manage the drug delivery component of the program themselves.

Can you give us a little more information about how the management is carried out and the reason for this, please?

Mr. Sony Perron: Thank you.

One of the guiding principles of our health intervention with first nations and Inuit is to ensure that the nations themselves have the greatest possible control over their health services, whether it be delivery, organization or design. Across the country, a number of nations have taken over parts of the program, with far more autonomy. The two examples you mentioned are more at the community level.

On a larger scale, British Columbia now has a health agency that manages that type of service. This covers the 200 first nations in the province. The agency has the flexibility to change the program if it wants to. The Inuit of Nunatsiavut also have an arrangement of this kind. This sort of change is allowed.

However, it is important to be careful with smaller public insurance plans. The fact that many clients are asking for very expensive drugs—such as the ones I mentioned earlier—can very quickly put the plan at risk. The risks are higher for those plans. Mechanisms must therefore be found to support first nations and organizations that assume those responsibilities. We must ensure that they do not become financially fragile because of new drug claims that they cannot afford. We are working closely with those organizations to ensure that the model remains viable.

In some cases, our department continues to provide support services. For instance, in the case of our British Columbia partners who have taken over the program, the department continues to process some of the claims as a service provider at this time. We expect the organization to transfer the management of its pharmacy program to the provincial program over the next few years.

● (0950)

Mr. Ramez Ayoub: You're talking about the British Columbia program?

Mr. Sony Perron: Yes. If you're interested, I can explain how alignment with provincial programs is beneficial.

Mr. Ramez Ayoub: I'm also interested in cost control, of course.

We are talking about 824,000 first nations members, an expenditure of $422 million and an increase of 1.4% year after year.

Can you tell me what is causing that increase?

Do you have any data on that?

What control methods are used to ensure that first nations' needs are being adequately met and that they are as independent as possible while being provided with special assistance?

Mr. Sony Perron: I'm going to start the answer, and then I'll ask my colleague to add more details.

We have an annual, multi-year mechanism that allows us to monitor our costs and know what they are associated with, in order to predict future costs. In addition, we examine whether the demand for drugs is similar for other public and private plans.

In order to project future costs, take action and make good decisions, we are studying the prevalence of certain diseases in the population we serve. Yes, the profile of its needs is often different.

After a period of relatively moderate growth in drug costs, we are now seeing an increase. This is happening this year and will continue over the next few years. This is mainly due to the new therapies on the market. For example, last year or two years ago, new hepatitis C therapies have emerged and this has had a significant impact on our public plan as well as a number of other plans across the country.

Mr. Ramez Ayoub: Does the use of fentanyl and other opiates have an impact on statistics?

Are you able to keep track of prescriptions like that?

Mr. Sony Perron: Yes. In my presentation, I briefly talked about the work we have done over the past 10 years on drug safety.

This was actually in response to a report by the previous auditor general. According to that report, the population we serve had wide access to drugs that lead to addiction problems. There was also a problem with the duplication of prescriptions. We have implemented several measures over the past number of years to try to contain the problem, which is not limited to the population we serve across the country. The profile is very different from one province or territory to another. The fact that our program is national and we have clients in every part of the country allows us to see how things are progressing. It is strongly related to the way doctors write prescriptions.

However, I would say generally that the last decade has created an environment in which people are exposed to drugs that can lead to addiction problems. We have implemented control measures. The non-insured health benefits program was one of the first programs to remove certain drugs from the list and to establish dosage limits. In an attempt to contain the problem, we contact the physicians who have prescribed the medication and inform them of any concerns about the dosage. This is not really a matter of cost management, but rather a matter of patient safety.

Mr. Ramez Ayoub: Mr. Chair, thank you for the extra time you've given us.

[*English*]

The Vice-Chair (Mr. Len Webber): I'm very good at treating you well, all of you.

We'll move on now to Ms. Harder. You have five minutes.

Ms. Rachael Harder (Lethbridge, CPC): My question is for Mr. Ferguson.

You make a point in number nine of your summary report here. You've actually cautioned us, it would appear, with regard to moving forward with a pharmacare program and making sure that we're taking into account delivery and the people, rather than looking at just the process.

I would ask you to reflect on a couple of things. First, what data is needed in order for us to move forward with a national pharmacare program from an educated standpoint, and with a delivery model that is going to be helpful rather than hindersome?

Second, what is the cost that would be associated with a pharmacare program?

Third, what would the impact be on choice be if we were to move forward with a pharmacare program?

● (0955)

Mr. Michael Ferguson: I'm not actually sure that I can answer a lot of those questions, but I can certainly speak to the comment that I made.

Again, it's something that we see over and over again in a number of our audits. Some programs are sort of putting the focus on the process, rather than on the individual.

I think the point of my comment simply is that, as you move forward with this, make sure that the point of view of the person receiving the service is considered important. I don't think that's just going to be a matter of just saying that people will want this type of a program. That may very well be true, but what is the cost going to be? How is that cost going to be covered? What will those cost offsets be? I think that's all important information to understand. The different steps in the process are also important to understand, but they need to be understood from the point of view of what the impact is going to be on the person receiving it.

I can't get down into the specifics of all of the types of data. I think that, with the information that Health Canada and Veterans Affairs have given, if you do a quick calculation, it gets to a fairly large number. However, there may very well be some offsets to that number because there are a number of different programs in this field already. If they don't have to exist, are there some cost savings there that could be put towards this?

Then I think the other thing to be very careful of is, again, the fact that often in these types of programs it's not just a matter of the cost increase by the regular consumer price index or anything like that. The way that inflation in the health field can be significantly larger than in other fields is something that any government taking on a project of this scope would have to understand. They need to understand how they're going to deal with those types of cost pressures in the future, as well.

Ms. Rachael Harder: Thank you very much.

My next question is also for you, and its in regard to the opioid problem or crisis that we just saw arise. You mentioned that, briefly, in your comments. You alluded to the fact that accountability was needed and that this problem actually went unchecked for a little too long. If we were to move forward with a national pharmacare program, what accountability is needed in order to make sure that there isn't an abuse of pharmaceuticals?

Mr. Michael Ferguson: I think maybe I'll reflect on something like the use of marijuana for medical purposes that was in the audit we did related to Veterans Affairs. Again, I think we've heard a little bit about that this morning.

That understanding of some of the prescribing practices.... We identified that Health Canada had talked about the types of situations were perhaps marijuana for medical purposes would not necessarily be the right choice, such as for people with bipolar disorder or people with depression. There were about 300 veterans, I believe, who had received prescriptions for antidepressants, as well as prescriptions for medical marijuana. That's an indication that it might not be consistent.

Similarly, in one of the years, we identified that 29% of the prescriptions for marijuana for medical purposes were provided by one physician.

Understanding the usage, understanding when there's incompatible drug usage, and even understanding, sometimes, what some of those prescribing patterns are, that's all part of the monitoring that's important for this type of a program.

Ms. Rachael Harder: Thank you.

The Vice-Chair (Mr. Len Webber): We'll move on from there to Dr. Eyolfson.

You're up for five minutes.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you all for coming. I've met some of you before. I also serve on the veterans affairs committee, so some of this testimony is familiar. My first question is for Mr. Doiron.

● (1000)

When you talked about how medication is approved to be covered by Veterans Affairs, you said it has to be medication for a service-related injury or service-related illness. We went on to talk about mental health. If a veteran has a significant mental health issue that is requiring medication, does the veteran have to prove it is service-related in order for Veterans Affairs to cover it?

Mr. Michel Doiron: Thank you for the question.

When it comes to the mental health services that Veterans Affairs provide, we acknowledge the fact that veterans are put into very difficult situations and often that causes mental health issues. We are extremely supportive of that with our programs and medication. If it's a mental health issue and there's any link—even a resemblance of a link—to any type of service or they've been in any special duty area, as we call them, Veterans Affairs will take care of that mental health issue.

Mr. Doug Eyolfson: All right, thank you.

If the veteran had any history of mental health problems before service, is there the risk that the veteran might be turned down due to this being considered a pre-existing condition? Do you know if this happens?

Mr. Michel Doiron: Veterans can be turned down if there's no proof that it's a service-related issue or they've never gone to an SDA or something like that. However, we do not turn them down because of a pre-existing situation or pre-existing condition. Because they joined the military, they are deemed to be healthy. We put them in harm's way and, if something happens, we make sure to take care of them, pre-existing situation or not.

Mr. Doug Eyolfson: All right. Thank you.

Mr. Michel Doiron: I'd like to mention that, even if it's not service related—I will put a little plug in—we actually have programs where they can get 20 treatment sessions with a psychologist. We take care of it. It doesn't matter if it's service related or not. We're there for the veteran, even if it's not.

Mr. Doug Eyolfson: That's good to know. Thank you.

To go further with what Mr. Oliver said about this being contracted out, the administration being contracted out to Blue Cross, can you briefly comment on, say, the strengths and the weaknesses of contracting this out to a third party rather than dealing with it internally?

Mr. Michel Doiron: Thank you for the question.

One of the strengths of Medavie Blue Cross is that it is professional in the provision of health care and the administration of that. It has an expertise that the department does not have or it's very hard to maintain. Therefore, we buy it and it does the administrative part, which is not always the highest value part—the money part is always high but I mean the contribution. We brought in a pharmacist and a doctor to do the right monitoring, as identified by the OAG, but for the widget counts and getting the payments out and paying the pharmacies, it was more cost-effective to go with a company like this. It's not the only company but it is our provider, Medavie Blue Cross.

The other thing is that Medavie Blue Cross has a relationship with the pharmacies across the country, with portals where the pharmacist can bill us through not a paper process but an electronic process, and then Medavie can do the right monitoring of any duplications. These are things we could not do. I think, on the whole, it was much more beneficial to us to have it administered by a third party.

Mr. Doug Eyolfson: All right, thank you.

My last question is for Mr. Perron. If we were to create a national pharmacare program, would you think it beneficial to have first nations health care needs administered through that same umbrella, or would you think it more beneficial to still have their medication benefits under the non-insured health benefits program for first nations?

Mr. Sony Perron: You're asking a very bold question. I will try to put my brain to work answering this.

I will say that there is some specific need for some specific segments of the population. Whatever model you have—and I think our colleagues from Veterans Affairs mentioned this—there will have to be a place for adjusting the formulary and the approach to some segments of the population.

I think the ambition of having first nations and Inuit take more control over their own programs would have to be thought about and accommodated. For example, right now with the Assembly of First Nations we are doing a joint review of the NIHB program to get their perspective not only on the pharmacy benefits but on all benefit areas to try to adjust and deal with a systemic issue they may be facing in one region, or involving one benefit.

I think we should not lose the ability to engage the nations in the program. This is as far as I can go.

I will say that one systemic issue we are facing is that this is a national program. We operate in 13 jurisdictions. Often we will have clients complaining about having difficulty accessing some products or services in one province, because suddenly the provincial plan will have made a decision to start to cover them and the other clients will want to get them changed from non-insured.

We are not there yet. The non-alignment of the formulary between provinces and territories has caused some difficulty for clients trying to access our program. For us to always have to monitor that is a challenge, because in the end we want to facilitate access to the drugs that the clients may need.

I don't know whether I answered your question—

● (1005)

Mr. Doug Eyolfson: Actually, you did.

Mr. Sony Perron: —but somehow I think there is a need for adaptation, whatever model we use.

Mr. Doug Eyolfson: Sure. Thank you.

Thank you, Mr. Chair, for your indulgence in that.

The Vice-Chair (Mr. Len Webber): You bet.

We'll move on to Mr. Davies.

You have three minutes. Thank you.

Mr. Don Davies: Thank you, Mr. Chair.

I'm interested in following up a little bit more on medicinal marijuana.

Mr. Doiron, you said you don't use prescriptions for it but do use scripts. What's the difference between a prescription and a script?

Mr. Michel Doiron: Actually, I should have said an "authorization". I typically say "script", but the real term is an authorization.

There are doctors on your committee, so they can correct me, but a prescription is for when the doctor can refer to certain criteria. For example, if you have pneumonia, you're going to take penicillin—a certain dosage per day times seven days. In the case of marijuana, that does not exist.

The "authorization" they often write on the same pad as you would a prescription, but the doctor says, "I authorize my client to have three grams a day". It's not a prescription, because in the drug world this is not a classified drug. It doesn't fall under that category; therefore, it's not a prescription.

The piece of paper is usually just about the same. There's no issue there, but it's the terminology.

Mr. Don Davies: I understand that, so we'll leave the technicalities aside.

The bottom line is that the Supreme Court of Canada has ruled that Canadians have a right to access marijuana for medicinal purposes. Doctors are writing, for lack of a better word, prescriptions on prescription pads for marijuana for medicinal purposes.

Veterans Canada is covering and paying for marijuana to be used for the treatment of certain things. For PTSD in particular it has been quite successful, I understand through some of my discussions with veterans, which I think would explain the explosive growth in usage among veterans, particularly those with PTSD.

My question, then, is to Health Canada. Health Canada, another branch of government, is not approving the use of medicinal marijuana for any first nations or Inuit people. Why the discrepancy?

Mr. Sony Perron: It goes back to the mandate of the program, which is to cover prescription drugs. We have reviewed the requests —there are a number of requests that have come forward in the last few years about this—but it doesn't fall under prescription drugs. This doesn't prevent the client from accessing the products at his home, but we do not have the authority at this time to cover and spend money on this product.

Mr. Don Davies: Are you feeling a pressure from the first nations and Inuit communities to have it covered in the way that veterans are getting it?

Mr. Michel Doiron: We have received requests. Volume-wise, I cannot tell. Maybe Scott can give us....

Mr. Scott Doidge: It's not very many. We get small numbers of them. They're more inquiries than requests.

Mr. Don Davies: Okay.

I want to leave it to all of you—I have a very brief time left—to say what advice you would give us. If Canada were going to set up a universal pharmacare system to cover all Canadians for a broad formulary, with your experience in looking at some angle of this, what is the best advice you'd give this committee?

Maybe I'll start with you, Monsieur Doiron.

The Vice-Chair (Mr. Len Webber): Excuse me, though, Mr. Davies. You are out of time, but I'm pleased to tell you, if I have unanimous consent around the table, we can add another five minutes to each of the parties and we can start with you.

Okay, you have five more minutes.

Mr. Don Davies: Great. Thank you.

Monsieur Doiron.

Mr. Michel Doiron: I guess we've learned a few things, and if I had any recommendations, one would be good monitoring. We've learned to make sure there are no counter effects. The other thing is to make it evidence-based, ensure that whatever is coming out is evidence-based. I think the OAG talked about that and I take that as very important, as well as understanding where the cost and the cost drivers are, and maybe at the end, the cost savings.

The other thing is that we're using a term more and more in the department to “go low and go slow”, to ensure that when you're starting with your prescriptions and the approvals and that, you start slowly and at lower levels. I think marijuana caught us maybe a little by surprise. When the regulations changed, we were perhaps a little slow to react to that. We went from no more than a couple of grams a day and 100 veterans using it, to 3,000 using it within a year or 18 months.

That's where I would go. Make sure you have the data, the evidence, and then know where the cost drivers are.

● (1010)

Mr. Don Davies: Thank you.

Monsieur Perron, or Mr. Doidge.

Mr. Sony Perron: I would mention rigorous, evidence-based formulary management. This is fundamental in managing a plan. You will always have challenges meeting everybody's expectations, but the science and the evidence about the cost-effectiveness and the relative effectiveness of various products is something that needs to be done rigorously. I think it's fundamental. Whether it is a regional, employee-based, or group-based plan, this is fundamental.

Mr. Don Davies: Mr. Ferguson, do you have any thoughts?

Mr. Michael Ferguson: I think they both mentioned the things we covered off in our audit in terms of it being evidence-based and the monitoring, and that type of thing. That's all very critical in the actual set-up of the program. However, there is the first step of making sure you understand what the demand is going to be. When you make this big change in the model, what is the demand that will be coming from the citizens? What is the cost estimate going to be? What is the inflation? What's going to happen when there is another big drug that costs $1 million a year, or whatever? If there is a large demand for it, how are all those things going to be managed?

I think there are two aspects. There is understanding the mechanics of managing this type of program, but there is also a matter of stepping back and saying, if you're going to take something this broad in scope, it's not necessarily just going to be exactly what Health Canada is offering or what Veterans Affairs is offering. It will probably come along with a different set of expectations. I think understanding what those are going to be and what impact those things could have on the program and the satisfaction of the people trying to access the program is something that would need some attention as well.

Mr. Don Davies: Those are wise words, but if I might say, these are exactly issues we deal with today. Every insurance plan of every type, whether it's private insurance or any government department, is dealing with exactly those issues today.

Mr. Michael Ferguson: It is exactly those types of issues today, but of course, when you put it into one program, you now only have the one place to deal with that. You're right that they're the same issues that exist today, but they're not issues that the federal government has today. Some departments do have them, but only to a small percentage. When the federal government has to take on all those issues, it needs to understand what it's taking on.

Mr. Don Davies: Okay, thank you.

I just want to drill down in my last question to first nations and Inuit. In the last six months we have heard some stories of particular problems in health care delivery, timely and adequate health care delivery to first nations, particularly first nations children. Certain doctors have testified about or have gone public with there being certain barriers to getting treatment and medications to first nations clients, barriers that don't exist, say, for non-indigenous people.

Mr. Perron, do you have any comments on that?

Mr. Sony Perron: Yes. I cannot talk about all of them, but I think some of the comments come about from the situation where we are requiring, as a department, additional information from the prescribing physician as to why he or she is going with this prescription. It goes back to the CADTH recommendation that says, okay, this product should be used as a second-line or third-line therapy or should only be used if there is an allergy to that kind of product.

As a payer, our responsibility is to go back to the physician and say, “We have received that script to be paid by that pharmacy. Could you please confirm the reason you went with this product? Is it because the person has already tried the first-line or second-line therapy, or is there an allergy element?” There are criteria and we ask the physician to answer these kinds of questions.

● (1015)

Mr. Don Davies: Are you satisfied that's not interfering, though, with the actual treatment?

Mr. Sony Perron: If the response of the physician points toward the criteria, we are going to authorize the treatment. If not, then we'll ask why they are not trying the first line and second line.

I would say physicians are busy people. They want to do good for their patients, and sometimes they may feel this is pressure on them, but all plans in Canada have a certain level of, I would say, limited use where you go back to the physician to ask for evidence.

As I've mentioned before, this is a small percentage. Ninety-six per cent of the claims we receive for drugs are paid at the counter of the pharmacy. The patients show up at their pharmacy, pharmacists fill the prescription and send us the bill, and the client leaves with the drugs. It's 96%.

There is a small percentage, and we are trying to look at opportunities all the time to change our status or refine our criteria to avoid having to go back to the physician, but sometimes it is the result of a client safety situation so we will go back to the physician and ask, “Could you please explain, because we see a problem?” There might be contraindications about the two prescriptions the patient is on. We have the information. It would not be responsible to not act on that.

Most of the time we get the answer, and we process that in half a day because all this is done electronically between the pharmacy desk, our drug exception centre, and the physician's office, and we try to expedite the process. We have put a higher scrutiny on children more recently because there seemed to be a sensitivity there to make sure our rules are up to date.

The other reality is that, since we are operating in 13 jurisdictions, the fact that some provinces use different processes is a bit confusing for people on the ground sometimes. This is because most of their clients will be covered by the provincial plan, for example, and an odd case will be covered by us, and they are not totally aligned or knowledgeable about our processes.

This is one of the challenges of being a very large plan distributed across the country. We are small everywhere, so we cannot really influence the practice. We have to learn about that all the time.

There was an issue in one of the provinces recently about one product. We were hearing an ongoing complaint about the fact that we denied coverage of that. It was only in that province because suddenly the provincial plan started to cover this product, and physicians started to prescribe that product there, and we were not aligned with them. There is a due diligence that we have to try to learn about what is changing in the provincial formularies so that we can take that into account in the way we administer products.

The Vice-Chair (Mr. Len Webber): Okay. Great.

I'll have to cut you off there, Mr. Davies.

We'll move on to Ms. Sidhu. You have five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Chair.

Thank you to all the witnesses for your testimony.

I want to share my time with John.

My question is for Veterans Affairs. What step does the department need to take to improve its ability to monitor drug utilization so that veterans can have more access to proper services?

Mr. Michel Doiron: Thank you for the question.

We've taken steps. I think the issue with Veterans Affairs is not more services. I do want to be clear. I think veterans can get the drugs they need if they are prescribed by a treating physician. Our processes are quite quick as long as it's service-related or you fall within some of the criteria.

We do have to take steps, and we are taking steps, to improve the monitoring and the management of our formularies to ensure that the right drug is available to the veteran at the right time. Those are some of the things that were highlighted by the OAG, and we have undertaken to do this. Most of it we're trying to do by the end of this fiscal year.

As I mentioned earlier, we have hired a pharmacist, and the pharmacist, a professional in medication, is reviewing the formulary and making sure that it's the right drug and that there are no contraindications. A lot of stuff that Mr. Perron talked about is there. This committee now is also chaired by a doctor, a medical physician who understands what another doctor may have prescribed and has a better understanding.

The other thing we've taken a lot more interest in, if I can use that terminology, is the whole area of opioids and benzodiazepines to make sure, as we get more into this and as we're advancing it, that we're not creating issues out in the field that other health professionals have to....

The third and the last one would be marijuana, the reimbursement policies put out a couple of weeks ago for marijuana. There's a lot more monitoring for that and closer associations with the various people in the industry.

I want to emphasize that the veteran can get drugs, and it's quite quick. It is very good as long as it's service-related or you fall within one of the criteria. A lot of the work we're doing presently is making sure our programs are being well managed and are meeting the needs.

● (1020)

Ms. Sonia Sidhu: I am saying that because I went to a round table discussion with veterans and I heard stories. Can you give me the data about the time frame for the mental health, how long it took to access treatment procedures, or about the big trail of papers that they have to fill out?

Mr. Michel Doiron: On mental health, the department has an incredible suite of services related to mental health. We have over 4,000 mental health practitioners coast to coast to coast on contract with us. If a veteran needs help and if we don't have our OSI clinics there, they can get to the services.

We have to realize that our programs are based on need and based on the service relationship. Eligibility is very complex and we're trying to facilitate that, but generally speaking those are the two areas, and there's a series of services available. We actually pay for psychologists and psychiatrists. We actually pay the provinces to run our OSI clinics that are dedicated to our proud men and women in uniform, and to the RCMP, who can get their services.

Is there a wait time? Yes, sometimes in a certain clinic you may have to wait a week or 15 days to see a psychologist. If you try to see a psychologist in many parts of this country.... I know that there are even some provinces where psychiatrists are at a premium and it will take you a year to see one. With us, it's about 15 days. Some veterans do think it's too long to wait 15 days.

We have to understand, though, if they are in a crisis, the service is immediate. We work with the hospitals, with the doctors, with the professionals.

I think what they're referencing is that when they put in a claim with us, the whole adjudication process that I talked about earlier.... We will get them in for PTSD quickly, but the entire process will take 16 or 17 weeks. They need medical diagnostics. We're not doctors, but a doctor has to say, “You have PTSD”, or “You have a bad knee”. We cover everything.

The OAG did highlight the timelines it takes to get there, and we're working on accelerating that. I believe, without having been at that round table, that some of the comments about waiting are not so much about the treatment, it's about the adjudication process that comes with treatment but also comes with disability awards, which come with disability pensions, which come with other services. I know there is a real frustration in the veteran community surrounding some of those timelines.

Ms. Sonia Sidhu: Thank you.

The Vice-Chair (Mr. Len Webber): I'm sorry, you're out of time.

We have to move on to Ms. Harder. You have five minutes.

Ms. Rachael Harder: Thank you.

I will also be sharing my time with my colleague.

I have two questions, one for the Department of Health and one for the Department of Veterans Affairs. It is the same question, and that is, what are the key cost drivers you are facing within your department on pharmaceutical coverage?

Perhaps we can start with Mr. Doidge.

Mr. Scott Doidge: Sure. Our current projected growth rate for this fiscal year is about 8.3% in our pharmaceutical benefit, and that's up from previous years where we were quite a bit lower than that.

In our plan, one of the main drivers of growth is always new clients accessing the benefits. Population growth among first nations and Inuit is nearly double the Canadian growth rate, so we have a strong underlying population effect.

What we're dealing with right now in terms of drug coverage is that we have strong growth in our hepatitis C medication coverage. We're up about 30% on that. Opioid addiction therapies—drugs like buprenorphine, under the brand name of Suboxone, or methadone—are up significantly, as are biologic medications—drugs for rheumatoid arthritis, Crohn's disease—as Sony mentioned in his opening remarks.

With oral chemotherapy, it was noted that we're seeing a shift from hospital-based chemotherapy coverage to drugs that are now in tablet format and they're coming into our reimbursement environment, so we're seeing a significant growth in terms of our payment of oral chemotherapy. For infectious diseases such as HIV/AIDS medication as well, as more clients are diagnosed they're put on drug regimes that can cost $10,000 to $15,000 annually.

Those are the types of examples in which we're seeing growth pressure.

● (1025)

Ms. Rachael Harder: Thank you very much.

Mr. Sony Perron: If I could add one thing, from a public health perspective, the fact that people are accessing these drugs, getting treated, and getting cured is very good news. It comes with a cost, though.

Ms. Rachael Harder: That's a good point.

Thank you very much.

I have the same question for Veterans Affairs.

Mr. Michel Doiron: Thank you for the question.

Some of the same points were raised by Mr. Doidge, but some are a little different, because for us it's a change in demographics.

For a long time, Veterans Affairs had an older cohort of veterans, but since the war in Afghanistan and some of the peacekeeping missions before that, the average age of our veterans has gone down and the needs of the veterans have changed.

The newer, younger veterans have different injuries we have to treat, and some of the medications used to treat some of these new injuries are a lot more expensive than some of the traditional medication we may have used in the past.

A lot of our changes.... Although the demographics are going down—we had over 700,000 veterans and now we're around 670,000—the needs are more complex, the medications they are using are different, and the costs of those medications are going up. Like I said, some of the injuries and illnesses we are seeing are a lot more complex than they were with some of our previous veterans.

Ms. Rachael Harder: Thank you.

Mr. Colin Carrie: Thank you very much.

I'd like to focus a bit on costs and how much a switch to a single-payer system would cost. I'm concerned, because even as this study goes on, it seems that our data is insufficient. It's older data, and from a practical standpoint, we also have the complexity of federal coverage, provincial coverage, and private coverage.

Apparently, there are 24 million Canadians who have private coverage through work. If the government makes a decision that's going to force 24 million Canadians to take government coverage—and in some cases, we've heard it can be inferior coverage and won't cover the drugs a private plan would cover—then what kind of effect are we going to have on our population from an outcome basis, with the whole kit and caboodle?

I don't have a lot of time, but what I would like to ask the Auditor General, Mr. Ferguson.... Health care delivery is pretty much a provincial and territorial jurisdiction. As a conservative cost, the program would be about $35 billion. Do you have the jurisdiction to audit a provincial and territorial program, and what do you think the costs would be just for your department to audit something of that size from a process standpoint?

Mr. Michael Ferguson: If it was a national program run by the federal government, then it would be something that would fall within our mandate. Of course, taking on a very large additional program in our audit world would have some impact on us, but we have the authority.

As for doing an audit on the way the system is structured now, we already do audits in the three northern territories. We have access to what's going on in the territories and what's going on at the federal level. With the provinces, we'd have to bring the provincial auditors general in to look at that, but that's based on the structure as it exists now.

If the structure was a national program run by the federal government, then we would have the ability to audit that. If it was some sort of a national program that was set with all of the jurisdictions being part owners, as we see with something like the Canadian Blood Services and other things like that, then there would be a question about whether we would have access or not. That would have to be sorted out in the way that organization was established.

The Vice-Chair (Mr. Len Webber): Thank you.

We will have a final question, for five minutes, by Mr. Oliver.

Mr. John Oliver: Thank you very much.

I wanted to come back to the Auditor General's recommendations around making sure this is patient-centred and works for patients. Let's assume that we have a robust formulary that's evidence-based and that we have good cost-management strategies in that formulary. In the rest of the health care system, the primary relationship is between a caregiver, usually a physician or a nurse practitioner—but it could be somebody else—and the patient. The physician-patient relationship allows access to hospital services and specialists, and that's how our current system stays patient-centred. Patient-focused is that primary relationship.

In terms of the national pharmacare plan, do you see a model where that relationship is the primary relationship in prescriptions? Is there any other role you can see for a bureaucratic overlay that would interfere with the decision between a doctor and a patient to have a prescription issued?

For example, I heard Veterans Affairs say that the veteran must demonstrate that a lower cost drug doesn't work. It sounds like you have an administrative process that tests whether a generic is as effective as the original drug. I would argue that probably is an important decision made between the patient and the doctor, and there isn't a bureaucratic process involved in that.

● (1030)

Mr. Michel Doiron: Thank you for the question.

In our situation, the relationship between the doctor and the patient is the main point. That said, often a doctor may prescribe something, and there is a generic drug on the market that is cheaper and gives you all the same attributes. Unless there's contradictory evidence, we go to the generic. If you had a national health care—and I never really thought about it, so I want to be careful what I say—I still think you would need that to ensure that you're getting the best cost for your dollar or bang for your buck. Therefore, you go to a generic first, and if it doesn't work, you go to the second or third order, and you get into what is best. I think my colleagues were talking about it earlier; they have the same thing in aboriginal.

I think any health care system, and even in pharmaceutical, the main point is the relationship between the doctor and the person. When you hit the pharmacy, you need checks and balances to ensure that if there is something more cost-effective...especially if we're talking $35 billion a year.

Mr. John Oliver: That's a good example. Generics is what I was going to come back to next. For instance in our Government of Canada plan, I'm on a prescription and my doctor wrote the brand name. I pay more for that at the counter whereas if I have the generic, I don't pay more. It's really a consumer choice then at the end between the two. As long as the physician has confirmed with me that they are equitable, then this is my own decision around that cost point.

Are you satisfied generally that the introduction of generics is happening efficiently in Canada? As the patent protection falls off and you see them coming on, are adequate generic processes in place and are those drugs being substituted in efficiently for Health Canada?

Mr. Sony Perron: We've been very aggressive in the financial benefit in implementing generic substitution and paying for generic, first, as an option. To answer your question, technology may bring some of the solution you're looking for. It's not necessary to have a plan or an individual between the physician, the patient, and the pharmacist. Technology can do a lot.

I was mentioning earlier that 96% of our claims go through directly, and a lot of controls are built into the technology. We can think about pushing that. Whether it's a national or local plan, we can think about using more technology so that when the physician prescribes something, the criteria are already made available to the physician up front and he or she can submit the reason why it is preferable to go to the second-line therapy right away, or whatever kind of information is needed.

We can simplify the life of the physician, the patient, the pharmacist, and the plan administrator as well. There is potential there and I think we are making some progress.

Mr. John Oliver: That efficiency is so important. We heard from the pharmacy association that there are hundreds of third-party private insurers. Every time a patient comes in to fill a prescription, there are hundreds of different processes that have to be looked at, different plans, different percentages, different copays. It's an incredibly complex system, let alone those who can't afford the drugs. They don't even show up in the pharmacy because they can't afford to fill their prescription, or if they do get it filled, they save some of it for the next time they get sick because they can't really afford it. There are tonnes and tonnes of clear advantages for Canadians to move towards a national pharmacare model.

● (1035)

The Vice-Chair (Mr. Len Webber): Thank you, Mr. Oliver. Your time is up, and our round of questioning is completed.

I'd like to thank all our witnesses from the Department of Health, from the Auditor General's office, and all the way from Prince Edward Island, our friends from Veterans Affairs. Thank you sincerely for being here. Safe travels home.

Mr. Michel Doiron: Thank you very much, Mr. Chair.

Mr. Colin Carrie: Could we have unanimous consent to do a bit of committee business before we end this, or maybe after the next meeting if we can't have unanimous consent?

The Vice-Chair (Mr. Len Webber): Because of the fact that it is not on the agenda, Mr. Carrie, we would have to get unanimous consent as to whether or not we can go into other business.

Do we have unanimous consent around the table to go into other business?

Yes, sir.

Mr. Don Davies: On a point of order, Mr. Chair, I find that hard to vote on. It would depend on what the business is. There's usually unanimous consent to discuss a particular issue. I can't vote on it until I know what it would be.

The Vice-Chair (Mr. Len Webber): Okay. Certainly, we can find out.

What would you like to bring to the table, Mr. Carrie?

Mr. Colin Carrie: It's basically that with all the witnesses and the testimony we're getting, could we maybe submit a few more witnesses?

The Vice-Chair (Mr. Len Webber): You're looking at putting extra witnesses moving forward. Is that something that is copacetic with everyone around the table to discuss in other business? Are there any comments?

Mr. Davies.

Mr. Don Davies: Thank you, Mr. Chair.

I'd be happy to entertain that. One thing that I think we'd have to revisit is the actual schedule we have for the pharmacare study. I don't have it firmly in my mind right now how many more meetings and how many more witnesses we have.

I actually think that maybe we should schedule some committee business time next week for that. I don't think this is urgent. I think we can take some time to do that. I'd like to know who the witnesses are and what the category of testimony is to determine whether or not the committee would need to hear from them.

The Vice-Chair (Mr. Len Webber): All right. I guess if we can get that on the agenda for the next meeting, you can bring it up at that time.

Mr. Colin Carrie: Thank you.

The Vice-Chair (Mr. Len Webber): Okay.

The meeting is adjourned.