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REPORT 4, DRUG BENEFITS—VETERANS AFFAIRS CANADA, OF THE SPRING 2016 REPORTS OF THE AUDITOR GENERAL OF CANADA

Report of the Standing Committee on Public Accounts

Hon. Kevin Sorenson
Chair

OCTOBER 2016

42nd PARLIAMENT, 1st SESSION

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THE STANDING COMMITTEE ON PUBLIC ACCOUNTS

has the honour to present its

SIXTEENTH REPORT

Pursuant to its mandate under Standing Order 108(3)(*g*), the Committee has studied Report 4, Drug Benefits—Veterans Affairs Canada, of the Spring 2016 Reports of the Auditor General of Canada and has agreed to report the following:

"REPORT 4—DRUG BENEFITS—VETERANS AFFAIRS CANADA," SPRING 2016 REPORTS OF THE AUDITOR GENERAL OF CANADA

INTRODUCTION

Veterans Affairs Canada's (VAC) "Health Care Benefits Program provides drug benefits for eligible veterans, some of whom are considered vulnerable and have complex health needs such as mental health conditions."[1] In the 2014–2015 fiscal year, the drug component of the Health Care Benefits Program covered drugs for roughly 51,000 veterans at a cost of $80 million dollars.[2]

VAC has a Formulary Review Committee, which is responsible for reviewing, maintaining, and revising its drug benefits program, as well as making recommendations and providing guidance to its senior management to help maintain and improve the services provided to veterans.[3] VAC relies on the Common Drug Review process of the Canadian Agency for Drugs and Technologies in Health—an independent, not-for-profit organization that evaluates new drugs, and makes non-binding recommendations to federal, provincial (except Quebec) and territorial drug plans—to determine whether new drugs should be added to its drug benefits list.[4] VAC has contracted the day-to-day administration of its Health Care Benefits Program to Medavie Blue Cross, a third-party provider that makes payments to pharmacies.[5]

General Walter Natynczyk (retired), Deputy Minister, VAC, clarified the Department's role in relation to its Health Care Benefits Program:

> [I]t is Health Canada that is responsible for the regulation of medications for all Canadians, including our veterans. Veterans Affairs Canada does not prescribe medication; rather, it pays for medical treatments authorized by the veteran's physician or health professional.[6]

In Spring 2016, the Office of the Auditor General of Canada (OAG) released a performance audit that examined whether VAC managed the drug component of its Health Care Benefits Program to contribute to the health of veterans by providing coverage for

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1 Office of the Auditor General of Canada (OAG), "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 1.

2 Ibid.

3 Ibid., p. 2.

4 Ibid.

5 Ibid.

6 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 9 June 2016, Meeting 19, 0850.

drugs based on evidence, by using cost-effective strategies, and by monitoring the utilization of drugs covered.[7]

On 9 June 2016, the House of Commons Standing Committee on Public Accounts (the Committee) held a hearing on this audit.[8] From the OAG, the Committee met with Michael Ferguson, Auditor General of Canada, and Casey Thomas, Principal.[9] VAC was represented by General Walter Natynczyk (retired), Deputy Minister; Michel Doiron, Assistant Deputy Minister, Service Delivery Branch; and Dr. Cyd Courchesne, Director General, Health Professionals and Chief Medical Officer.[10]

AUDIT FINDINGS AND RECOMMENDATIONS

A. Management of the Drug Benefits List

The OAG "examined whether VAC used a systematic approach in making evidence-based decisions related to what is on its drug benefits list."[11] The OAG also examined "whether [VAC] had developed criteria for what would constitute evidence, timelines for updating the drug benefits list, and whether it had analysed the utilization of drugs not available on the drug benefits list."[12]

The OAG found that VAC had not clearly defined what types of evidence its Formulary Review Committee should consider. However, the Department agreed with the OAG's proposed approach that information about veterans' needs, current health practices and policies, clinical research, and cost-effectiveness were appropriate criteria for the purpose of the audit.[13]

The OAG examined 32 of the 60 drug benefits decisions the Formulary Review Committee made in the 2013–2014 and 2014–2015 fiscal years to determine whether VAC had implemented a systematic, evidence-based decision-making approach.[14] The OAG found that 17 of the 32 decisions examined were not adequately supported by evidence of veterans' needs, current health practices and policies, clinical research, and cost-effectiveness.[15] "For 11 of the 15 decisions that were adequately supported, the

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7 OAG, "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 2.

8 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 9 June 2016, Meeting 19.

9 Ibid.

10 Ibid.

11 OAG, "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 5.

12 Ibid.

13 Ibid.

14 Ibid.

15 Ibid.

[Formulary Review Committee] relied primarily on the recommendations of the Canadian Agency for Drugs and Technologies in Health."[16]

The OAG also found that there were no timelines established for updating the drug benefits list with the Formulary Review Committee's decisions.[17] For example, VAC took 12 months or longer to update the list to reflect the Formulary Review Committee's decisions for five of the 32 drug decisions examined.[18] In one case, the OAG **"found that the Formulary Review Committee's decision to limit access to a particular narcotic only to those veterans with cancer in palliative care had still not been implemented more than two years later and, in the meantime, the drug remained available to veterans as a standard benefit."**[19]

The OAG also found that VAC had not established limits, based on maximum recommended limits, for its coverage of narcotics and sedatives, which are commonly used and which may pose abuse or safety risks if improperly used.[20]

The OAG found that although VAC has noted that requests for non-formulary products can lead to delays and possible out-of-pocket expenses for veterans, it has not analysed the use of non-formulary drugs, the extent of delays associated with them or tracked which drugs were routinely approved and thus could be added to the drug benefits list.[21]

In 2008, seven years after the enactment of Health Canada's *Marihuana Medical Access Regulations*, VAC began to pay for marijuana for medical purposes as part of its drug benefits program.[22] Although VAC advised the OAG that it covered only the amount of marijuana for medical purposes recommended by a physician or a medical specialist, as outlined in the Regulations, the OAG "found that the Department had not established limits on cost or the amount to be covered."[23] Michael Ferguson, Auditor General of Canada, OAG, told the Committee:

> [T]hat the decision to cover marijuana for medical purposes was made at the senior management level rather than by the department's formulary review committee. We were unable to determine why this decision did not go through the committee's normal review process.[24]

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16 Ibid.

17 Ibid.

18 Ibid., pp. 5–6.

19 Ibid., p. 6.

20 Ibid.

21 Ibid.

22 Ibid. The spelling in the title of these regulations differs from the more commonly recognized spelling of "marijuana."

23 Ibid.

24 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 9 June 2016, Meeting 19, 0850.

Mr. Natynczyk explained why this decision did not follow the normal review process, and summarized the regulatory changes that contributed to the increase in the costs associated with marijuana for medical purposes:

> In 2007, based on the approval of a senior manager, the department approved the payment for marijuana for medical purposes on an exceptional basis for one client for compassionate reasons. Starting in 2008, Veterans Affairs allowed for coverage of costs related to marijuana for medical purposes for eligible veterans who were approved by Health Canada. In fiscal year 2008-09, five clients were reimbursed, with expenditures in the order of $19,000. By 2013, these numbers rose to 112 approved clients with expenditures in the order of $400,000. In 2014, Health Canada introduced regulatory changes that reduced its role to regulate and licence private producers. Restrictions were removed on the quantity of marijuana that could be authorized by physicians and the price was established by private producers licensed by Health Canada.[25]

The Committee finds this explanation inadequate. An exception on compassionate grounds is reasonable. But seven years of prescriptions of a new substance in extraordinarily large quantities, without a decision or policy from the Formulary Review Committee, is not.

In June 2013, the Health Canada *Marihuana for Medical Purposes Regulations* were enacted, while the 2001 regulations were repealed in March 2014.[26] "The new regulations simplified the requirements for obtaining access by permitting any physician or nurse practitioner to authorize the utilization of marijuana for medical purposes, and the restrictions of use for specific medical conditions were removed."[27] In 2014, VAC decided to establish a limit on the number of grams of marijuana for medical purposes per day that it would cover for eligible veterans.[28] However, during its audit, OAG was unable to determine how the Department used evidence to support this decision.[29] For example, while Health Canada indicated in an internal departmental briefing document that more than five grams per day may pose some health risks and increase the risk of drug dependence, the OAG found that VAC "had set the limit at 10 grams per day per veteran, and that in rare circumstances it could increase this limit after consulting with a veteran's health care provider."[30]

As regards the limit of 10 grams per day, Mr. Ferguson stressed that this amount:

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25 Ibid., 0855.

26 OAG, "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 6.

27 Ibid., pp. 6–7.

28 Ibid., p. 7.

29 Ibid.

30 Ibid.

> [W]as double what was identified as appropriate in the [D]epartment's consultations with external health professionals and more than three times what Health Canada reported to be the amount most commonly utilized by individuals for medical purposes.[31]

Mr. Natynczyk reassured the Committee that Dr. Cyd Courchesne, Director General, Health Professionals and Chief Medical Officer:

> [R]eviews any requests that exceed the 10 grams per day. While six such requests were approved previously and now grandfathered, no amounts greater than 10 grams per day have been approved under the current guidelines.[32]

Dr. Courchesne suggested that veterans who are authorized to use 10 grams per day of marijuana for medical purposes may not smoke this entire amount because "some put it in their smoothies, some make brownies with it, and some extract oil, which requires higher quantities."[33] However, the Committee noted that many studies show that Canadians who are authorized to use marijuana for medical purposes also consume it in alternate forms besides inhalation, but have on average a significantly lower daily consumption level than the veterans cited in this audit.[34]

Mr. Natynczyk mentioned that in light of the significant increase in the number of veterans using marijuana for medical purposes since 2014:

> Earlier this year, the Minister of Veterans Affairs, the Hon. Kent Hehr, requested a departmental review to assess how we provide marijuana for medical purposes as a benefit to veterans.[35] This departmental review, including various consultations, was launched in order to assess the current approach to providing marijuana for medical purposes to veterans as a medication. We will be able to take stock of the review in the coming months. Departmental representatives are consulting medical specialists, suppliers and veterans who have been prescribed medical marijuana in order to learn more about the issue. These consultations are intended to help devise an effective monitoring approach to ensure veterans' well-being.[36]

The Committee recommends:

Recommendation 1

That, by 31 May 2017, *Veterans Affairs Canada* investigate how one exception in 2007 became the rule without going through the Formulary Review Committee, and report to the House of Commons Standing Committee on Public Accounts the changes that have been implemented to address this concern.

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31 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 9 June 2016, Meeting 19, 0850.

32 Ibid., 0855.

33 Ibid., 0945.

34 Ibid., 0950.

35 Ibid., 0855.

36 Ibid., 0900.

Mr. Ferguson also noted that it was not always the veterans' family physicians that authorized them to use marijuana for medical purposes.[37] For example, in the audit, the OAG "found that [53%] of the approximately 1,400 veterans authorized to use marijuana for medical purposes had obtained this authorization from four physicians."[38]

The Committee recommends:

Recommendation 2

That *Veterans Affairs Canada* investigate why so many of the authorizations for marijuana for medical purposes were granted by so few doctors and that the Department report its findings back to the House of Commons Standing Committee on Public Accounts by 31 May 2017.

When questioned about what VAC did when it learned that few physicians were providing most of the authorization to utilize marijuana for medical purposes, Dr. Courchesne said that this situation raised some red flags, and noted that in one case the Department:

> [D]id file a complaint with the College of Physicians and Surgeons against the individual whom we thought was prescribing a lot. But the issue is that many doctors are not authorizing it. For people who want it, because the courts have said they must have reasonable access to marijuana, some doctors are more willing to provide the authorization forms than other doctors.[39]

The OAG recommended that VAC "implement a decision-making framework that specifies the type of evidence and how it is considered. The Department should use this framework to decide which drugs to pay for and to what extent it will pay for them. The framework should also include requirements that the Department update the drug benefits list on a timely basis."[40]

In response, VAC stated that it is "currently developing a decision-making framework that will outline the type of evidence, including cost-effectiveness, to be considered when making formulary decisions, and will establish a governance structure and senior management oversight. The Department will also work with Health Canada and recognized experts in the field of marijuana utilization for medical purposes, and will consult with other federal departments to identify areas of best practices to model."[41] The Department also noted that a recently hired pharmaceutical advisor will develop

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37 Ibid.

38 OAG, "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 15.

39 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 9 June 2016, Meeting 19, 0925.

40 OAG, "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 7.

41 Ibid.

standardized procedures for formulary reviews that outline the decision-making process; this is to be done in collaboration with federal partners and other jurisdictions.[42] Lastly, VAC plans to "add resources to the treatment benefits program management team. All of these initiatives will be implemented by May 2017."[43]

In its action plan, VAC provided the following three key milestones for developing its decision-making framework:

- First quarter of 2016–2017: "Define a governance structure, identify an approval authority and develop approval processes for formulary management decisions."[44]

- Second quarter of 2016–2017: "Identify what evidence is to be considered, when it will be considered, and how it will be assessed for the purpose of listing drugs on VAC's formulary."[45]

- Third quarter of 2016–2017. "Review and update existing processes to formalize a systematic evidence-based decision making approach."[46]

VAC also provided the following key milestones for developing standardized operation procedures:

- Second quarter of 2016–2017: "[Analyze] data on drug requests and utilization."[47]

- Third quarter of 2016–2017: "Utilize data analysis and information gathered from consultations with other federal drug partners (e.g., best practices) to develop Standardized Operating Procedures."[48]

- First quarter of 2017–2018: "Implement Framework and Standard Operating Procedures."[49]

Lastly, VAC provided the following key milestones for enhancing transition pharmaceutical services between the Canadian Armed Forces and VAC:

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42 Ibid.

43 Ibid.

44 Veterans Affairs Canada's Detailed Action Plan in Response to Audit Findings and Recommendations in Chapter 4: "*Drug Benefits – Veterans Affairs Canada*" of the Spring 2016 Report of the Auditor General of Canada (VAC's action plan), provided to the House of Commons Standing Committee on Public Accounts on 8 June 2016, p. 1.

45 Ibid.

46 Ibid.

47 Ibid.

48 Ibid., pp. 1-2.

49 Ibid. p. 2.

> First quarter of 2017–2018: "Work with [Canadian Armed Forces] and [Royal Canadian Mounted Police] to review and [analyze] respective formularies with a goal to establish a framework for aligning formularies to the extent possible."[50] In addition, during the same quarter, "[r]eview, [analyze] and amend the processes that are in place for releasing [Canadian Armed Forces members] to ensure a seamless continuation of drug coverage based on members' history and eligibility."[51]

Mr. Natynczyk provided an example of how VAC is improving this transition:

> For example, last year in April we implemented changes to ensure that retiring sailors, soldiers, airmen and women continue to receive the same drug benefits from Veterans Affairs that they were receiving from the military based upon drug history and their eligibility for Veterans Affairs programming.[52]

In response to questions about the recently hired pharmaceutical advisor, Mr. Natynczyk explained:

> [O]ver time, in the effort to find efficiencies throughout the department and to structure.... There used to be a pharmaceutical team. That team was decentralized throughout the department and involved a reduction overall in the number of folks with expertise in pharmaceuticals within the department. That's why last year we recreated this team and brought aboard the expertise to address and really create the leadership, the management, and the structure for us to put together a decision-making framework and move forward with a very deliberate plan.[53]

Dr. Courchesne noted that this advisor's role is mainly to provide analysis and advice to the Department and the Formulary Review Committee in order to improve the written analysis included in the records of the decisions of that Committee.[54]

The Committee recommends:

Recommendation 3

That, by 31 May 2017, *Veterans Affairs Canada* (VAC) provide the House of Commons Standing Committee on Public Accounts with a report outlining its decision-making framework, its standardized operation procedures, and its enhanced transition pharmaceutical services between the *Canadian Armed Forces* and VAC.

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50 Ibid.

51 Ibid.

52 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 9 June 2016, Meeting 19, 0855.

53 Ibid., 0900.

54 Ibid., 0905.

B. Cost-Effectiveness Strategies

The OAG examined the cost-effectiveness strategies that VAC had identified and implemented, and whether the Department had assessed the results of these strategies.[55]

VAC's policy is to pay for the generic version of brand name drugs when available, unless otherwise directed by a physician, because generic drugs are usually less expensive than the brand name version.[56] The OAG found that VAC did not know the compliance rate with its generics policy.[57] Additionally, VAC has entered into agreements with Saskatchewan and British Columbia pharmacy associations, the Quebec association of pharmacy owners, and some pharmacies in the Atlantic provinces to secure lower prices by negotiating lower mark-ups and dispensing fees for drugs.[58] The OAG found that VAC had not assessed the cost-effectiveness of the various agreements it had in place.[59]

To address higher-cost patented drugs, some drug plan providers enter into Product Listing Agreements, which are contracts between a drug plan provider and a pharmaceutical company whereby the provider agrees to add the company's drug to its drug benefits list in exchange of rebates.[60] VAC investigated whether it could use these agreements as a cost-effective strategy, and in March 2013, determined that it could.[61] However, the OAG found that over the following two years, Department officials did not pursue Product Listing Agreements with pharmaceutical companies.[62]

Furthermore, Mr. Ferguson told the Committee that VAC had "not implemented strategies related to expensive new drugs entering the market."[63]

The OAG recommended that VAC "periodically review its cost-effectiveness strategies to identify whether they are up to date and are leading to reduce costs for drugs and pharmacy services," and whether "other potential strategies should be pursued alone or in collaboration with other federal departments."[64]

In response, VAC stated it plans to "enhance its cost-effectiveness strategies through regular assessments and reviews of the formulary, and research strategies used

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55 OAG, "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 9.

56 Ibid.

57 Ibid.

58 Ibid.

59 Ibid.

60 Ibid., p. 10.

61 Ibid.

62 Ibid.

63 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 9 June 2016, Meeting 19, 0850.

64 OAG, "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 10.

by other drug plans."[65] Furthermore, the Department plans to leverage partnerships with federal departments, as well as other jurisdictions, to seek efficiencies and cost-effective solutions for veterans; some of this work, including collaboration with the pan-Canadian Pharmaceutical Alliance has already begun.[66] Lastly, VAC stated that all of this "will be completed by May 2017."[67]

In its action plan, VAC provided the following key milestones for enhancing its cost effectiveness strategies:

- Second quarter of 2016–2017: "Implement a framework and processes for obtaining rebates on drug costs through [Product Listing Agreements]," and "[consult] with federal drug partners and private industry to assess best practices in place for cost-effective formulary management strategies."[68]

- Third quarter of 2016–2017: "Describe the cost-effectiveness strategies that are to be part of formulary management including when and how they will be assessed."[69]

Mr. Natynczyk added that VAC plans to "regularly assess and review its drug benefits list and claims data" in order "to help reduce the administrative burden for veterans and lower the costs for delivering the program."[70]

The Committee recommends:

Recommendation 4

That, by 31 May 2017, *Veterans Affairs Canada* provide the House of Commons Standing Committee on Public Accounts with a report explaining how it has enhanced its cost-effectiveness strategies.

The OAG also found VAC did not establish a dollar limit for covering marijuana for medical purposes despite knowing in advance that the 2013 Regulations would increase the number of veterans requesting this drug.[71] VAC estimates that expenditures related to

65 Ibid.

66 Ibid.

67 Ibid.

68 VAC's action plan, provided to the House of Commons Standing Committee on Public Accounts on 8 June 2016, p. 2.

69 Ibid.

70 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 9 June 2016, Meeting 19, 0855.

71 OAG, "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 11.

marijuana for medical purposes could reach $25 million in 2016–2017, which would amount to almost a third of the drug costs under its Health Care Benefits Program.[72]

The OAG recommended that VAC "explore ways in which the costs associated with marijuana for medical purposes can be contained."[73]

VAC agreed with this recommendation. The Department plans to develop a policy on marijuana for medical purposes.[74] Moreover, VAC added that it "will leverage medical expertise to identify the most efficient and effective approach. This may require regulatory consideration. This policy will be developed and implemented by May 2017."[75]

In its action plan, VAC provided the following key milestones for developing its policy on marijuana for medical purposes:

- April 2016: "Convene an Expert Panel on marijuana for medical purposes," and "[c]onsult with producers."[76]
- May 2016: "Consult with Veterans," and "[c]onduct a review of [VAC's] approach to the reimbursement of marijuana for medical purposes."[77]
- June 2016: "Review Health Canada's Information for Health Professionals' Guide," and formulate a "Departmental policy position."[78]
- August 2016: "Create a comprehensive implementation plan including strategies for Veteran care and well-being, communications, and staff training."[79]
- May 2017: "Complete implementation."[80]

When asked whether the high costs associated with marijuana for medical purposes reduced the availability of other drugs covered by VAC's Health Care Benefits Program, Mr. Natynczyk responded:

72 Ibid.

73 Ibid., p. 12.

74 Ibid.

75 Ibid.

76 VAC's action plan, provided to the House of Commons Standing Committee on Public Accounts on 8 June 2016, p. 3.

77 Ibid.

78 Ibid.

79 Ibid.

80 Ibid.

> [N]o, not at all. Again, we provide support to the attending physician so that the attending physician who is supporting the veteran can make whatever prescriptions or authorizations they require.[81]

In response to questions about the main medical issues for which veterans are authorize to use marijuana for medical purposes, Mr. Natynczyk said that some veterans use it to treat mental health issues and Post-Traumatic Stress Disorder, but the most prevalent medical issues are musculoskeletal issues.[82]

When questioned about the main factors that contributed to the recent increase in the cost of a gram of marijuana for medical purposes, Michel Doiron, Assistant Deputy Minister, Service Delivery Branch, VAC, responded:

> A couple of factors have influenced the cost per gram. Initially, Health Canada controlled the cost and they had capped it. When the regulations changed in 2014, the cap was no longer there and it turned into a free market. The cost per gram varies according to the strain of marijuana based on the percentage of THC or other products in the marijuana. It goes anywhere from $7 or $8 per gram up to $20 per gram depending on the strain you buy. The Auditor General in his report highlighted that we had not capped the price per gram. That was correct. It's something that we've been asked to look at as part of the research by Minister [Hehr]. We want to look at the best strains and whether there is any cost-effectiveness when it comes to these strains.[83]

The Committee recommends:

Recommendation 5

That, by 31 May 2017, *Veterans Affairs Canada* provide the House of Commons Standing Committee on Public Accounts with its policy on marijuana for medical purposes, the evidence and expert input on which it is based, and confirm that it has been implemented. The Department should also outline how the key milestones for developing its policy on marijuana for medical purposes have been met.

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81 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 9 June 2016, Meeting 19, 0930.

82 Ibid., 0940.

83 Ibid., 0935.

C. Monitoring of Drug Use

The OAG examined whether VAC monitored the use of drugs it paid for to detect patterns of misuse, and whether it obtained the drug use information it needed to manage its program.[84] The OAG also examined whether VAC had implemented selected recommendations from the OAG's 2004 audit[85] related to pharmacy alerts and to monitoring how veterans used drugs over time.[86]

The OAG found that VAC "did not have a well-defined approach to monitoring the utilization of drugs it paid for that considered its mandate, the objectives of its drug benefits program, and the risks the program and veterans face."[87] The OAG found that VAC had directed Medavie to monitor claims data for high-risk use patterns for some drugs, such as narcotics and sedatives, but it did not document the direction it provided to Medavie regarding the quantities or usage levels it considered excessive, or when it is appropriate to intervene and inquire further about a veteran's drug usage.[88]

The OAG also found that VAC carried out limited monitoring and analyses of program-wide use that could help detect trends important to the health and well-being of veterans and program management.[89] "For example, the Department had not directed Medavie to monitor and report regularly on trends in the drugs that veterans commonly use, such as antidepressants and non-steroidal anti-inflammatory drugs."[90] Further, the Department's monitoring activities did not adequately consider the potential financial risks posed by covering newer, more expensive drugs, such as biologics—drugs derived from living organisms—which are used to treat chronic diseases such as cancer, rheumatoid arthritis, and diabetes.[91]

In response to the OAG's 2004 audit, VAC strengthened its alerts for the potential overuse of narcotics and some sedatives so that alerts are issued regardless of the pharmacy where the veteran filled the prescription.[92] VAC also partly addressed the OAG's recommendation to monitor instances in which pharmacists dispense drugs to

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84 OAG, "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 13.

85 In 2004, the Office of the Auditor General of Canada (OAG) published a report entitled "Chapter 4–Management of Federal Drug Benefit Programs" in which it "reported on the drug benefits programs managed by six federal departments, including Veterans Affairs Canada [VAC]." Ibid., p. 1.

86 OAG, "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 13.

87 Ibid., p. 14.

88 Ibid.

89 Ibid.

90 Ibid.

91 Ibid.

92 Ibid.

veterans in spite of a pharmacy alert; however, other instances, such as those related to a potential drug interaction, were not monitored.[93]

When questioned about the reasons for which VAC did not fully address the OAG's 2004 audit recommendation on pharmacy alerts, Dr. Courchesne said:

> There are alerts in the system. I don't want to leave the impression that everything is reimbursed and that there are no alerts. What was not happening in 2004 was that we were not asking for regular reports of Blue Cross Medavie, who administer the program for us, to give us those reports. But they do send us reports of people who are exceeding the limits, and we do scrutinize those send them back to their care providers. We send letters to their care providers saying, "Did you know that we've been asked for two prescriptions?" But things have changed in Canada with pharmacy. Pharmacists and pharmacies in every province are all connected now. There used to be a time when you could go doctor shopping for prescriptions and to three different pharmacies and nobody would know. Well, now they know. Now these alerts for drug interactions and for shopping around are done at the point of service, so we don't need to monitor that because it happens right there.… It's the same for drug interactions. Because we are not the care providers, we don't monitor those.[94]

The OAG found that VAC had not done any monitoring or analysis to determine whether the growing use of marijuana for medical purposes for chronic pain and Post-Traumatic Stress Disorder was contributing to a reduction in the program-wide or veteran-specific use of more conventional drugs that treat these conditions, such as narcotics and antidepressants.[95]

Mr. Natynczyk shared with the Committee anecdotal evidence of the positive impacts that medical marijuana for medical purposes had on some veterans, and how it reduced their use of other drugs with stronger negative side effects on their well-being:

> When you meet our veterans, they will lay out all the bottles of various medications they no longer take because they are now able to take marijuana for medical use. They are able to sleep, they're able to eat, and they're able to undergo treatment at our operational stress injury clinics. They're able to undertake vocational rehab and education, whereas under all of these other various drugs whose names I can't pronounce, they were in a fog and could not function.[96]

When asked whether the increase in the usage of marijuana for medical purposes reduced the usage of other drugs, Mr. Doiron responded:

> [W]e are seeing a decrease. Now, whether it's causal or not, it's very difficult at this point, because we've just started to see that decrease.… We're starting to look at it to try to determine if there is a causal effect. Will that causal effect mean, going forward, that our

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93 Ibid.

94 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 9 June 2016, Meeting 19, 0925.

95 OAG, "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 15.

96 House of Commons Standing Committee on Public Accounts, *Evidence*, 1st Session, 42nd Parliament, 9 June 2016, Meeting 19, 0955.

> forecasts have to change? At this point, I would not even dare to give an answer on that because I think it's way too early in the analysis, but we have seen a decrease in the use of opioids and tranquillizers.[97]

When questioned about whether this reduction in the utilization of other drugs was proportional to the increase in the utilization of marijuana for medical purposes, Mr. Doiron said:

> We've seen a very big increase in marijuana usage and cost, but the relationship is not one for one. We have seen a decrease in the use of other medications. We're trying to analyze that decrease, and why, but it is not directly proportional—far from it actually. That's what we're trying to analyze.[98]

The OAG also found that VAC did not monitor trends in the usage of marijuana for medical purposes that may suggest higher-risk use.[99]

The OAG recommended that VAC "develop a well-defined approach to drug utilization monitoring that serves the needs of veterans and helps the Department manage its drug benefits program."[100]

VAC agreed with this recommendation, and committed to improving its monitoring process pertaining to drug use, for the health, safety, and well-being of veterans.[101] Furthermore, the "Department recognizes that the individual health of a veteran is the primary responsibility of the physician or regulated health professional and the medical system. The drug utilization monitoring process will be based upon this reality."[102]

To this end, VAC plans to "develop an efficient approach, governance structure, and oversight in order to establish safeguards, monitor trends, and determine potential risks that could affect the health and well-being of its veteran population. This will better inform Departmental decision making at the program level and further support the well-being of the veteran population."[103] VAC also intends to borrow best practices from other jurisdictions, and plans to review performance data, set targets, and implement procedures to monitor the drug benefits program.[104] Lastly, given the breadth of consultation required, the Department states that this entire endeavor will be completed by May 2017.[105]

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97 Ibid., 1000.

98 Ibid., 1030.

99 OAG, "Report 4—Drug Benefits—Veterans Affairs Canada," *Spring 2016 Reports of the Auditor General of Canada*, Ottawa, 2016, p. 15.

100 Ibid., p. 16.

101 Ibid.

102 Ibid.

103 Ibid.

104 Ibid.

105 Ibid.

In its action plan, VAC provided the following key milestones for establishing its comprehensive Drug Utilization Evaluation and Monitoring Program:

- First quarter of 2016–2017: "Prepare draft of a proposed monitoring process on Drug Utilization Evaluation activities for VAC."[106]

- Second quarter of 2016–2017: "Conduct external consultations with other jurisdictional (both federal and provincial) drug programs and organizations that conduct [Drug Utilization Evaluation] activities to obtain more information and learn best practices."[107]

- Third quarter of 2016–2017: "Consult internally on the draft monitoring process including determining what and how data will be collected to support [Drug Utilization Evaluation] activities. Incorporate comments into proposed document."[108]

- First quarter of 2017–2018: "Finalize implementation plans and set [Drug Utilization Evaluation] reporting priorities for fiscal year," and "[l]aunch new VAC Drug Utilization Monitoring services and report on an ongoing basis to the VAC Formulary Review Committee."[109] Finally, "[i]mplement; analyse collected data and report on findings yearly; adjust [Drug Utilization Evaluation] strategy based on findings or departmental requirements."[110]

The Committee recommends:

Recommendation 6

That, by 31 May 2017, *Veterans Affairs Canada* provide the House of Commons Standing Committee on Public Accounts with a report outlining how it has improved its drug use monitoring process.

CONCLUSION

In this audit, the OAG concluded that VAC "did not adequately manage the drug component of its Health Care Benefits Program." The OAG also concluded that the "Department used some cost-effectiveness strategies to manage drug costs, but it did not use all the information at its disposal to decide and document which drugs it would cover." Finally, the OAG concluded that the "Department monitored the utilization of some high-risk drugs, but it has not developed a well-defined monitoring approach that could help

106 VAC's action plan, provided to the House of Commons Standing Committee on Public Accounts on 8 June 2016, p. 4.

107 Ibid.

108 Ibid.

109 Ibid.

110 Ibid.

detect trends important to the health and well-being of veterans as well as to the management of the program."

In this report the Committee made six recommendations to obtain the information it will need to assess whether VAC fully addressed the issues identified in the OAG's audit after the implementation of its action plan.

With an evidence-based decision-making framework to help it manage its drug benefits program, proper cost-effectiveness strategies to manage drug costs, and a well-defined drug monitoring approach, the Committee believes that VAC will have all the right tools to improve the health and the well-being of veterans by providing them with prescription drug coverage that meets their needs in an economical way regardless of what new drugs it adds to its drug benefits list in the future.

SUMMARY OF RECOMMENDED ACTIONS AND ASSOCIATED DEADLINES

Table 1 – Summary of Recommended Actions and Associated Deadlines

Recommendation	Recommended Action	Deadline
Recommendation 1 (p. 5)	*Veterans Affairs Canada* (VAC) needs to investigate how one exception in 2007 became the rule without going through the Formulary Review Committee, and report to the Committee the changes that have been implemented to address this concern.	31 May 2017
Recommendation 2 (p. 6)	VAC needs to investigate why so many of the authorizations for marijuana for medical purposes were granted by so few doctors and report its findings back to the Committee.	31 May 2017
Recommendation 3 (p. 8)	VAC needs to provide the Committee with a report outlining its decision-making framework, its standardized operation procedures, and its enhanced transition pharmaceutical services between the *Canadian Armed Forces* and VAC.	31 May 2017
Recommendation 4 (p. 10)	VAC needs to provide the Committee with a report explaining how it has enhanced its cost-effectiveness strategies.	31 May 2017
Recommendation 5 (p. 12)	VAC needs to provide the Committee with its policy on marijuana for medical purposes, the evidence and expert input on which it is based, and confirm that it has been implemented. The Department also needs to outline how the key milestones for developing its policy on marijuana for medical purposes have been met.	31 May 2017
Recommendation 6 (p. 16)	VAC needs to provide the Committee with a report outlining how it has improved its drug use monitoring process.	31 May 2017

APPENDIX A
LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
Department of Veterans Affairs	2016-06-09	19
Cyd Courchesne, Director General, Health Professionals and Chief Medical Officer		
Michel Doiron, Assistant Deputy Minister, Service Delivery Branch		
Walter Natynczyk, Deputy Minister		
Office of the Auditor General of Canada		
Michael Ferguson, Auditor General of Canada		
Casey Thomas, Principal		

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant Minutes of Proceedings (Meetings Nos. 19, 24, 26) is tabled.

Respectfully submitted,

Hon. Kevin Sorenson
Chair