Legislative Assembly of Ontario

Assemblée législative de l'Ontario

STANDING COMMITTEE ON PUBLIC ACCOUNTS

DRUG PROGRAMS ACTIVITY

(Section 4.09, 2003 Annual Report of the Provincial Auditor)

1st Session, 38th Parliament
53 Elizabeth II

Legislative Assembly of Ontario

Assemblée législative de l'Ontario

The Honourable Alvin Curling, M.P.P.,
Speaker of the Legislative Assembly.

Sir,

Your Standing Committee on Public Accounts has the honour to present its Report and commends it to the House.

Norman Sterling, M.P.P.,
Chair.

Queen's Park
July 2004

STANDING COMMITTEE ON PUBLIC ACCOUNTS

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PREAMBLE

The Provincial Auditor reported on a follow-up to a 2001 audit of the Drug Programs Activity in Section 4.09 of his *2003 Annual Report*. The Standing Committee on Public Accounts held hearings on this follow-up on February 12, 2004, with representation from the Ministry of Health and Long-Term Care.

This report constitutes the Committee's findings and recommendations as they relate to those areas of particular interest to Committee members. *Hansard*, the official record of the hearings, should be consulted for the complete proceedings.

The Committee extends its appreciation to officials from the Ministry for their attendance at the hearings. Furthermore, the Committee acknowledges the assistance provided during the hearings by the Office of the Provincial Auditor, the Clerk of the Committee, and staff of the Legislative Library's Research and Information Services.

Ministry Response to Committee Report

The Committee requests that the Ministry of Health and Long-Term Care provide the Committee Clerk with a comprehensive written response within 120 calendar days of the tabling of this report with the Speaker of the Legislative Assembly, unless otherwise specified in a recommendation.

1. OVERVIEW

The Drug Programs Branch of the Ministry of Health and Long-Term Care administers the province's drug programs, and co-ordinates policies and activities dealing with the provision of and funding for prescription drugs and related products to eligible Ontarians.

The Ontario Drug Benefit (ODB) Program is available to Ontarians aged 65 and older, residents of long-term-care facilities and homes for special care, and recipients of professional home care services and social assistance. (Recipient co-payments have been charged since 1996.) The Trillium Drug Program assists those who are not eligible for the ODB Program but have high drug costs in relation to their income. The Special Drugs Program covers the full cost of certain expensive outpatient drugs used to treat specific diseases or conditions.

Legislative authority for transfer payments made under these programs is established under the *Ontario Drug Benefit Act* (*ODBA*), the *Drug Interchangeability and Dispensing Act* and the *Health Insurance Act*.

The Health Network System (the Network) is a computer system that links pharmacies to the Ministry. The Branch is responsible for monitoring its development, operation and maintenance. The Network validates eligibility, generates pharmacist payments, calculates the government's share of eligible prescription costs, and provides utilization and information messages. It also

identifies potentially dangerous drug interactions, duplicate prescriptions, multiple doctoring, inappropriate or fraudulent use of the system, and co-payment levels.*

The Drug Quality and Therapeutics Committee (DQTC), established in 1968, provides independent advice on matters such as the evaluation of new drugs, monitoring and evaluating ODB Formulary/Comparative Drug Index (Formulary) listings, and pharmaceutical and therapeutic questions.

The Drug Utilization Advisory Committee (DUAC) and the Ontario Program for Optimal Therapeutics Committee (OPOTC) were both established in 1998. The former reviews issues related to the utilization of prescription drugs, while the latter oversees the development of prescribing guidelines and related projects.

Initiatives to contain annual drug program expenditures, recommended by the Cabinet Committee on Financial Planning, were approved by the government in 1998. They included modernizing the ODB Formulary, introducing written agreements with brand-name drug manufacturers, establishing a new generic drug pricing rule, and developing new prescribing guidelines.+

Both the Ministry of Health and Long-Term Care, and the Ministry of Community and Social Services fund the ODB Program which had total expenditures of over $2.6 billion in 2002/03, a 14.3% increase over the previous year.[1]

2. ONTARIO DRUG BENEFIT AND TRILLIUM DRUG PROGRAMS

2.1 Drug Use Review

Auditor's 2001 Annual Report

Health-care experts consulted by audit staff indicated that inappropriate prescribing and patients' failing to follow prescribers' instructions were significant problems. They also indicated that research had shown that not prescribing drugs when they should have been prescribed may affect patient care, and increase pressure on other parts of the health system.

The Auditor's *1996 Annual Report* noted that the Ministry had taken a number of steps to encourage appropriate prescribing, including sponsoring the development of prescribing guidelines. By the end of the 2001 audit, the OPOTC had commissioned the development and issuance of seven guidelines but had not decided on implementation strategies.

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* Over 62.5 million claims were processed in 2002/03. See Ontario, Legislative Assembly, Standing Committee on Public Accounts, *Official Report of Debate (Hansard)*, 38th Parliament, 1st Session (12 February 2004): P96.

+ Generic drugs are lower-priced bioequivalents of brand-name drugs. See Ontario, Office of the Provincial Auditor, *2003 Annual Report* (Toronto: The Office, 2003), p. 196.

In 1996, the Auditor recommended the establishment of a drug use review program to promote the appropriate and economical prescribing of drugs. In its response, the Ministry said it supported a drug use review and was working with the Ontario Pharmacists' Association towards an agreement to institute such a review.

The 2001 audit noted that while the Ministry had not established a drug use review program, some other jurisdictions (e.g., Saskatchewan, Quebec, Medicaid in the United States) had programs in place. The Auditor recommended that the Ministry, in consultation with other stakeholders, establish a drug use review program and ensure that the Network provide accurate and complete information for its implementation.[2]

Committee Hearings

The Ministry has established a drug strategy review (DSR) mandated to find ways to optimize pharmaceutical care to ensure access to the drugs needed now and in the future. The DSR is undertaking a review of the ODB Program. It is also developing a strategy aimed at improving pharmaceutical care for patients that will include an examination of access to new and existing drugs, the cost-effectiveness and pricing of drugs, appropriate drug use, and program administration. The next steps planned include the release of an interim report and sectoral consultations, followed by a final report.

The Ministry is studying the drug review process with the pharmaceutical industry and the DUAC to ensure there is no duplication of other work, such as DQTC modernization. An evaluation conducted by the Institute for Clinical Evaluative Sciences is being used to support work on DQTC modernization and identify areas that may benefit from interventions to improve appropriate prescribing and utilization. Consideration is also being given to the future use of electronic prescribing tools and shared drug profiles.[3]

At the time of the hearings, Ministry staff were asked when they expected a DSR report on drug pricing policies in other jurisdictions.[4] Following the hearings, the Committee was informed that an interim report was expected to be presented to the Minister in the spring of 2004.[5]

Committee Recommendation

The Committee recommends that:

> **1. The Ministry of Health and Long-Term Care report to the Committee on the Drug Strategy Review Steering Committee's report on drug pricing policies in other jurisdictions, expected in the spring of 2004, the Steering Committee's final report, and how and when it plans to respond to the findings and recommendations in each report.**

2.2 Drug Formulary – Timely Updates

Auditor's 2001 Annual Report

The Formulary lists the drug products covered by the ODB and Trillium Drug programs along with the prices that the Branch will generally pay pharmacists for them. It also identifies brands of drugs that are considered interchangeable, and serves as a prescribing and reimbursement guide for doctors and pharmacists.*

Drug manufacturers must make a submission to the Branch before a product can be listed. The submission is reviewed by the DQTC which may recommend inclusion in the Formulary. The Branch then prepares an analysis of the DQTC's recommendations for review by Ministry senior management. Final recommendations are forwarded to Management Board of Cabinet (MBC) for approval. Approved additions or revisions are included in the Formulary in accordance with regulations made under the *ODBA*.

After the 1996 audit, the Branch introduced a number of measures to streamline the submission, review and evaluation processes. These included removing administrative barriers and, where possible, harmonizing its processes with those of Health Canada.

Timely Updates to the Formulary

Delays in listing in the Formulary, particularly those for generic drugs, can be costly. During the 1996 audit, the Ministry advised that part of the Branch's review cycle was fast-tracking the addition of products to the Formulary. Two years later, it committed to quarterly updates of the Formulary. The 2001 audit reviewed DQTC recommendations made between June 1999 and November 2000. Of the 182 drugs recommended for listing, 142 were not included in the next update. The need for subsequent review and approval delayed the listing.

The Branch calculated that generic drugs added to the Formulary between December 1998 and November 2000 resulted in the Ministry saving $57 million annually. Audit staff selected a sample that represented approximately 50% of identified savings and found an average of eight months elapsed between recommendation and listing. The audit calculated that savings of approximately $16.7 million would have been generated had the listing of these drugs not been delayed.

The 1996 audit recommended that manufacturers' price reductions be incorporated in the Formulary on a timely basis. The 2001 audit found that reductions were still not being incorporated on a timely basis and lost savings totalled $840,000. The Ministry advised that, despite the potential significant savings, there were no processes for expediting the listing of drugs recommended by the DQTC or the implementation of manufacturers' price reductions.

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* At the time of the hearings, there were over 3,600 drug products listed in the Formulary. See Standing Committee on Public Accounts, *Official Record of Debates*, p. P96.

The Auditor recommended the Ministry pursue more timely updating of the Formulary when adding approved generics and implementing manufacturers' price reductions. The Ministry replied that it had been making quarterly updates to the Formulary for three years. With respect to the approximately $16.7 million identified as lost savings, the Ministry indicated that it had reduced listing times since the December 31, 1998, update.[6]

Committee Hearings

The government's goal is to continue issuing quarterly updates to the Formulary. At the time of the hearings, the Ministry had released 15 updates in a 57-month period, since 1998.

For submissions received in 2002, the average time from receipt of submission to listing in the Formulary was 303 days. The Ministry has met with Health Canada to further harmonize the listing process for generic products. The Ministry also fast-tracks drugs, particularly generics, once it has received a complete submission. Monthly updates for generic products are under consideration.

The Ministry participated in federal/provincial/territorial (F/P/T) discussions on generic streamlining in March 2003, and indicated that Ontario had one of the most streamlined drug submission review processes. Ongoing work at the F/P/T level is now on an information basis only.[7]

The Auditor's reference to approximately $16.7 million in lost savings and the Ministry's acknowledgement of an average of 303 days from receipt of a submission to listing in the Formulary, led to a request for information on the steps involved in the drug approval process.

Before being considered for the Formulary, a drug must receive a drug identification number (DIN) from the federal government. The DIN process determines if the drug is effective for the submitted indications, and establishes that the drug is safe and can be used in the areas sought by the manufacturer. The federal government then establishes a maximum price for the drug, based on a review of comparisons with other G-7 countries.[8]

After receiving a notice of compliance and a DIN, the manufacturer then submits a request for listing its drug to the Branch. That request is reviewed by the DQTC. Following the review, a recommendation is brought forward in the Formulary. The Formulary then needs to be approved by the Ministry, followed by MBC, the Legislation and Regulations Committee of Cabinet, and Cabinet itself. About three to four weeks after completion of the Cabinet process, the Formulary is published and the drug becomes available at the price listed.

In some provinces, the minister can approve a listing on the formulary. If that were the case in Ontario, there would be no need for approvals from MBC, the Legislation and Regulations Committee of Cabinet and, finally, Cabinet. An efficient submission process and removal of the Cabinet process could result in

very short turnaround times. However, a change from Cabinet to ministerial approval would require legislative change.[9]

Ministry staff were asked if their wish to eliminate Cabinet approval pertained to generic as opposed to brand-name drugs. Both were said to need scrutiny, the question was at what level. Generics were described as cost savings while brand-names tend to be cost increases. Ministry staff wondered if significant increases in cost might be better put through the Cabinet process.[10]

After the hearings, the Committee received information on the generic approval process in other provinces. Brand-name and generic products are approved in the same manner in all (i.e., there is no separate process for the approval of generics). Provinces that approve product listings at the ministerial level include Alberta, Saskatchewan and Nova Scotia. Those that approve product listings at the directorial level include British Columbia and Newfoundland.[11]

Changes in the Approval Process

Federal and provincial ministers of health announced the establishment of the Common Drug Review (CDR) process in September 2002. Since September 1, 2003, these reviews have been used by the Canadian Expert Drug Advisory Committee (CEDAC) to make formulary listing recommendations to participating publicly-funded drug plans.[12] The CDR process will perform the effectiveness and cost-effectiveness evaluations formerly undertaken by the DQTC. Individual provinces will continue to decide whether or not to list a product on their formularies, based on their respective economic situations.

Ministry staff hoped that the time taken to get a drug listed will improve with the CDR process. The DQTC met monthly and the Ministry hopes the CEDAC will meet as often, although it originally planned to meet every two months.[13]

Committee Recommendation

Timely updates to the Formulary have the potential to reduce the costs of Ontario's drug programs. The increased frequency of Formulary revisions and changes to the approvals process could be of benefit to the current situation.

The Committee therefore recommends that:

> **2. The Ministry of Health and Long-Term Care investigate the consequences of possible changes (e.g., ministerial-only approval, separate processes for generic and brand-name drugs) to the current ministry/cabinet approvals process with respect to the Ontario Drug Benefit Formulary/Comparative Drug Index.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 120 days of the tabling of this report in the Legislature.**

2.3 Pricing

Auditor's 2001 Report

The 2001 audit compared the prices Ontario paid with those paid by the drug plans of Quebec and Saskatchewan for a sample that accounted for a significant portion of the ODB Program's expenditures. Prices were generally similar for most brand-name drugs, however, both Quebec and Saskatchewan paid lower prices for one drug for which Ontario incurs significant expenditures. If Ontario had obtained the same price as Quebec, the Ministry would have saved approximately $5 million annually.

In 1998, the Cabinet Committee on Financial Planning recommended that a generic pricing rule be introduced to reduce the prices paid for those drugs. The maximum price the ODB Program will pay for the brand-name and all generics in each category is usually the price of the lowest-priced generic in the Formulary.

In May 1998, a regulation under the *ODBA* was approved requiring that, when the first generic of a brand-name was added to the Formulary, the price had to be 60% or less of the original price of the brand-name. The prices of the second and subsequent generics had to be 54% or less of the original brand-name price. In November 1998, a revised regulation increased the maximum price of the first generic to 70% (the 70% rule), and the second and subsequent generics to 63% or less of the brand-name price.

Between December 1998 and November 2000, 133 generic drugs were added to the Formulary without any savings. The primary reason was that prices approved for third and subsequent generics were 63% of the original price of the brand-name. Savings would only accrue to the province if subsequent generics were priced below 63% of the brand-name. Due to increased competition with the brand-name and between generics trying to increase market share, pharmacists and drug wholesalers may get lower prices from manufacturers. The Ministry, however, could still be paying pharmacists the higher formulary price.

The audit selected a sample of generics and compared the prices Ontario paid with those paid by Quebec and Saskatchewan. Quebec's were somewhat lower. Saskatchewan's prices, where it had tendered for those drugs, were on average 50% lower than Ontario's. Although a smaller purchaser, Saskatchewan secured lower prices by tendering on a competitive basis for certain generics. The Auditor estimated that Ontario could save approximately $54 million annually if it paid the same prices as Saskatchewan for these drugs.

The Auditor recommended that the Ministry routinely compare the prices it pays for drugs with the prices paid by other provinces and review the generic pricing rule to ensure that it does not impede obtaining generic drugs at the lowest possible price.[14]

Committee Hearings

Prices are set in agreements between the Ministry and the manufacturer in accordance with the regulations. A study for the F/P/T working group on drug prices compared the retail prices for drugs claimed under the programs of Nova Scotia, Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia. Ontario was the lowest-cost province for patented drugs. On average, its prices were 1.5% below Canadian prices. For non-patented drugs, Saskatchewan was the lowest-cost province and Ontario was the second lowest. On average, Ontario's prices were 2.4% lower than Canadian prices. For generics, Saskatchewan was the lowest-cost province and Ontario was second lowest. Ontario prices were on average 1.3% below the Canadian average.[15]

Saskatchewan uses an annual tendering process for generic products. Where multiple products are available, individual companies are asked to put forward a tender. Ministry staff said that such a process was easier for a relatively small province without a generic drug manufacturing system. If Ontario, with its 12.2 million people, were to engage in a tendering process, great “seas of production” would be created for the different generic companies located here.[16]

Ontario’s generic pricing policy is being reviewed through the DSR. (The federal Patented Medicine Prices Review Board establishes brand-name prices.) The DSR has led to awareness of significant pharmacy rebates from generic drug companies, suggesting there is room for some price reduction. (Rebates occur where there are multiple products in the same treatment area.) Through the use of G-7 comparisons, it has been learned that Canadian generic prices are further above the median than those for brand-names.

Options for change inlcude a tendering process or a review of the 70% rule and a new pricing formula for generic drugs. The question is whether the pharmacist should get the full benefit of discounts or whether it should be shared with the ODB Program.[17]

Committee Recommendations

The Committee appreciates that the number of drug benefit program recipients and the volume of sales, particularly for generic drug products, should afford the province some leverage when negotiating the prices paid for drugs in the Formulary.

The Committee therefore recommends that:

> **3. The Ministry of Health and Long-Term Care report to the Committee on the viability of options for change to the province’s generic drug pricing policy (e.g., introducing a tendering process, reviewing the 70% rule).**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a response to this recommendation within 120 days of the tabling of this report in the Legislature.**

4. The Ministry of Health and Long-Term Care periodically collect and analyze data on the prices paid for comparable drug products in other provincial jurisdictions. It should provide the Office of the Provincial Auditor (OPA) with an annual itemized list of and the reasons for those instances where it pays a higher price than other provincial jurisdictions for a specific drug product. If that information is not forthcoming, or where the OPA is not satisfied with the explanations provided, the OPA may wish to bring the matter to the Committee's attention.

The Committee requests that the Ministry provide the Committee Clerk with a response to this recommendation within 120 days of the tabling of this report in the Legislature.

2.4 Written Agreements with Brand-Name Drug Manufacturers

Auditor's 2001 Annual Report

The Cabinet Committee on Financial Planning recommended written agreements between brand-name manufacturers and the Ministry. Agreements would include manufacturers' forecasts of how much a new drug would cost in the three years after listing. A 1998 regulation made under the *ODBA* required written agreements for all new brand-name drugs added to the Formulary.

In September 1998, the Ministry and manufacturers' representatives signed a Memorandum of Understanding that outlined a process to provide the ODB Program with spending predictability. Under the new process, if the use of a drug exceeds what was forecasted, the manufacturer would be expected to demonstrate that such usage is appropriate. However, there was no indication of what action the Ministry can take if the manufacturer's explanation is deemed unsatisfactory.

The forecasted amounts in the agreements signed since June 1, 1998, were reviewed and compared to actual Ministry expenditures. The review found that in most cases actual expenditures were at least 10% below the forecasted amounts.

A sample of drugs with expenditures significantly above or below the amounts forecasted was selected. In most cases, audit staff were unable to determine how the forecasted amounts had been arrived at because they were often significantly higher than the amounts in the Ministry's supporting documentation. Where expenditures exceeded the amounts agreed to, Branch staff indicated action was being taken to address the potential overutilization.

The Auditor recommended that the Ministry evaluate the extent to which the current written agreement process with drug manufacturers is meeting its objectives and make improvements as required.[18]

Committee Hearings

The need for a review of the written agreement process was identified in 2000 and an internal report on the process had been completed. Internal work had begun and was expected to be completed in the spring of 2004.[19]

Ministry staff reported that they were looking at more robust agreements that would deal with items such as price performance in the marketplace and utilization performance. The prices of drugs in the Formulary had not been increased since 1994 and manufacturers felt that 10 years was a long time without a change. The DSR is looking at this matter as well. When asked if this item could have some significant implications for Branch costs, Ministry staff said it could create costs and benefits.[20]

Committee Recommendation

The Committee recommends that:

> **5. The Ministry of Health and Long-Term Care provide the Committee with an update on the progress it is making in developing a new written agreement process.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a response to this recommendation within 120 days of the tabling of this report in the Legislature.**

2.5 Health Network System

Auditor's 2001 Annual Report

The Ministry issued a request for proposals for a new computerized system for the ODB Program in 1993. The successful bidder was awarded a five-year, $86 million contract to develop and maintain the Network.

In February 1996, MBC issued an Alternative Delivery Framework to assist ministries in determining how to best deliver services. One approach was contracting out existing services to the private sector, with a ministry retaining ownership, overall responsibility, and control of an activity. Citing Y2K risks, the Ministry obtained MBC approval to extend the Network contract for two years, in May 1998. The extension was approved on the conditions that the total amount paid did not exceed the original $86 million and the contract was retendered by June 1999.

In January 2000, with MBC approval, the Branch and its consultants began negotiating a new three-year contract with the vendor, who submitted proposals for both a three and a five-year contract. After reviewing the Ministry's analysis, MBC approved a five-year, $63 million contract, signed in September 2000.

In reviewing documentation on the contracting process, the Auditor noted that the current vendor's knowledge and experience could inhibit future competition. This risk was even more significant given the service's impact on drug programs. The

Ministry hired consultants to assess the process and ensure fairness in the Branch's review of costs and services. However, their conclusions were not decisive.

Contrary to directives, the Ministry did not publicly announce its intent to renegotiate the 2000 contract without tendering and had not obtained MBC approval to waive this requirement. This meant other potential suppliers may not have been formally aware of the Ministry's intentions.

The Auditor recommended that when the Ministry is selecting a vendor to provide long-term services without a competitive process, it should still ensure that it receives value for money and complies with MBC directives.

In its initial response, the Ministry reported that it was satisfied that the consultants' opinions supported the agreement. Because the Network had many unique features, no direct comparisons could be made with other systems or contractual arrangements. The contract with the current vendor was for five years, over which time the Ministry planned to evaluate the services provided, and the options available for future operations, maintenance, and development. An extensive evaluation of the Network was to be commissioned in the current contract's third year. The Ministry would also ensure compliance with all MBC directives.[21]

Committee Hearings

A consultant was hired to develop a business case and a request for review for a vendor of record to conduct a value-for-money audit of the Network contract. The audit will be completed before the next contract renewal so that changes can be incorporated into the new request for proposals (RFP).

The Ministry has looked at the terms of reference necessary to complete a value-for-money assessment of the Network, both the on-line transaction process system and ancillary systems. (It had not retained a consultant to perform this work.) Over the next year, the current system's present and future capability, including viability in terms of software and hardware, will be examined. The expected date of completion is the winter of 2004.

When asked if the Ministry had any specific concerns with the current vendor contract, which will be up for renewal in 2005, Ministry staff replied that there were no concerns. They were looking at improving the efficiencies of the contract's management and other opportunities as they continued to use the system for claims adjudication. The Auditor's concern was said to be with ensuring that value for money was received for any contract the Ministry signs.[22]

Committee Recommendation

The Committee recommends that:

6. The Ministry of Health and Long-Term Care report to the Committee on the results of and its response to the Network assessment, which is expected in the winter of 2004.

2.6 Inspections and Verification – Inspection Coverage

Auditor's 2001 Annual Report

At the end of the 1996 audit, the Auditor noted that one of the Branch's five inspector positions was vacant. While approval had been obtained to fill the position, it remained vacant until October 30, 2000. During the vacancy, the only inspections conducted in the affected region were as a result of complaints, even though this region accounted for approximately 20% of annual Ministry expenditures for the ODB and Trillium Drug programs.

As of April 2001, over 3,300 dispensing pharmacies, including approximately 2,700 retail pharmacies, were operating in Ontario.* Branch management estimated that most agencies were being inspected once every 10 years (i.e., most billings would not be inspected since pharmacies retain documentation for two years only). In some instances, more time-consuming, in-depth inspections were required. The Branch had not assessed how frequently pharmacies should be inspected.

According to the Ministry, inspectors focused their efforts on pharmacies judged to be potentially at high risk for fraud or error. Audit staff recognized that many factors determine which pharmacies are high risk. They requested a report of pharmacies whose billings suggested they might be high risk and obtained information about pharmacists who had been disciplined by the College of Pharmacists for offences suggesting a lack of integrity. Based on the Ministry's information, audit staff concluded that a number of pharmacies should have been inspected but were not.

The Auditor recommended that the Ministry ensure that sufficient resources are assigned for the inspection of pharmacies to minimize the risk of paying for invalid claims.[23]

Committee Hearings

Cases of suspected fraud are reported to the Fraud Programs Branch. The Ministry has reviewed and will continue to review inspection activities in other jurisdictions to determine the most effective method of identifying and inspecting high-risk pharmacies. It will also review the resources in place to inspect pharmacies. The Drug Programs Branch is working with the Fraud Programs Branch on a review of inspection resources, with an expected completion date of fall/winter 2004.[24]

* There were approximately 2,800 pharmacies on the Network in February 2004. They represented over 99% of all pharmacies.

Five inspectors are each responsible for a region. The inspectors are all former pharmacy managers and aware of the types of fraudulent transactions that could occur. All have been with the Ministry for a significant period of time, and are familiar with their territories and the types of services provided in those regions.

The Ministry tries to ensure that it uses its inspectors in the most time-efficient way. Considerable time has been spent looking at claims submitted through the Network to the Ministry for payment. The Ministry tries to identify trends that may be of concern, and those pharmacies that need a closer inspection, either on-site or through a more detailed review of claims submitted over a certain time period.

Another component of an inspector's job is educational. If one pharmacy in a region submits a higher volume of claims compared to others within that area, the inspector will review the claims with pharmacy staff. Processes are sometimes misunderstood, so time is spent explaining the results of the audit or inspection and identifying areas needing improvement. Inappropriately submitted claims are referred to the Ministry-OPP Fraud Team.[25]

Ministry staff were asked if the cost of an increase in the number of inspectors would pay for itself through education and the claims verification process. They reported that based on the number of inspectors and the recoveries identified through the inspection process, inspectors recoup their salaries. Therefore, the number of inspectors could, potentially, be increased beyond the current five.[26]

Committee Recommendation

The Committee recommends that:

> **7. The Ministry of Health and Long-Term Care report to the Committee on the results of its review of inspection resources, after the review's expected completion date of fall/winter 2004. The report to the Committee should include how the Ministry plans to respond to the review.**

3. LIST OF COMMITTEE RECOMMENDATIONS

The Committee requests that the Ministry of Health and Long-Term Care provide the Committee Clerk with a written response to the following recommendations within 120 calendar days of the tabling of this report, unless otherwise specified in a recommendation.

> 1. The Ministry of Health and Long-Term Care report to the Committee on the Drug Strategy Review Steering Committee's report on drug pricing policies in other jurisdictions, expected in the spring of 2004, the Steering Committee's final report, and how and when it plans to respond to the findings and recommendations in each report.

2. The Ministry of Health and Long-Term Care investigate the consequences of possible changes (e.g., ministerial-only approval, separate processes for generic and brand-name drugs) to the current ministry/cabinet approvals process with respect to the Ontario Drug Benefit Formulary/Comparative Drug Index.

3. The Ministry of Health and Long-Term Care report to the Committee on the viability of options for change to the province's generic drug pricing policy (e.g., introducing a tendering process, reviewing the 70% rule).

4. The Ministry of Health and Long-Term Care periodically collect and analyze data on the prices paid for comparable drug products in other provincial jurisdictions. It should provide the Office of the Provincial Auditor (OPA) with an annual itemized list of and the reasons for those instances where it pays a higher price than other provincial jurisdictions for a specific drug product. If that information is not forthcoming, or where the OPA is not satisfied with the explanations provided, the OPA may wish to bring the matter to the Committee's attention.

5. The Ministry of Health and Long-Term Care provide the Committee with an update on the progress it is making in developing a new written agreement process.

6. The Ministry of Health and Long-Term Care report to the Committee on the results of and its response to the Network assessment, which is expected in the winter of 2004.

7. The Ministry of Health and Long-Term Care report to the Committee on the results of its review of inspection resources, after the review's expected completion date of fall/winter 2004. The report to the Committee should include how the Ministry plans to respond to the review.

NOTES

[1] Ontario, Legislative Assembly, Standing Committee on Public Accounts, *Official Report of Debates (Hansard)*, 38th Parliament, 1st Session (12 February 2004): P95-P96; and Ontario, Office of the Provincial Auditor, *2001 Annual Report* (Toronto: The Office, 2001), pp. 189-191.
[2] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P193-P195.
[3] Ibid., *Official Report of Debates*, pp. P97.
[4] Ibid., *Official Report of Debates*, p. P104.
[5] Memorandum from the Assistant Deputy Minister, Health Services Division, Ministry of Health and Long-Term Care, to the Chair Standing Committee on Public Accounts, 24 March 2004.
[6] Office of the Provincial Auditor, *2001 Annual Report*, pp. 195-197.
[7] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P97 and P101.
[8] Ibid., pp. P96 and P102.
[9] Ibid., p. P101; and Memorandum from the Assistant Deputy Minister, Health Services Division.
[10] Standing Committee on Public Accounts, *Official Report of Debates*, p. P102.
[11] Memorandum from the Assistant Deputy Minister, Health Services Division.
[12] Canadian Coordinating Office for Health Technology Assessment, *General Guidelines for Reviewers – Common Drug Review Process* (Ottawa: The Office, December 2003), p. 1. Internet site at http://www.ccohta.ca/CDR/cdr_pdf/cdr_guidelines_general_reviewers.pdf accessed 10 June 2004.
[13] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P102.
[14] Office of the Provincial Auditor, *2001 Annual Report*, pp. 198-200.
[15] Standing Committee on Public Accounts, *Official Report of Debates*, p. P98.
[16] Ibid., pp. P106-P107.
[17] Ibid., pp. P98 and P105-P106.
[18] Office of the Provincial Auditor, *2001 Annual Report*, pp. 201-202.
[19] Standing Committee on Public Accounts, *Official Report of Debates*, p. P98.
[20] Ibid., p. P104.
[21] Office of the Provincial Auditor, *2001 Annual Report*, pp. 202-204.
[22] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P98 and P104-P105.
[23] Office of the Provincial Auditor, *2001 Annual Report*, pp. 213-214.
[24] Standing Committee on Public Accounts, *Official Report of Debates*, p. P99.
[25] Ibid., p. P105.
[26] Standing Committee on Public Accounts, *Official Report of Debates*, p. P108.