



ISSN 1710-9477

Legislative Assembly
of Ontario
Second Session, 38th Parliament

Assemblée législative
de l'Ontario
Deuxième session, 38^e législature

Official Report of Debates (Hansard)

Monday 29 May 2006

Journal des débats (Hansard)

Lundi 29 mai 2006

**Standing committee on
social policy**

Transparent Drug System
for Patients Act, 2006

**Comité permanent de
la politique sociale**

Loi de 2006 sur un régime
de médicaments transparent
pour les patients

Chair: Shafiq Qadri
Clerk: Trevor Day

Président : Shafiq Qadri
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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
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Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 29 May 2006

Lundi 29 mai 2006

The committee met at 0902 in committee room 1.

SUBCOMMITTEE REPORT

The Vice-Chair (Mr. Khalil Ramal): Good morning, ladies and gentlemen. Welcome to Queen's Park. Welcome to the standing committee on social policy. Before we start today, we're going to ask the government side to report to us about the subcommittee report.

Ms. Kathleen O. Wynne (Don Valley West): Your subcommittee met on Thursday, May 11, 2006, to consider the method of proceeding on Bill 102, An Act to amend the Drug Interchangeability and Dispensing Fee Act and the Ontario Drug Benefit Act, and recommends the following:

(1) That the committee meet in Toronto from 9 a.m. to 12 noon and from 3:30 p.m. (following question period) to 6 p.m. on May 29, 30 and June 5, 2006, for the purpose of holding public hearings;

(2) That the committee clerk, with the authorization of the Chair, post information regarding public hearings in English and French dailies, and certain French weeklies for one day, during the week of May 15, 2006, and that an advertisement also be placed on the OntParl channel and the Legislative Assembly website;

(3) That interested parties who wish to be considered to make an oral presentation contact the committee clerk by 5 p.m. on Tuesday, May 23, 2006;

(4) That in the event all witnesses cannot be scheduled, the committee clerk provide the members of the subcommittee with a list of requests to appear by 6 p.m. on Tuesday, May 23, 2006;

(5) That the members of the subcommittee prioritize and return the list of request to appear by 12 noon on Wednesday, May 24, 2006;

(6) That groups and individuals be offered 10 minutes for their presentation. This time is to include questions from the committee;

(7) That the deadline for written submissions be 5 p.m. on Friday, June 2, 2006;

(8) That no summary of presentations be prepared by the research officer;

(9) That the committee meet for the purpose of clause-by-clause consideration on Tuesday, June 6, 2006;

(10) That the clerk of the committee, in consultation with the Chair, be authorized, prior to the adoption of the report of the subcommittee, to commence making any

preliminary arrangements necessary to facilitate the committee's proceedings.

I'd like to move that report, Mr. Chair.

The Vice-Chair: Is there any debate?

Mr. Ted Chudleigh (Halton): I wonder how many applicants there were to make presentations and how many are being accommodated.

The Vice-Chair: Three hundred and twenty-four applied.

Mr. Chudleigh: And how many are being accommodated?

The Vice-Chair: Ninety-nine.

Mr. Chudleigh: Does it not appear that these times are rather restricted and perhaps we should have more hearings as opposed to less?

The Vice-Chair: This number, I guess, was directed by the House.

Mr. Chudleigh: The other thing is that there's no time to do a clause-by-clause analysis. This whole thing is being rushed through with undue haste. This bill is going to affect the income and livelihood of pharmacists across this province. It's going to drive some of them out of business, from all the reports we've heard, from all the discussions I have had with pharmacists and from all the newspaper reports I have heard. Surely there should be some time given to an analysis of what effect it is going to have when a provincial government of the day is going to drive people out of business. It's unjust that they not have a suitable amount of time to do an analysis and to make representation to the government as to the effect this bill is going to have on the livelihood of these people in the province of Ontario.

Ms. Shelley Martel (Nickel Belt): New Democrats have serious concerns about the bill. I spoke about those concerns at length on second reading, and that's why we voted against this bill on second reading. It should be pointed out that the subcommittee wasn't given any choices with respect to the timing of this bill and with respect to how many people could be accommodated, because it was time-limited and the debate on third reading is also time-allocated. So the whole attempt here is to rush this bill through as quickly as possible before the end of this session. There was no consultation with the opposition parties about how the public hearings would occur or how third reading would occur. I am very much opposed to that, so I'll be voting against the subcommittee motion as a result of the time allocation motion which led to this.

The Vice-Chair: Any further debate? Okay, I'll put the motion to a vote.

Mr. Chudleigh: I'd like a recorded vote.

Ayes

Fonseca, Van Bommel, Wynne.

Nays

Chudleigh, Martel.

The Vice-Chair: Carried.

TRANSPARENT DRUG SYSTEM FOR PATIENTS ACT, 2006 LOI DE 2006 SUR UN RÉGIME DE MÉDICAMENTS TRANSPARENT POUR LES PATIENTS

Consideration of Bill 102, An Act to amend the Drug Interchangeability and Dispensing Fee Act and the Ontario Drug Benefit Act / Projet de loi 102, Loi modifiant la Loi sur l'interchangeabilité des médicaments et les honoraires de préparation et la Loi sur le régime de médicaments de l'Ontario.

CANADIAN ASSOCIATION FOR PHARMACY DISTRIBUTION MANAGEMENT

The Vice-Chair: We are going to move on to the first presenter on Bill 102, An Act to amend the Drug Interchangeability and Dispensing Fee Act and the Ontario Drug Benefit Act. We have with us the Canadian Association for Pharmacy Distribution Management: Phil Rosenberg, president; Maria Castro, chair of the board; and Ted Wigdor. You have 10 minutes for your presentation. You can speak for the whole 10 minutes, or you can split it for questions.

Ms. Maria Castro: I think we'll have some time toward the end for some questions.

Good morning, and thank you for the opportunity to present to the standing committee today. My name is Maria Castro, chair of CAPDM and executive vice-president of Kohl and Frisch Ltd. Joining me, as you just indicated, is Phil Rosenberg, president of CAPDM. Just to note a correction, to my right is Ron Frisch, president and CEO of Kohl and Frisch Ltd. Ted Wigdor couldn't be with us today.

Over the next few minutes, I would like to provide each of you with an overview of consolidated pharmacy distribution and the impact that Bill 102 in its current form will have on pharmaceutical wholesale/distributors. We are very supportive of the government's effort to create a framework for a more cost-effective and efficient system for the delivery of health care with Bill 102, but we would like to present some areas of opportunity that would ensure the long-term sustainability of the pharmaceutical network.

CAPDM has its focus on achieving ongoing innovation and excellence and ensuring that retail pharmacies and patients have safe, efficient and timely access to vital pharmaceutical products, thereby enhancing health outcomes for Ontarians.

Our distributor members in Ontario consist of McKesson Canada, Kohl and Frisch Ltd. and AmerisourceBergen Canada. Our combined organizations employ over 1,400 people and operate a network of nine distribution centres that deliver tens of thousands of pharmaceutical products to over 3,000 retail pharmacies daily.

0910

As an integral component of pharmaceutical distribution, we transform the supply chain into a value chain by providing benefits to all key stakeholders as follows:

For patients, we ensure that their prescriptions are available in a safe and secure manner in all parts of the province, including remote areas, by virtue of robust delivery systems that provide pharmacies with up to 11 deliveries per week.

For government, we comply with various regulations and utilize our network for the distribution of information packages, such as we did during the SARS outbreak, and on numerous other topics to all pharmacies across Ontario.

For retail pharmacy, we provide one-stop shopping for all their pharmacy inventory requirements, returns and recalls.

For manufacturers, we reduce their shipments, receivables, inventory and returns that they would otherwise be dealing with directly.

Our proposition and services are complex and based on significant investments in technology, processes and people.

Our value is well-exemplified in a recent US study conducted by Booz Allen Hamilton that concluded that if manufacturers were required to make daily delivery to retailers, their costs would increase by \$10.5 billion annually. Within the context of Ontario, this would translate into a cost of C\$470 million that eventually would translate into higher drug prices.

Clearly our proposition is well-recognized, as today all leading pharmacies and manufacturers have endorsed and adopted consolidated distribution based on its inherent efficiencies and value-added benefits. We all would like to ensure that this system is safeguarded and encourages that investment and improvements in service continue, allowing pharmacists to focus on servicing their patient needs, and manufacturers on delivering valuable new drugs and therapies.

Let me now turn your attention to the impact that Bill 102 has on our organizations. It is important to note that pharmaceutical wholesale/distributors operate on razor-thin net margins of around 1%, so I am sure you can appreciate that any change in our margins would be significant. Our issues are as follows:

First, the bill does not recognize fees that we currently receive from manufacturers for our services. Where these fees are received, the pharmacies are provided the

products at cost. On products where this exists, this represents our entire revenue stream that is at risk.

Secondly, the bill also calls for a reduction in pricing, both on generic and brand name products. Given that our revenue is based on a percentage of cost, the following impact on margins will occur: There will be a 20% drop in revenue based on the rollback of generics; there will be a 4.7% decrease in revenue on brand name products; and overall, the result will be a reduction of 8.22% to our bottom line.

Lastly, given that generic rebates are a very significant factor in the overall health of drugstores in Ontario, if eliminated, it would increase exposure on our receivables and, long-term, on our business models.

Overall, these changes could impact our ability to provide necessary services to retail pharmacy, which might result in the reduction of deliveries and the inability to invest in technology enhancements, which would impinge on pharmacists' ability to provide optimal service to their patients.

We understand the government's intent behind Bill 102 and its desire to curb the rising cost of pharmaceuticals. Our general concern is that the bill does not recognize the role that distributors play in the pharmaceutical supply chain. Moreover, Bill 102 provides for a balance to other stakeholders; however, there is no balance in the form of compensation provided for distributors in the bill. This is especially necessary as costs for distribution continue to escalate, as we see, for example, with the higher fuel costs that impact all of our businesses and us as individuals.

We then respectfully submit the following recommendations for Bill 102:

(1) That all fees from manufacturers to wholesale/distributors be classified as a standard business practice and excluded from the definition of "rebate." We are pleased that the definition specifically excludes discounts for prompt payment, as this is a legitimate business practice. Similarly, we feel that fees from manufacturers should be classified as a legitimate and standard business practice.

(2) Due to the significant financial impact of the changes included in Bill 102, we strongly encourage the government to phase in their implementation. For instance, we recommend that the new pricing model be attributed to new products entering the market and that products already listed on the formulary be grandfathered for a period of time, or have the prices reduced incrementally.

(3) We endorse a transparent system of educational allowances with proper controlling measures in an effort to safeguard the viability of retail pharmacy.

(4) We encourage the government to eliminate the cap on the retail pharmacy markup for high-value drugs, as this will likely result in direct sourcing for manufacturers by retail pharmacy and will result in delays in accessing prescription drugs.

(5) We support the creation of a pharmacy council. We wish to have a representative on the pharmacy council and that the council have a clear and strong mandate.

The pharmaceutical wholesale/distributors serve a vital function for the effective and efficient delivery of health care in Ontario, and we strongly urge you to consider our perspective during your deliberations. We also ask that you examine the significant impact that Bill 102 has on our organizations and our desire to have our needs balanced as others have. Clearly we are here for the long term as a partner to the government of Ontario as well as Ontario patients, pharmacies and manufacturers, and look forward to continuing to contribute and ensuring that we have a world-class health care system.

Thank you. I'll now turn to Ron Frisch.

Mr. Ron Frisch: Thank you. I'm an owner of a company here in Ontario. In fact, my company is in its 90th year in business, being Ontario-owned. Just very briefly, we are in the just-in-time delivery business for pharmacy in Ontario. Just as the auto business has just-in-time, so does pharmacy, except I would submit that pharmaceuticals are more critical in terms of need than other products.

I am concerned about the impact of Bill 102 as set out for two reasons. One is on the manufacturer's side. The manufacturers of pharmaceuticals delegate their distribution function to us because it's efficient and a drugstore can get every drug they need every day from one source in one shipment, and then they can spend their time working with their patients. I'm concerned about the fact that currently the arrangements we have with the manufacturers are fair, they're appropriate, and they need to be maintained in order for just-in-time inventory systems to maintain themselves.

Secondly, I'm concerned about the impact on retail drugstores, our customers and, by translation, their patients. Pharmacies have to be financially viable in order to support the structure we have in Ontario today. I trust you will bear this in mind: The infrastructure we have in place is important on a day-to-day basis. When we're faced with the unknown, as happened with SARS a few years ago, and as we think about the possibilities for the future, it's important to maintain a very strong infrastructure for the delivery of drugs to drugstores.

The Vice-Chair: Thank you for your presentation. We don't have any time left.

Mr. Frisch: Do you have questions?

The Vice-Chair: Well, we don't have any more time left.

Mr. Chudleigh: No, they've orchestrated this so there's no time left.

The Vice-Chair: This is the normal procedure; we do it all the time. We ask the presenter to speak—

Mrs. Elizabeth Witmer (Kitchener–Waterloo): It's not normal procedure. They don't want—

Ms. Wynne: Mr. Chair, as the second presenter is coming, I just want to be clear that—

The Vice-Chair: I'm sorry. We don't have much time. Williamsburg Pharmacy?

Interjection.

The Vice-Chair: Not coming? Okay.

LANE FAMILY PHARMACY

The Vice-Chair: Lane Family Pharmacy? I'll say it again: You have 10 minutes. If you wish, you can speak for the full 10 minutes, or you can split it between speaking and answering questions. Thank you. You can start now, sir. Can you state your name, please?

Mr. Gordon Lane: Thank you for accepting my request to present to you today. My name is Gordon Lane. I'm a pharmacist and a pharmacy owner who lives in Parry Sound. Parry Sound has a market area of 12,000 to 15,000 people. It does not have any major employers. Most people in the region are employed by small business such as mine.

We are located just north of Muskoka on the shore of Georgian Bay. Because of the growing number of baby boomers, our population of retired seniors is growing and will continue to grow over the next 20 years as they choose to retire in cottage country.

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My wife and I are partners in our business, which we purchased in 2003 after relocating to Parry Sound three years prior. We invested in the business because we thought it would be a good investment for our savings and because we wanted to have control over our pharmacy practice, to be able to have not just financial but also personal success. I enjoy being a pharmacist in our community because of the relationships I've developed and continue to develop with my customers. I enjoy helping people. On a daily basis, I offer advice on the safe use of medication that prevents illness and reduces the burden on our hospitals, our emergency medical system and other medical offices. The mental and physical health and productivity of our community benefit from the health advice I offer. Our store employs seven full-time and six part-time staff.

The focus of our business is to meet the needs of our community. We offer a number of services to our community that I believe would not be offered if we were to discontinue them, including breast pump rentals for mothers of nursing babies and compression stocking therapy for people with peripheral vascular disease. Parry Sound area residents were driving one and a half hours to the nearest supplier before we offered the service. We offer public health education activities. I do a monthly article in a free local newspaper on various health topics. I offer seminars on the safe use of medication and heart-healthy lifestyles. Our pharmacy serves the health of our community.

A financial analysis of what is known about Bill 102 reveals that, if unchanged, it will have a devastating effect on my business. The only way to survive financially would be to cut service. I would discontinue my employee benefit plan and cut back on staff. The level of personal service offered would decline. We would not be able to give customers the attention they have come to expect. A pharmacist may not be available to answer questions from customers who walk in or telephone about common medical conditions and drug therapy. Fee-based appointments will have to be scheduled. Many of

the public will choose instead to go the emergency department, or to not seek advice and suffer the consequences. Training on the use of breast pumps, sizing for compression stockings and public health education services that require significant man-hours will be discontinued.

I believe that the health of my community would suffer. On a personal level, I am concerned about the investment that I've made in my business, but I am here mostly out of concern for my community. Ontario is currently experiencing a significant shortage of both nurses and doctors. I expect that you all agree that these shortages are somewhat due to cuts to our health care system that occurred in the 1980s and 1990s. Let's not let the same thing happen to the pharmacists of Ontario.

I have two problems that I have identified with Bill 102, the first one being that it fails to recognize the value of the relationships that have evolved between manufacturers of generic prescription medications and pharmacies. These relationships have evolved out of necessity. The cost to dispense a prescription in my store is \$9.38 per prescription. In 2005, my income per government-funded prescription averaged \$8.50. Dispensing government-funded prescriptions costs me 83 cents per prescription. My store does not profit from offering that service. The generic drug manufacturing industry has been contributing to pharmacies to allow for the ODB system to continue to be offered to the citizens of Ontario at a price below what it costs the pharmacy. It would be a mistake to create legislation that ends this relationship which benefits both the government and the Ontario public.

Secondly, it fails to recognize the cost to operate a drugstore. The proposed new fee of \$7 is well below the market average and does not cover my costs. The markup cap of \$25 will create ridiculously low gross profit margins—net losses in some cases—and will prevent investment in pharmacies and discourage students from seeking a career in pharmacy.

What I would like to see changed in the bill—three points:

—Do not legislate against the financial relationships that have evolved between generic drug manufacturers and pharmacies. Allow for the market to balance things out as it always does.

—Recognize the cost to operate a pharmacy. Offer realistic compensation and enforce regularly scheduled reassessments of the compensation based on the consumer price index.

—Thirdly, continue to develop a healthy relationship with the Ontario Pharmacists' Association. We are the drug therapy experts, and we can help ensure that the money spent on the Ontario drug benefit program is well invested into the health of Ontarians.

Thank you for your attention. I'd be happy to answer any questions.

The Vice-Chair: Thank you very much for your presentation. We have four minutes that we can divide equally between the two sides. Ms. Witmer.

Mrs. Witmer: Thank you very much, Scott, for coming from Parry Sound to make your presentation.

Mr. Lane: Gordon Lane is my name.

Mrs. Witmer: Oh, I'm very sorry.

Mr. Lane: I think the second presenter wasn't available, so I was bumped ahead.

Mrs. Witmer: Okay; Gordon Lane. You said you're from Parry Sound. I did get that right?

Mr. Lane: That's right.

Mrs. Witmer: Okay. I do appreciate your coming. Certainly we've heard from probably hundreds of individuals like yourself about the negative impact this is going to have on your ability to respond to the needs of your patients. What do you think is going to be the most harmful? You've said that if you don't have the time to provide them with the individual service they require, there's going to be pressure on emergency rooms.

Mr. Lane: I would expect; yes. They won't get answers that they're used to getting from the drugstore, so they're going to seek other solutions, and the visible solution would be a doctor's office or a hospital emergency nearby.

The Vice-Chair: Ms. Martel?

Ms. Martel: Thank you for driving from Parry Sound today. I live north of Sudbury, so you've had quite a drive. The government today, I think under pressure from many pharmacists like yourself, decided that they would get rid of the \$25 cap, but I don't think that's going to go very far in dealing with the financial realities of most pharmacists, because the dispensing fees you've already said still remain far below your actual costs, and the government is still intent on essentially destroying that relationship between yourself and the generics when it comes to educational allowances.

Can you give the committee an idea of how much better the situation is going to be with that one change, or are you still looking at a serious financial situation for your own pharmacy?

Mr. Lane: Just give me a moment. I do have an analysis that I did of my store—the \$25 cap. In my store, I was estimating that if this bill had been in place in 2005, my revenues would drop \$157,000. The markup cap of \$25,000 would account for about \$5,000 of that \$150,000.

The Vice-Chair: Ms. Wynne.

Ms. Wynne: Thanks for being here, Gordon. Just off the top, what I want to say is that there is no intention on the part of the government to put small pharmacies out of business. That's not what this is about. So the move this morning—

Mr. Chudleigh: That's exactly what's going to happen.

Ms. Wynne: The move this morning that the minister has made in terms of removing the \$25 cap is an indication of that.

I wanted to ask you generally, Gordon: Do you agree that it's in all of our best interests—pharmacists, patients, the whole province, pharmaceutical companies—to maintain the drug system to make sure that it's sustain-

able over time? Do you think that's in our best interests and in your best interests?

Mr. Lane: Absolutely, and I agree with the principle of cost containment in the drug system.

Ms. Wynne: Right. Thank you very much.

The Vice-Chair: Thank you very much. I want to call on Genpharm Inc. Is anybody here from Genpharm Inc.?

WAYNE MARSHALL

The Vice-Chair: If there is not, we're going to move to Wayne Marshall.

Wayne, I want to repeat what I've said before. If you have a—

Mr. Chudleigh: Chairman, due to the TTC strike, is it possible that if these people show up later, they can be slotted in?

The Vice-Chair: Definitely. We're going to accommodate them.

You have 10 minutes. You can speak for the whole 10 minutes or you can split it.

Mr. Wayne Marshall: There will be time for questions.

Mr. Chair, committee members and guests, good morning. My name is Wayne Marshall. I am the owner and sole pharmacist at Marshall's Pharmasave in Englehart, Ontario. I serve the communities of Englehart, Earlton, Charlton, Elk Lake, Larder Lake and all points between. I was born and raised in Englehart, and I'm a believer in being a person from the north for the north. I became a pharmacist to bring the people of my community a vital health care service in an underserved area, to provide that care at a high level of quality that northerners deserve. To that end, I have been a pharmacist in Englehart for the past five years and in December of last year opened up Marshall's Pharmasave to further increase my opportunities to provide care for my community.

Examples of this care go to speaking at public schools and high schools. I've spoken at community clubs and groups. I've held clinic days and public education talks in regard to health care. I am the pharmacist on our hospitals' new family health team. I'm the provider of pharmacy consultation services to the Englehart and District Hospital. I'm the provider of our pharmacy service to the long-term-care facility in our community. You can see that the pharmacy has become a trusted and accessible health resource in our community, and I'm here this morning to tell you that Bill 102 puts all that in jeopardy. Let me explain.

0930

Basically, a pharmacy has three sources of revenue. It essentially comes from our professional fee, which, under this bill, will be \$7, an increase of only 53 cents in the last 21 years; it comes from revenue made on goods that are sold; and finally, it comes from an investment made through manufacturers' allowances. To follow best business practices as understood by the minister, I understand that the more I buy, the greater investment allowance I

receive. That, my friends, is pharmacy revenue in Ontario.

Bill 102, as it stands, eliminates one of those sources. The total ban on manufacturers' allowances will result in a decrease in my business of more than \$100,000 a year. For any start-up business, this is a devastating blow, and mine is not exempt from it.

But I'm here to answer the other question for you this morning: What would the average taxpayer in Ontario see? First, I would have to decrease my staffing. This is going to directly translate into a decrease in public care, in quality of care for my patients. Thus, the truly groundbreaking fee for cognitive service that is reported in the bill would vanish in any meaningful way before my professional eyes, like the mirage of a glass of cold water in the desert. Don't get me wrong: I applaud the government's attempt to access pharmacists' brainpower, as they put it in the bill, but I'll be so busy bailing water out of the Good Ship Pharmacy that I won't have time to set the sail on this new course.

Another example of the service we provide is a call I fielded just last week from one of our local physicians. The content of the call basically was as follows: He wanted to improve his patient care because of the shortage of doctors in rural and northern Ontario and was requesting that I advocate on behalf of our patients to ensure that they receive their refill medications on time, in an appropriate manner and with no error. To this end, he told me that he had instructed his patients to phone the pharmacy whenever they ran out of their medication and, in his words, "Wayne would fix the problem." I'm happy to do this for my patients, and I'm happy to do this for my doctors under the current funding system. But under this bill I may have to have them call someone else. Perhaps my local MPP would volunteer to help.

I want to get to the point this morning. I know that the government is aiming to improve the quality of health care for Ontarians. But the reality of this bill on the ground is as follows: Without funding, I'm not going to be able to hire a pharmacist to take my spot while I go and provide in-service training at my local long-term-care facility. It's going to be a decrease in patient care. Without this funding, I'm not going to be able to fulfill my responsibilities on a newly formed family health care team. It's going to be a decrease in patient care. Without this funding, I'm not going to be able to be the resource that the hospital wants me to be to fulfill their accreditation requirements. This is going to be a decrease, a lowering, of patient care. Without this funding, I'm not going to be able to carry the stock I presently carry. This will mean that when someone comes in with their prescription, there are some things I'm not going to have on the shelf and they're simply going to have to wait to get their prescriptions—obviously, a decrease in patient care.

The ripple effects affect not just me, not just my family, not even just my patients whom I care for, but the quality of life for all Ontarians; most specifically, those in northern Ontario. So this morning I'm here to plead with this committee and with this government to make

Bill 102 workable. We need you to understand what this legislation is really going to do on the ground at the local pharmacy level, and to the health of every Ontario taxpayer. I want this committee and this government to allow the OPA and the pharmacy coalition to come alongside this committee and make a system that is fair for all parties involved. The problem with Bill 102 can be solved. We can make pharmacy sustainable in northern Ontario and in Ontario at large, but we need a fair deal.

There are 12 pharmacies in a 400-kilometre stretch between North Bay and Timmins. Eight of those pharmacies are independently owned, like my own. If left unfixed, Bill 102 will make this entire stretch of Ontario a pharmacy wasteland, a disaster in health care.

At best, Bill 102 is a prescription for Ontarians that is going to introduce them to pharmacy wait times, and in all likelihood it's going to be far worse. So I plead with you today: Fix Bill 102.

Thank you for your time, and I'll take your questions.

The Vice-Chair: Thank you for your presentation. We have almost seven minutes. Ms. Martel, it's your turn.

Ms. Martel: Twelve pharmacies between Timmins and Englehart?

Mr. Marshall: North Bay.

Ms. Martel: Second question—you might have heard this earlier; I asked Mr. Lane. The government tried this morning to "soften the blow"—I put that in quotation marks because I don't think it's going to do the trick—around the \$25 cap. Can you tell me what that means in your business?

Mr. Marshall: It means I'll be able to dispense things that are high-cost items without taking a significant loss—I would not have been able to dispense them before—under this bill. What does it mean financially for the bottom line? It still means I'm losing about \$125,000 in revenues for my pharmacy.

Ms. Martel: The \$125,000 you mentioned is related to the promotional allowance or the educational allowance?

Mr. Marshall: Absolutely.

Ms. Martel: So the \$25 cap is peanuts.

Mr. Marshall: It's a great start, but we need to work to make it work.

The Vice-Chair: Mr. Fonseca.

Mr. Peter Fonseca (Mississauga East): Wayne, thank you for presenting. I have to say that you're doing a commendable job for Englehart and for your community, working in your pharmacy, working on the family health team, working with the long-term-care home. It's what we want to see in Ontario as we build our health network.

For too long, pharmacists have been seen by some as just pill dispensers, but you do so much. In your submission, you presented some of the things you do in terms of disease management and helping the community stay healthy. This piece of legislation wants to access the brainpower that pharmacists have and provide those professional services to the community, which you're

doing already, but we'd like to compensate you for that work. Can you answer—

Mr. Marshall: Don't get me wrong. There are portions of this bill that are very encouraging and something that pharmacists and the OPA have been working for for many years. But at the same time, it's kicking the feet out from under pharmacies, because although we're getting a certain level of funding back for cognitive services, we're losing one of our main revenue sources. What I'm here to tell you today is that we simply won't be alive to do those cognitive services. It's that simple.

The Vice-Chair: Mr. O'Toole.

Mr. John O'Toole (Durham): Thank you very much, Wayne, for your presentation and for the service you provide to your community in the north, similar to my area. My riding is Durham, and I've spoken to about 15 independents like you. They're providing a very important part of health care, which you've said is now in jeopardy.

Everyone knows the rising cost of prescription medication is a serious issue for whoever is the government. But what's missing here, and it's quite disappointing but not surprising with this government, I might say—a lot of the initiatives have reverse-onus provisions and downloading with very little analysis. To me, if they knew that for you, as a single business entity, it's \$125,000, would you not be a bit suspicious that not just the minister but the drug secretariat—there is some work that's been done to show that there's \$350 million going to saved. It's going to be saved by cheating small pharmacists like you. Do you think there is some research that has been done on this bill?

Mr. Marshall: I don't have access to that type of thing. I don't know.

The Vice-Chair: Thank you for your presentation. Your time is over.

STOUFFVILLE PHARMASAVE

The Vice-Chair: I now want to call on Stouffville Pharmasave: Nayan Patel. You have 10 minutes. If you wish to split them between a presentation and questions and answers, you can do that. Go ahead.

Mr. Nayan Patel: Members of provincial Parliament, guests and fellow health care workers, I'd like to thank you for giving me the opportunity to speak before you today.

My name is Nayan Patel. I'm the owner of two independent pharmacies, one in Scarborough and the other one in Stouffville, Ontario. Perhaps this will allow me to give you a better perspective of the impact of Bill 102 on small-town Ontario, as well as on an urban pharmacy.

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My family immigrated to Ontario from India some 32 years ago. Like many immigrants, we came here with very little to our names. My parents set an example for my sister and me by working hard, contributing to our community and helping others. My parents believed that if you were to follow these principles, you would be

justly rewarded. I do not expect enormous rewards from the government. However, I do expect that legislation that the government passes be written to ensure that it is fair to all the people of Ontario, whether they represent a large corporation or a mom-and-pop operation.

Bill 102 will severely impact the ability of my pharmacy to provide even the minimum amount of health care required by the residents of the community. Over the last six weeks, pharmacists have pondered what changes they would be required to implement in order to survive the impact of Bill 102, if passed without significant changes. Pharmacies would have to reduce their staff, reduce their hours of operation, reduce their inventory and eliminate free services for patients such as delivery for immobile patients, blister packaging medications for patients with compliance issues, and counselling on health conditions that eventually result in reduced visits to doctors and hospitals. Staffing reductions would also mean that the remaining staff would not be able to meet the minimum standards that are currently required by the Ontario College of Pharmacists. This means that pharmacists will have less time to spot drug interactions, less time will be allowed to counsel patients on optimal use of their medications, and less time will be spent on disease-state management and preventative medicine issues. Overall, these changes translate into less-than-optimal outcomes for medications—medications that have been paid for by hard-earned taxpayers' dollars. This will be when the government will be able to say that they're not getting good value for their money. In short, patient care will suffer.

Most pharmacies that reduce these services will survive. However, approximately one in 10 pharmacies will be forced to close their doors despite making drastic cutbacks. A large proportion of these stores that will close will be in small rural areas, often one-pharmacy towns. This, compounded by physician shortages already in these rural areas, may eliminate the provision of any type of health care in their communities. My store in Stouffville will be one of those casualties of Bill 102. The store is currently losing money, since it is only 18 months old and is still considered a start-up business. There is no doubt that this pharmacy is a necessity for the community, since it is on the verge of a large growth spurt. If Bill 102 passes without significant changes, it will stifle new stores opening up in new and developing communities across Ontario.

Currently, pharmacies provide consistent and equitable service to their patients, whether they are covered by the government, by private insurance or if they pay out of their own pockets. Bill 102 may force pharmacies to adopt a two-tier pharmaceutical care model, where pharmacies limit the number of ODB prescriptions they fill or only fill ODB prescriptions during off-peak hours, meaning longer wait times for patients who depend on the Ontario drug benefit plan. We have seen this occur with dentists, lawyers and physiotherapists, just to name a few.

Although unintentional, Bill 102 will unfairly affect small independent pharmacies when you compare them

to large national chains. A major flaw of the bill will penalize small independent pharmacies over the chains. Nationally-owned chains have the ability to circumvent Bill 102's ability to eliminate rebates, as supplier investments could be channelled through and remain in other provinces and perhaps even the United States. All legislation should be fair to all residents. The Ontario government should not pass legislation that cannot be enforced equally on all parties. A law that cannot be enforced is not a good law.

Minister Smitherman says that the government needs to get good value for money, since they are the largest purchaser of drugs in the province. Let me tell you that the Ontario government receives great value for money from the pharmacies of Ontario. No one gets a lower price than the government, period. The average professional fee of a drug store in Ontario is more than twice the amount that the government pays pharmacies directly to provide exactly the same service to all residents in Ontario. I have never treated my clients differently based on how much money I was receiving for providing the exact same service. If Bill 102 is not significantly altered, I will have to revisit this credo in order to survive.

At my Scarborough store, the Scarborough Hospital out-patient mental health clinic had approached me with a problem. They were experiencing a higher rate of treatment failures in their Clozaril treatment program. Clozaril is a drug that is used to treat schizophrenia, and is covered by the government through a special access medication program where the drug is only dispensed through hospitals. Some of their schizophrenic patients were not able to see the psychiatrist in our building, then travel 30 minutes by bus to pick up their Clozaril prescription at the nearby hospital. I agreed to fill these prescriptions free of charge to the patient as long as the drug was supplied to me free of charge, so basically at my expense. Currently I fill over 1,000 prescriptions for these Clozaril patients under this arrangement. Minister Smitherman, you are getting great value for money.

I would like to provide the committee with financial information on how the bill will impact my stores. After taking into consideration financial gains and losses as a result of Bill 102, my Scarborough store would lose approximately \$102,000 from the bottom line, which would then put my store in a net loss position. After I make drastic changes to services and staffing, I believe that I could break even, or manage a meagre \$10,000 profit, hardly enough for incentive to own and operate a pharmacy. My Stouffville store would lose an additional \$26,000 a year, compounded with the losses that I currently have. Even drastic changes to services and staffing would not make my pharmacy viable.

I would like to request the committee to consider the following amendments, of which I believe I've given out some copies, in order to maintain the viability of pharmacy and the services it offers to the residents of Ontario. Thank you for your time.

The Vice-Chair: Thank you very much. We have two minutes left. We're going to start with the government side. Mr. Peterson.

Mr. Tim Peterson (Mississauga South): You're part of a chain of stores. Did Pharmasave help you, in analyzing your financial statements, to come up with these conclusions, putting in the extra gross profits, putting in the cognitive fees and putting in the extra revenues we're giving you?

Mr. Patel: Actually, I've been very active in this bill and I'm a person who has actually helped formulate these spreadsheets to figure out the impact on our stores.

The Vice-Chair: Mr. Chudleigh.

Mr. Chudleigh: Thank you very much for coming in today and fighting the TTC.

It's very difficult to know where this bill is going to go, especially without a good cost analysis. I think if a cost analysis had been done, all of these points that you're bringing up would have become crystal clear to those who are drafting this bill.

In your experience in this country, have you ever seen a piece of legislation, such as this one brought forward by this government, that is going to drive independent businessmen out of business?

Mr. Patel: Frankly, I didn't think the government was capable—

Mr. Chudleigh: Thank you very much.

The Vice-Chair: Ms. Martel.

Ms. Martel: Thank you for the letter that you sent to a number of us well over three and a half weeks ago, which I used in my remarks and which talked about your concerns. It was clear that you were doing some work on this a long time ago. One of your points under "fiscal gap for pharmacies" is that the pharmacy markup has actually been reduced from 10% to 2.4% after a wholesale upcharge of 5.6%. Can you explain to the committee what that means and how that works?

Mr. Patel: If the markup is reduced to 8% under Bill 102—the government has not factored in that a lot of drug companies do not sell directly to pharmacies. We are forced to buy from wholesalers. Wholesalers provide a service and they charge a markup to us. The markup is 5.6%. So if you take 8% minus the 5.6%, that's basically the markup that we have.

The Vice-Chair: Thank you, Mr. Patel, for your presentation.

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GENPHARM INC.

The Vice-Chair: I believe Genpharm is here. If they're ready, they can present to the committee. I believe we have Ian Hilley. Good morning. You have 10 minutes. If you wish, you can speak for the whole 10 minutes, or you can split it between speaking and questions and answers. The floor is yours.

Mr. Ian Hilley: Good morning, everybody. Thank you very much for being patient, waiting for me to get through the traffic this morning. It's a privilege to have the opportunity to present to you, and I hope you have been delivered a package of six or seven brief slides that will explain Genpharm's feelings with regard to Bill 102.

The theme of my talk this morning is access, change and innovation. You'll see, for those who have a copy of the presentation, a small photograph on the bottom right-hand corner of the cover page. That is a photograph of four of my colleagues in space-like suits, working at Genpharm's newest facility in the southwest corner of Brampton. That's our Verbena facility. We have invested about \$20 million in that facility over the last three years. That facility is approved by the federal drug administration of the United States to make high-potency medicines such as blood thinners and anti-cancer agents.

We at Genpharm have a global mandate from our parent company, Merck KGaA, based in Darmstadt, Germany, and our governing organization, Merck Generics, to make these high-potency medicines for the entire world.

I'd like to introduce myself. I'm a Canadian, though it doesn't sound very much that I am. I have spent a third of my life in Ontario. I have a wife and two children, and we live in the north of Toronto.

Genpharm is located on two sites: one in southwest Brampton and the other in Etobicoke, which is traditionally our home base. I want to tell you a little bit more about who Genpharm is, why we support Bill 102 and why Genpharm is part of the solution.

Who is Genpharm? Genpharm is 624 people. It's approximately \$100 million of R&D spending over the last three years. It's \$150 million of capital improvements in Etobicoke and Brampton in the future five years. We got our first product approved in Canada in 1989, and since then, we market nearly 90 different molecules in Canada. That represents approximately one third of our production capacity, two thirds of which goes to the United States and the rest of the world. We've been exporting to the United States since the early 1990s. We're the strategic site for development and manufacturing in Merck Generics, which is the third-biggest generic company in the world. We're a part of Merck KGaA, which is one of the top 25 innovative drug companies. We have, as I say, 624 people. That has expanded from a 400-person workforce since 2000. As I say, we have a state-of-the-art facility in high-potency production.

In 2005, we launched three major initiatives: (1) Gennium, a sales and marketing organization in Canada, which is a brand new independent pharmaceutical company that represents Genpharm products across Canada; (2) Prempharm, our brand specialty pharma company, which is the new vehicle which will introduce Merck KGaA's innovative treatments to Canada for the first time in its own right; and (3) Genpharm LP, which is our US affiliate in Long Island.

We are members of the oldest pharmaceutical company in the world, based in Darmstadt, Germany. We're over 350 years old. We have specialties in chemicals and in pharmaceuticals. E. Merck is the single largest producer of liquid crystal chemistry to fuel the growing flat-screen TV, telephone and laptop computer screen business. Genpharm is one of four major R&D sites. As I said, we spent \$100 million over the last three years

developing new products for Canada and the rest of the world.

Today, 80% of our 600 people—500—have higher than secondary education. Over 200 have multiple degrees. Over 100 have been educated in Ontario colleges; a similar number, almost, have been educated at universities in Ontario. About 3% of our workforce have PhDs.

Tomorrow, we want to be a global generics R&D site, a manufacturing site, and we want to manufacture high-potency drugs for the world. We are a strong exporter. In the next three years, we will grow our specialty pharma business, our innovative business. We have a drug that's already been submitted to Health Canada for the treatment of alcoholism. We have a product that's approved for oncology. We are subject to a submission for a product that will help people undergoing hemodialysis who are having challenges getting to their clinics this morning. We already promote a dermatology product for acne to doctors. Finally, in 2008 we will be launching a groundbreaking treatment for Parkinson's disease.

So why do we support Bill 102? We'd like to see access to medicines improved. We'd like to see interchangeability in Ontario on a level playing field with all other provinces. We support the initiative on OFI, off-formulary interchangeability. We think that the government has made a constructive move to improve access with new innovative therapies with the establishment of a thaw around conditional listings. Four of Genpharm's products are already limited to section 8.

We'd like to see the current system change. We'd like to see the system change because we think it's the only way that elements of the system will be sustainable: the system itself, a vibrant generic manufacturing and development industry, a vibrant pharmacy and pharmacist industry. We want to see health outcomes. We want to see new medicines, affordable medicines, and we want to see the enhanced role for pharmacy in patient health care recognized. We want to have investment in pharma manufacturing encouraged in Ontario. We want to be innovative in terms of the provision of pharmaceutical care, similar medicines, educational programs for pharmacists and health care personnel. We'd like to see innovation in new therapeutic areas, and I've already mentioned half a dozen of those that we're involved in.

We want to see innovation in supporting employment of skilled Ontarians. Genpharm has already demonstrated this. Most of the employees we have at Genpharm work in Ontario. Many of them, more than 20%, are graduates of Ontario colleges and universities. Those who aren't, we support through English-as-a-second-language programs to help them master our ways, our culture.

We advocate for a strong Ontario-based pharmaceutical research and development and manufacturing industry. As I say, we spent \$100 million over the last three years. We have a robust domestic and export-driven manufacturing business. We want to employ highly skilled, well-educated people. We're innovative in programs in supporting patients' needs—vital to change in

the health system. As I said, we want to encourage broad access to pharmaceutical products in particular through OFI and conditional listings, and end the use of limited use. We want to consummate and reward the valued effort of front-line pharmacists and front-line pharmacy to satisfy the health care needs of patients.

Thank you very much for listening to me this morning. I'd be happy to answer any of your questions.

The Vice-Chair: Thank you very much. We don't have much time left, about 20 seconds, so I guess there's not enough time for questions. Thank you very much for your presentation.

Mr. Chudleigh: I have a 20-second question.

The Vice-Chair: Sorry. I want to call on West Elgin Pharmacy. Is anyone from West Elgin Pharmacy here? No.

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RxCANADA

The Vice-Chair: We'll go back down to RxCanada. Is there anybody from RxCanada? I believe you are Wendy Nelson?

Ms. Wendy Nelson: Yes, I am.

The Vice-Chair: Okay. You have 10 minutes. If you wish, you can speak for the whole 10 minutes, or you can split it between speaking and question-and-answer. Go ahead. The floor is yours.

Ms. Nelson: Thank you and good morning. My name is Wendy Nelson and I'm president and CEO of RxCanada. I appreciate the opportunity to address you today.

Bill 102 will change the Ontario Drug Benefit Act to allow for pharmacists to be reimbursed for "professional services." This recognizes the added value that professional pharmacists bring to the delivery of health care in the province.

We're pleased that Minister Smitherman has announced that at least \$50 million would be made available to support professional services provided by pharmacists, with a focus on programs for patients with chronic disease. This bill provides long-overdue recognition of the value of community pharmacists as members of the patient's primary health care team.

Established in 1997, RxCanada is a pharmacy-sponsored organization that develops and implements programs that can be delivered in the retail pharmacy setting. Our programs assist pharmacists to provide enhanced professional services to their patients. Our focus has been on programs that improve medication adherence.

I joined RxCanada about two years ago after a 20-year career as a senior health care administrator, most recently as vice-president of patient services and chief operating officer with Trillium Health Centre. From my experience, I know the business and the human side of health care from the perspective of hospitals, physicians, nurses and community health providers. Now I am committed to

helping community pharmacists expand their role in our health care system.

I have always believed that community pharmacists play a valuable role in patient care and are underutilized and under-recognized in our health care system. Recent surveys indicate that apart from doctors, patients rely on pharmacists as the second most frequently consulted health care professional on their team. However, it's very difficult for these busy professionals, working in retail settings, to be an integral, connected part of this team.

RxCanada provides what's needed: the necessary electronic connections and patient care programs to allow pharmacists to deliver counselling services and provide medication information to their patients. In Ontario, our 1,300 participating pharmacies are some of the busiest, and dispense the majority of prescriptions filled in Ontario.

Pharmacists in these settings offer RxCanada's programs to their patients. Our programs allow pharmacists to assist patients living with diabetes, asthma, mental health conditions and cardiovascular disease. Large pharmacy chains as well as over 400 independent pharmacies offer our programs to their patients.

Why is the area of medication adherence in pharmacy practice so important to patients and health care funders? Well, consider the following: Patients are aging and living longer, often with chronic disease. These patients account for the majority of medications dispensed through community pharmacies and the majority of our drug and health care resources in Canada. We know that patients with chronic disease frequently discontinue their prescribed treatment over time. They may miss doses or discontinue their medications entirely. For example, in the area of statins, which are used to manage cardiovascular disease, our data at RxCanada mirrors other research findings. An astounding 60% of patients discontinue their medication in the first year. Heart disease, meanwhile, lies silent, waiting to present itself in the acute form of a cardiac arrest or stroke.

There are similar statistics for patients in every chronic disease group, but suffice it to say that medication adherence rates must be improved and be a priority, and community pharmacists are a key in this process.

Pharmacists know when patients understand their medications and take them as prescribed. This improves overall health outcomes and quality of life. This means the health system actually saves money. Research estimates that medication adherence problems and waste cost the national health care system between \$8 billion and \$10 billion per year.

Did you know that 20% to 50% of drug-related problems are caused by issues related to adherence? Did you know that drug-related problems are the single most frequent cause of emergency visits and hospitalization of seniors? These are patients who are hospitalized because they are not taking their medication properly or at all. This translates to about 140,000 hospital admissions and possibly up to 35,000 deaths annually in Canada. These numbers are Canada-wide, not the breakdown for On-

tario, but there is no information to suggest that this province would be any different.

The additional resources promised by the government will enable community pharmacists to change this landscape for patients in Ontario, and it's a wise investment on your part. We know that cognitive services provided by community pharmacists can and do improve medication adherence.

Let me tell you just a bit about RxCanada's adherence programs and how they work. One of our programs is called the professional pharmacy consultation service. It's offered by pharmacists to patients taking only certain medications for a chronic disease. The program, which is currently funded by pharmaceutical manufacturers, prompts community pharmacists to place counselling calls to their patients. During the call, pharmacists answer questions and provide valuable information to patients. As a result, a personal and professional relationship between the patient and the caregiver pharmacist is created. Pharmacists in our participating stores can also offer reminder calls to patients who forget to renew their prescriptions. These calls motivate patients to continue taking their medication and to take it properly. Our data shows that 85% of patients who receive prescription reminder calls from their pharmacy actually renew their prescriptions and stay on their medication. Pharmacists offering these value-added services to their patients are remunerated through a standard fee schedule administered through RxCanada. There is no cost to the patient.

RxCanada's pharmacist consultations are carefully structured to be evidence-based, informational and educational, not promotional. Our programs are recognized by the pharmacy profession because they are developed by pharmacists, for pharmacists—a real pharmacy for pharmacy patient care solution.

But most importantly, our programs do make a difference in patient care. We maintain a secure, anonymized prescription database for compliance tracking and program evaluation. That database is now even used by Canadian researchers who are assisting in the development of drug policy and protocols. Independent evaluation of RxCanada's programs show that adherence rates are 10% to 35% higher in patients who get these services. So just to reassure you, this prescription database is secure, and complies with all provincial and federal privacy legislation.

RxCanada believes, by the way, that this prescription database we retain could contribute to the electronic health record and form the basis of e-prescribing systems across the country, but that, I guess, is a discussion for another day in another forum.

With specific reference to Bill 102, we believe the initial \$50-million annual investment in professional services of pharmacists is a very positive development. This investment will supplement and leverage the modest investments that are already being made in these pharmacy programs.

Current investment is inadequate to allow pharmacists to reach all chronic patients who require these services.

Support and funding from the province of Ontario is welcome news.

Imagine the immediate and tangible benefits to patients in Ontario if the initial \$50-million investment in this bill is coupled with existing proven pharmacy programs. Imagine how quickly this could occur if services can be delivered through established and respected pharmacy organizations such as RxCanada and others, who already have a track record in this field. Imagine an expanded network of pharmacists equipped with the latest drug evidence and tools to effectively deliver the professional pharmacy services Bill 102 envisions. Imagine the efficiency and savings when more patients with chronic disease are cared for by a health care team which includes their community pharmacists.

This is not beyond imagination; this can be a reality in Ontario. These benefits can be realized quickly if, in collaboration with government, pharmacy professional services can be delivered through expansion of established and proven programs.

I want to congratulate this government on their recognition of the value of pharmacists in delivering professional services. As our 10-year history demonstrates, this investment is money well spent.

Thank you for your time today. I'm pleased to take your questions in any remaining time.

The Vice-Chair: You don't have much time. Thank you very much for your presentation.

WILLIAMSBURG PHARMACY

The Vice-Chair: Now I believe we have Williamsburg Pharmacy here. If they are ready, they can come forward. Are you Scott Hannay?

Mr. Scott Hannay: I am.

The Vice-Chair: Sir, you have 10 minutes for your presentation.

Mr. Hannay: I'll have lots of time left.

I want to start by thanking you, Mr. Chair, committee members and guests, for the opportunity to speak here today and tell you how pleased I am that independent community pharmacists were included in the discussions on Bill 102. I hope and expect that pharmacists will continue to be included in our collective search for a solution to rising drug costs in the province.

1010

My name is Scott Hannay. I'm a part-owner of two independent community pharmacies in Kitchener-Waterloo. One of our stores has been owned by my partners for the better part of 30 years and the other opened up for the first time at 9 o'clock this morning. I haven't yet heard how it's going, but I hope it's going better than my morning so far.

The majority of our current business is supplying medications and services to nursing homes and various group homes. I have been certified as a diabetic educator and an asthma educator and am currently the lead clinical pharmacist providing services to our nursing homes. We

employ 25 staff and have a forecasted payroll of \$1 million this year.

I'd like to focus this morning on just one aspect of Bill 102 and hopefully illustrate how it will impact our ability to provide services to the homes, and the subsequent consequences I foresee: the loss of profitability for my store through the reduction of generic drug prices and the reduction or elimination of professional allowances provided by the manufacturers. I need you to understand, as backwards as it may seem—and it does seem backwards—that the arrangement we have with our top generic drug supplier is a critical contributor to keeping our pharmacy profitable. If their prices get cut, our profits get cut, and if the professional allowances are eliminated, our profits will be eliminated. I guarantee you that my situation is not unique. In the past year we've been in negotiations to purchase three other pharmacies in our area and have been privy to their financial records, and it's the same story in every one of those cases.

How will this impact the 1,600 nursing home and retirement home residents we service? I'll try to explain with some examples of what services and products we provide to these homes.

On the services side, we are on call 24 hours a day, seven days a week. It's our commitment to the homes that if they need a medication in the middle of the night, we'll get it. They sometimes do, and we get it there. We're expected to have a pharmacist in the homes one day a week. We do resident medication reviews at that time. We look for appropriate drug use, we reduce drug use, we look for interactions, side effects. We audit the homes to make sure the staff are following procedures correctly in the distribution and administration of medications. We provide educational in-services to the nurses. We fund educational dinners for the nurses. And we sit on most committees in the homes.

On the products side, we provide a lot of medical equipment to the homes. Recently, I bought a home a \$1,500 blood pressure machine, because it wasn't in their budget to buy one. I just finished buying another home \$900 worth of pill crushers, because it wasn't in their budget. Last week I got asked to buy an autoclave for a home, at about \$2,000, so they could sterilize their toenail clippers. We've purchased over \$100,000 in medication carts this year alone so that the nurses can push the pills around. All our diabetes monitors are free. All our diabetes products are given to the homes at cost. To help staff quit smoking, we provide anything they need to quit smoking at cost. In April, we bought \$5,000 worth of textbooks for the homes. And every year we provide over \$50,000 in free drugs to residents, which we're not able to bill ODB for.

As a major supplier, pharmacy is expected to make significant contributions to the homes for areas like education, recreation, home improvement, charity work, fundraisers and physician recruitment—a significant investment.

If Bill 102 passes as is, I don't imagine I'll go out of business, but will it be a business worth having? I will

have to make two major adjustments that will affect what we feel is outstanding patient care that we currently provide. The first is that we'll have to cut staff hours. That's going to lead to busier days, slower service and a greater potential for medication errors. The second is that I'll have to reduce time and funds available to our nursing homes, which will lead to poorer quality of care and lifestyle in the homes.

I know that Bill 102 is not going to go away. I just ask for a guarantee that pharmacy, and specifically the Ontario Pharmacists' Association, be given every opportunity to advise and negotiate a sustainable model for all sides. Thank you.

The Vice-Chair: Thank you very much for the presentation. We have a lot of time: almost six minutes. We can divide it equally. We'll start with Mr. Chudleigh.

Mr. Chudleigh: The professional services that you mention—the government has suggested that there's going to be about \$50 million in that budget. I'm given to understand that the professional allowances that the generics currently give you is about half a billion dollars, about \$500 million province-wide. They're going to replace your current income from a private source with about 10% of public money. So one source comes from the industry, the other comes from the taxpayer. Does it make a lot of sense to you that somehow in this bill we're going to save money by taking half a billion dollars of private money out of the system and putting back \$50 million of public money from the taxpayers? How is the taxpayer going to save money on that? Do you have any thoughts on that one?

Mr. Hannay: I thought I just didn't understand. I don't understand.

Mr. Chudleigh: I've been struggling with it myself. And to lower costs of Canadian drugs—I mean, the Americans are already coming over here in droves to buy our cheaper drugs. So what is this bill really going to try to accomplish, other than take half a billion dollars off the expenses of the generic companies and replace it with \$50 million of taxpayers' money? It's very confusing, don't you agree?

Mr. Hannay: I do. I certainly appreciate the recognition of paying for services. I've been graduated for 10 years now, and it was told to us in school that that's where pharmacy is going. The recognition of that is important—

Mr. Chudleigh: Front-line health care workers—absolutely.

Mr. Hannay: The two don't equal each other, from our point of view.

Ms. Martel: Thank you for making it here this morning, despite your difficulties.

I want to return to this, because on one side of the ledger we have the government saying that they're going to provide \$50 million for counselling services. We don't know what the structure of that is, because it's not outlined anywhere in the bill, and we certainly don't know what that means per pharmacist. It's not very much if you look at all of the pharmacists operating in the

province; and about a 40-cent increase in the dispensing fee, which will not bring you up to what the current cost is to dispense in the first place. And on the other side, there's the end of the promotional allowance and a reduced markup, from 10% to 8%; but it's bigger than that, because if it's on the wholesale price then the reduction is even greater. So in terms of those two sides of the ledger, do you see that with the \$50 million and the change in the dispensing fee, most pharmacists are going to be able to make it?

Mr. Hannay: It's tough to speak for most pharmacists. In our own situation, we're in a more fortunate position. Doing nursing home work, the increased fee would help us, but it would still—and we don't know how much of that \$50 million would be available, but we're looking at probably \$100,000 less profit a year in our store, based on guesses that we have and allowances. In today's market, that's a full-time process.

Mr. Peterson: It's the government's position that we're going to be giving you a real dispensing fee, increasing that, and that we're going to be giving you a real 8% markup plus a cognitive fee. But the rebates—what kind of rebate would you get on your generic sales or purchases?

Mr. Hannay: From our top supplier, across the board, it would probably average out to 40% to 45%.

Mr. Peterson: For you directly as the retailer?

Mr. Hannay: Yes.

Mr. Peterson: And that comes through a wholesaler?

Mr. Hannay: No, it comes in the form of credit to the supplier. From our non-top suppliers we get zero. We kind of put all our eggs in one basket and live with that.

Mr. Peterson: Would you negotiate these rebates directly with the suppliers yourself?

Mr. Hannay: Yes.

Mr. Peterson: And they mainly came from the generic industry?

Mr. Hannay: Yes.

The Vice-Chair: Thank you, Mr. Hannay, for your presentation.

WEST ELGIN PHARMACY

The Vice-Chair: I believe we have with us right now West Elgin Pharmacy. Welcome. You have 10 minutes for your presentation. If you wish, you can speak for the whole 10 minutes or you can divide it between speaking and questions and answers. Go ahead; the floor is yours.

Mr. Faye Kosa: My name is Faye Kosa. In fact, I'm representing Mr. Bill Nicholson, who couldn't attend today. I'm not really well prepared, but I have a general idea and I want to share it with you. I'm an elected council member of the Ontario College of Pharmacists. I represent almost 1,000 pharmacists in my district. My district consists of Etobicoke, Mississauga and Toronto West.

1020

In fact, I agree with the minister in trying to save money with the bill, but to an extent I don't agree with

the way we are trying to save money. I think the best way is to try to get the positive from this bill, which is mainly trying to give pharmacists a little bit of authority and to involve pharmacists in the health care system which, in turn, is going to save a lot of money.

The second thing I want to mention here is that Mr. Bill Nicholson authorized me to speak about his business. It's a small community pharmacy, and this small community pharmacy is not going to achieve a lot of profit like chain drugstores, so they are trying to make a personalized and customized service between the patient and the pharmacist. What I'm trying to say here is that by making cuts for the pharmacy in that way, which is a rebate—I already provided the committee with three pages that I was provided with by Bill. It's regarding how much money he makes for now, which is almost 1% or 2%. By applying this bill, he will lose almost 5%.

I think I agree with the member of the committee here that what we are trying to do is save money, but the way we are trying to achieve it is a little bit misleading. What we are trying to say is, we can go with this bill, but with a little bit of modification, a little bit of amendment that all members here might agree with me. I would agree with a lot of pharmacists I spoke with who said, if this 8% is going to be from the wholesaler price, which is really a fair amount—8% is really a fair amount—I think they will be happy to go with this bill with no problem. The main idea is cutting 40% that generic companies are giving to the pharmacist and the government is going to reduce the prices 20%, so there is 20% extra. With this 20% extra, with the approval of the government, if it goes directly to the pharmacy, for sure they will go 100% with the bill. What I'm trying to do is give the extra 20% to the pharmacies, to the drugstores, so they can achieve the services that they provide now—they don't have to lay off staff; they don't have to get rid of staff or reduce services or hours—and at the same time you are going to also save 20%. I'm asking you to give 20% to the pharmacy, and at the same time, you give the 8% from the wholesaler. I think most of you will agree with me that this will be a fair deal. That's all, sir.

The Vice-Chair: Thank you very much. Would you mind stating your name again for the clerk? They didn't catch it very well.

Mr. Kosa: My name is Faye Kosa.

The Vice-Chair: Faye, you have six minutes to answer questions. We're going to start with Ms. Martel.

Ms. Martel: Thank you for coming here and replacing somebody else this morning. You said you're from the college and you represent a number of pharmacists. In terms of the dispensing fee as it currently stands, even with the increased amount that the government proposes, what's the difference between what the government proposes and what the real dispensing fee cost is in a pharmacy these days? Can you respond to that?

Mr. Kosa: Yes. The dispensing fee in fact, the \$6.54—most independent drugstores, due to competition, are like some chains, like food chains maybe: they waive the \$2. So the actual fee is almost \$4.50, or something

like that. If you're going to deliver this medication to the patient, you're also going to lose \$2 to \$3 at least for their prescription. So actually you don't really get anything from the fee except a buck or two. This is actual life, yes. But because there is competition, you can't say, "I'm not going to waive the \$2," because they're going to go some other drugstore. Some stores don't waive the \$2, which is their choice. It really depends on the location. If you're independent, you need to get a little bit of money because you don't have a front shop; otherwise, you can't survive. The problem with this bill—it's a very good bill to save money, to an extent—is, it's mainly going to affect independent stores. This is the main idea. We don't want to make it a monopoly here. We want to make it like free trade, that's all.

Mr. Peterson: Most pharmacies retail things other than just drugs, but let's deal with the 8% markup. In the past, a generic or a branded pharmacy could increase their prices to you and that would eat into your markup. We are planning on eliminating that so that your markup becomes a real gross profit, and that is intended to replace some of the rebate money. Could you let us know what you see the rebate money as, and do you trust the government to eliminate this markup?

Mr. Kosa: I agree with the government entirely about trying to give the pharmacist a fixed amount, but what I don't agree with is that the bill doesn't say this 8% is going to come from the wholesaler. In fact, the wholesaler in Canada usually gets between 5% to 5.5% from the company. Let's say I'm a wholesaler and I buy something for \$10. I'm not going to sell it to you for \$10. No, I'm going to add 5.5% to get a profit for me, and then I'll give you the rest. So if the government allows 8%, the pharmacy is actually going to get only 2.5%. For now, there are a lot of medications where we go by something called "acquisition cost," which means that I don't get any money from the government. I give the medication only with a dispensing fee. I only get a dispensing fee. If you calculate the amount of the drugs that have acquisition costs and the drugs that don't have and the government gives me the 10% now, you will see that it's almost 8%.

I agree with the government 100% if they approve the 8% for the pharmacy, not for the wholesaler. They're not going to make any money. Do you think any business anywhere, not only pharmacies, is going to survive with 2.5%? I doubt any business is going to survive. If you go to a grocery store, they add 30% or 40% at least. They have a lot of expenses. In order to cover all these expenses, if you're going to reduce everything for the pharmacies, they have to close, or maybe they have to move their business to another province or another country; I don't know. But I agree 100% if the minister agrees to give the 8% from the wholesaler to the pharmacy. That's it. I don't know how much the wholesaler will get, but this is what should be fair, in my opinion.

Mr. O'Toole: Thank you very much, Favez, for your presentation this morning. I thought it was quite sincere and honest. In fact, just listening to your discussion with

Mr. Peterson, it surprises me that for a bill this complicated in terms of a phenomenal business relationship change being initiated by the government, there isn't more research available.

As Mr. Chudleigh pointed out, \$50 million to replace for the dispensing fee, the potential loss in revenue is surprising. It's \$50 million to replace \$500 million. You're now talking about this 8% markup between the actual pharmaceutical company and the wholesaler. Do you have any confidence that they have the kind of clout to make sure independent pharmacists actually get that 8%? If there isn't any research, what would you recommend to Mr. Peterson? Perhaps Dalton is listening to him; I don't know. Because this bill is faulty and frail; it's going to eliminate the small pharmacist. What do we need in here to make sure that that is actually passed on to the pharmacist?

Mr. Kosa: In fact, as I said, there are a lot of positive things in the bill that are giving a little bit of authority to the pharmacist, so we're going to reduce expenses on health care, so I agree with the minister in trying to involve pharmacists more in the health care system. What I'm saying is that it should be a little bit clearer. A lot of people say, "The 8% is for whom? Is that for us? Is that for the wholesaler? How are we going to divide this 8%?" I would suggest the point made by Mr. Bill Nicholson here, which is to fix the 8% for the pharmacists; 8% is really fair.

Mr. O'Toole: Implement the 8% markup.

Mr. Kosa: Yes. I think this will cover any losses even from the repeat. At the same time, you're also going to save 20%.

Mr. O'Toole: So the 8% would actually come from the consumer, then, because the person paying for it, either through a drug plan or out of their pocket, would be paying for it.

Mr. Kosa: I'll tell you what, sir: In fact, they are now paying 10%.

The Vice-Chair: Thank you for your presentation. The time is over.

1030

ONTARIO COALITION OF SENIOR CITIZENS' ORGANIZATIONS

The Vice-Chair: I believe the Ontario Coalition of Senior Citizens' Organizations is here. Welcome. You have 10 minutes. If you wish, you can speak for the whole 10 minutes.

Ms. Judith Jordan-Austin: Thank you very much for seeing us this morning, ladies and gentlemen. It's good to be here.

The Vice-Chair: Would you mind stating your name?

Ms. Jordan-Austin: Yes, I'm going to do that right now. We represent OCSCO. This is Ethel Meade, who is the co-chair. I'm Judith Jordan-Austin, a vice-president of OCSCO. After all these professional people who have been speaking, we're glad to be here as professional volunteers.

The Ontario Coalition of Senior Citizens' Organizations brings together over 150 seniors' organizations throughout the province, with a combined membership of over half a million, so although we're all consumers, we feel we are speaking in a loud voice for consumers today. On the whole, we are very supportive of this bill, and the government's aim of containing ever-rising costs is an aim we fully endorse.

I know you have this presentation before you, so I shall just skip through it.

We are very glad that there's less paperwork, but we're a little concerned about the accessibility and the speed of the accessibility for the patient. I understand we have been told that the chief executive officer will report directly to the deputy minister and not have to go through cabinet, so we're hoping that expedites the matter. We sincerely hope that this establishment of an executive officer reporting to the deputy minister will have that effect.

We urge the government to include in the bill a clear declaration that Ontario will co-operate fully with Health Canada's effort to achieve a common drug formulary, and we hope that Bill 102 fits in well with the national research project on drug benefits.

What we don't have, but what we badly need, are tests of one drug's efficacy as compared to another drug that claims to be effective in treating the same health problem. As you know, there's interchangeability with drugs, generic and patented, but sometimes that interchangeability is dangerous for the patient. Because of the base that is very often used—for instance, if a pill has a lactose base and people are lactose-intolerant, it can cause problems—whether that will show up in the chemical analysis of the two kinds of interchangeable pills is a question.

We hope that research and development will be taking place in Ontario as well as elsewhere.

There is a tendency for the pharmaceutical industry to keep their patents evergreen; that is, to change one thing slightly but actually pretend it's the same pill, and we're concerned about that.

We would suggest that it's necessary for Ontario to do their own funding of research. We believe that pharmacists who are fighting to keep their rebates are doing so at the expense of their patients and of the taxpayer-supported Ontario drug benefit program. We hope that such rebates will stop.

We're not in favour of increasing what some people call dispensing fees, and I have been corrected to say that it should be "professional fees." This concern extends particularly to subsidized residents of long-term-care homes, who now must pay dispensing fees out of their so-called comfort allowance, which is \$117 per month that they receive.

There's a certain part of the bill, part II, paragraph 2, which says, "The public drug system aims to involve consumers and patients in a meaningful way." We especially hope that that indeed will take place. We know that there will be some advisory committees established.

We have been briefed on that. I just hope that it does occur before everything is already set in stone.

We are satisfied with the main thrust of Bill 102 and hope it can be modified to meet the concerns we have addressed. Thank you very much. Are there any questions?

The Vice-Chair: We have a lot of time for questions. We have four minutes, and we'll start with the government side. Ms. Wynne

Ms. Wynne: Thank you, Judith and Ethel. Thanks very much for being here. You raised the issue of public involvement, Judith, and you talked about part II—

Ms. Jordan-Austin: Part II, paragraph 2.

Ms. Wynne: Okay. So what you're looking for is involvement with the process. Whatever the drug executive officer is going to be planning or questioning, you're asking for public involvement in that, specifically seniors' involvement?

Ms. Jordan-Austin: Oh, yes, because seniors are more prone to difficulties with drugs and drug benefits, and they require, I think, input.

Ms. Wynne: That's the other thing I wanted to comment on, more than a question. Some of the issues that you've raised go beyond the scope of the bill, but they point to questions—as usual, both of you get to the heart of the matter, and I think you're raising issues that need to be looked at. As I say, they're outside the scope of this bill, but what I'm assuming is that you're pointing to some things that you'd like to see looked at in the future. Is that a fair assessment?

Ms. Jordan-Austin: Yes, I think so. Ethel, do you want to say anything?

Ms. Ethel Meade: We also are interested in the government involving itself with Health Canada in meaningful ways. There are a lot of flaws in the way Health Canada handles the approval of drugs, and we point out some of them in our paper here. To be speaking on equal terms with Health Canada, we need to have our own research and development going on in Ontario.

The weakest thing about the tests that are given us about drugs is they are always tested against a placebo instead of against another drug. That just means it's better to take this than to do nothing, but it doesn't tell you what is the best thing that you should be taking. That is a very, very serious flaw.

Ms. Wynne: Thank you very much for the work that you've done all along on this issue.

The Vice-Chair: Mr. O'Toole.

Mr. O'Toole: Thank you very much for your presentation. It's very important to respond. This is a very important program for seniors. I'm rapidly approaching that era myself, so I appreciate your guardianship over this important aspect of health.

You do raise two very important points: the efficacy trials, which I think are important to the reliability and the predictability of some of these claims by some of these very expensive drugs. I think that is important. Otherwise, the pharmaceuticals, the multinationals—they do have shareholders, whether it's Merck or whoever. Their shareholders—primary importance. It's about a

15% annual increase in the actual cost and application of drugs, so a lot of attention has to be paid to this.

1040

But you mentioned a couple of things. You're critical of the hidden rebates from the small, independent pharmacists. I know in my riding, they're capital A citizens in small-town Ontario. They provide, as they said, to seniors' residences, in a very generous way, a lot of what you do: voluntary service, long-term care etc. Yet you're also saying that you oppose any increase in the dispensing fee—

The Vice-Chair: Mr. O'Toole, do you want to leave any time for an answer?

Mr. O'Toole: Unanimous consent just to have a little more time.

The Vice-Chair: Unanimous consent?

Interjection: No.

The Vice-Chair: It's no.

Mr. O'Toole: How are the independent pharmacists going to get more revenue?

The Vice-Chair: We have to move on to Ms. Martel. Thank you, Mr. O'Toole, for your questions.

Mr. O'Toole: You see, they're not allowing a full discussion on this bill. It's tragic.

Ms. Martel: Thank you, both of you, for your participation this morning. You raised some concerns, and perhaps, given the limited time, I want to share those concerns.

Number one, you talked about a new process for section 8. Part of the problem is, there isn't any process for section 8 that's listed in the bill. It's null and void.

Number two, it says that there's going to be a more rapid process to approve new generic drugs, and of course, there's nothing outlined in the bill about what that process is going to be, so we operate in the dark some more.

We talk about some of the committees that the government promised to establish: a citizens' council, there's no provision in the bill to establish that; there's no provision in the bill to establish the pharmacy council.

Finally, we could have involvement of seniors in the work of the executive officer. That's not outside the scope of the bill; it's just that the government doesn't want that. They have an unelected individual who's got huge powers and huge control, and if the government really wanted to involve seniors in any of the work of the executive officer, that could be written into the bill. I think the government just doesn't want to do that.

So your concerns are really valid, and most of the bill is a shell. Most of what the government talks about in its briefing notes doesn't even appear as provisions in the bill, so we should all be very worried about where this is going to end up.

The Vice-Chair: Thank you very much for your presentation. The time is over. Thank you, Ms. Martel.

TIM TOWERS

The Vice-Chair: Now we call on Mr. Tim Towers. Mr. Towers, you know the rules, I believe. You have 10

minutes. You can speak the whole 10 minutes if you wish; if you don't, you can split it between speaking and also question and answer. The floor is yours when you are ready.

Mr. Tim Towers: Good morning. Thank you, Mr. Chair, committee members and guests. My name is Tim Towers, and I own a community pharmacy in southwest Mississauga, better known as Tim Peterson's riding.

My pharmacy, Keene Guardian Pharmacy, has been a part of the Clarkson community for almost 45 years. My father purchased the pharmacy from the original owner in 1976. Pharmacy ownership has been a part of my life for over 30 years. So I am before you today speaking with passion about a large part of my life.

As I tried to prepare for today, I was struck by the limited time I have to express to you how we as pharmacists participate on a regular basis in the lives of our patients.

I am reminded of this past weekend when I met two of my patients, a husband and wife, in Orillia, who were also participating in the Ride for Dad, a motorcycle rally to raise funds for prostate cancer. This couple introduced me to their group—quite proudly, I might say—not as Tim but as their pharmacist. Make no mistake. I've known these people for 20 years; they know my name. This is the kind of relationship we as community pharmacists develop on a daily basis with our patients. It's these kinds of relationships, which have allowed pharmacists to achieve a 98% trust rating with the people of Ontario.

Our patients trust us and listen to us. It is this trust that allows pharmacists to engage in patient-focused care and education on a continual basis.

I'd like to give you an example of the kind of non-traditional programs that pharmacists provide to their patients. Imagine, if you can, giving CPR to someone on the side of one of our Ontario highways. Now imagine that that person is one of your own children. That is a surreal experience that I had almost one year ago today. It is that experience which was the genesis of a program which I am now offering at my pharmacy. I believe that CPR training is invaluable and most especially in my community, which has an older population. This program may in fact just save someone's life one day.

By the way, the funding for this initiative is being provided by Drug Trading's very transparent professional pharmacy enhancement program, also known as the acronym PPEP. This is a program which uses professional allowances from our generic partners and allows participating pharmacists to create programs such as this.

If you're looking for transparency in health care for professional allowances, I would encourage you to look at this program as your model. Pharmacists and pharmacies commit in writing to using these professional allowance dollars in various ways, all with the intent of improving patient care.

I understand that the health system is broken. I recognize that Bill 102 is a bold step to create a new system which is progressive and serves the patient better. I applaud the creation of the pharmacy council. After 18

years in the background, pharmacy finally has the recognition as a rightful participant in the creation and maintenance of a better health care system for the citizens of Ontario. I enthusiastically endorse and appreciate the government's recognition of the value we as pharmacists have between our ears. To finally get paid for our intellectual contribution to health care is a huge step in the right direction.

There is a fly in the proverbial ointment, however. The proposed change in reimbursement may prove to create an environment in which pharmacy is no longer sustainable, especially in the expanded vision the government has for pharmacy.

I am an executive board member of the Ontario Pharmacists' Association, the OPA, and in that capacity, I am privy to some of the amendments to Bill 102 that the OPA will be suggesting tomorrow. I encourage you to look closely at these suggestions, as OPA is a recognized voice for pharmacy and pharmacists in the province of Ontario.

Specifically, drug manufacturers must be able to continue to invest in the ever-increasing level of care of our patients via a truly transparent system like that of Drug Trading's PPEP program, which I mentioned earlier. This participation should be strictly controlled by a code of conduct. Also, the true cost of providing the more mechanical process of provision of drugs—i.e., the fee and markup—must be revisited with the intent of addressing the erosion of pharmacy profit margins over the last number of years.

You have an ally in health care in pharmacy. We want to participate, we want to help, and we can. Through our involvement in the pharmacy council and moving in concert with government to expand the scope of pharmacy practice, we can significantly improve patient access to care, as well as creating a more cost-effective health care system.

The Vice-Chair: Thank you, Mr. Towers. We have four minutes for questions, and we'll start with Mr. O'Toole.

Mr. O'Toole: Thank you very much for a very committed—I liked your description of the professional allowance application in your own case, real life. I think that speaks well to pharmacists I've heard from in my riding of Durham who are concerned. I would say that the impression I'm getting from them—I also know the director from the OPA from my area. He's the person I speak to regularly. I think they've been sort of hood-winked by the OPA, sort of got—somebody used the term earlier—misled by the secretariat or the minister, because there's nothing in here. There doesn't seem to be the research, but the OPA's Marc Kealey actually said—I saw him on television—this is a good deal.

Now, you're right: It's the carrot-and-stick kind of issue going on here. Two good parts are the council as well as the professional fee. Those are very good and have been long sought after for the profession.

1050

What's bad is the lack of public openness, and the money part. I see some of these business plans here

where their bottom line is shredded. What kind of information do you need from Tim—your MPP at the moment—to get you to endorse Bill 102? We all know the challenges of drugs and the rising costs. What could you tell them and us today that would improve this bill? Just some of the analyses that the \$500 million that's being taken out of the system, and they're going to give you \$50 million back—

The Vice-Chair: Mr. O'Toole, I guess your time is over. Ms. Martel—

Mr. O'Toole: See, they're limiting the debate here.

Mr. Towers: May I briefly respond to that question?

Mr. O'Toole: You're limiting the debate—

The Vice-Chair: He's not leaving time for your answer.

You're doing a statement. I have to move to Ms. Martel. Sorry.

Ms. Martel: Go ahead and answer, if you'd like, Mr. Towers.

Mr. Towers: My response to that is, from an OPA perspective, I don't believe that the OPA was necessarily misled. There was a consultation process. Marc Kealey did acknowledge that OPA is onside for it. There are a lot of things that pharmacists have been arguing for years that we need to have put back in the legislation; we need our rightful place at the table. There are some good things in that. But Marc also addressed the issue that there is concern about the sustainability of pharmacy. He has always addressed that concern.

That was one thing that I wanted to at least comment on; your statement.

The Vice-Chair: Thank you very much. Mr. Peterson?

Mr. Peterson: Thank you, Ms. Martel, for letting him answer that question. It was much appreciated in parliamentary democracy.

Ms. Martel: If we had more time, we wouldn't have to do it like this.

Mr. Peterson: Tim, thank you for all your help in consulting with us and being very informative in terms of the financial statements of the pharmacies etc.

One of the areas that we're trying to speed up is new drug delivery and breakthrough drugs, as a way of helping the drug companies get faster access to the market and patients get faster access to the market. Do you have any experience in this that you can enlighten us with?

Mr. Towers: The process currently seems to be one that's slower than obviously the public would like. I think creating a more open review of drugs in the province, something like—the OPA operates a drug information centre called DIRC which does analyses for a number of different companies as well as jurisdictions. DIRC is a vehicle that the government may want to consider as a publicly accessible and open interpretation of what should be listed in the formulary.

The Vice-Chair: Thank you, Mr. Towers. Your time is over.

MULTIPLE SCLEROSIS SOCIETY
OF CANADA, ONTARIO DIVISION

The Vice-Chair: Now we can call on Multiple Sclerosis Society of Canada, Ontario division. They are here.

As has been said before, you have 10 minutes.

Ms. Deanna Groetzinger: My name is Deanna Groetzinger. I'm vice-president of government relations and policy for the Multiple Sclerosis Society of Canada, Ontario division. I was to be joined this morning by a volunteer with MS, but unfortunately, because the situation with the TTC, she wasn't able to be with us. I will carry on without her. We are very pleased to offer the perspective of people with MS on Bill 102.

Overall, the MS Society is pleased with many aspects of the proposed changes to the drug system as outlined by the minister. We believe the views of the MS Society have been heard on many aspects of the proposed changes.

For example, we are very supportive of giving people affected by the drug program a direct say in the decision-making about which drugs Ontarians will have available to them to improve and maintain their health. It's a very positive step forward to include two patient representatives as voting members of the committee to evaluate drugs.

The MS Society also supports the creation of a citizens' council to give the public a say in drug policy development. The government of Ontario is to be congratulated for this initiative.

Likewise, it's an excellent step forward to have a more open and transparent approach to the status of drug reviews and the decisions of the committee by making them available on a website. For far too long, these decisions have been wrapped in secrecy.

We also appreciate that the cumbersome section 8 process will be removed and replaced—we most certainly hope—by other mechanisms that won't involve the paperwork that currently faces physicians who try to assist their patients in obtaining one of the MS therapies.

Our strong recommendation is that these therapies be placed on the full formulary, since we are convinced that no one would take an injectable medication that causes significant side effects just because it's there. They are being used properly.

Indeed, there are many positive parts to the proposed reform of Ontario's drug system. However, most of them are not even contained in Bill 102. Some initiatives in the bill do give rise to a number of concerns, concerns which the MS Society hopes the members of this committee will help resolve.

For example, the MS Society recommends strongly that the language in the legislation regarding interchangeability of "similar" medications be clarified. When we asked the staff of the Drug System Secretariat about interchangeability, we were told that it is not intended to allow therapeutic substitution, but merely to allow greater interchangeability of brand and generic drugs,

and to prevent the practice of "evergreening." If this is the case, then we urge that Bill 102 be amended to ensure this intent is realized.

We have also been assured that physicians will retain the right to specify "no substitution" when they write prescriptions. This is an important aspect of the physician-patient relationship, and we urge this committee to ensure that there are no changes to this right.

We've also been told by the minister and Drug System Secretariat staff that a key aspect of Bill 102 is that it will improve patient access to drugs by allowing rapid funding decisions to be made and by eliminating restrictive listing categories. This is commendable, but the MS Society urges that this committee look at two possible amendments to the parts of the bill that are intended to speed access. We strongly recommend that a definition of "breakthrough drugs" be carefully defined, and that quality of life be included as an important health outcome criterion. The legislation is silent on both of these issues right now, and we suggest it should provide guidance on these issues for the subsequent regulations.

The main way that improved patient access goals are to be realized, it appears, is through the creation of a new executive officer position. We are concerned with the seemingly unfettered power of the executive officer to list and delist drugs that will be included on the provincial drug formulary. Certainly, this position will exist with the usual checks and balances within the civil service; however, the MS Society does not believe that this is enough when dealing with decisions that literally could mean the difference of life or death to thousands of Ontarians. We recommend strongly that a formal appeal process be instituted so executive officer decisions on "no listing" or delisting drugs can be appealed. Not to include this important mechanism would be contradictory to the other goals of transparency and accountability.

On behalf of the MS Society of Canada, I thank you for the opportunity to share our views on this very important issue, and I look forward to your questions.

The Vice-Chair: Thank you for your presentation. Ms. Martel?

Ms. Martel: Thank you for your presentation. I want to deal with some of the positives steps that you said: number one, that the government is including two patient representatives as voting members of the committee to evaluate drugs. You'd know that that provision doesn't appear anywhere in the bill.

Ms. Groetzinger: Yes, I do.

Ms. Martel: Secondly, there is no provision in the bill to create the citizens' council. Thirdly, there's no provision in the bill to know what the more open and transparent approach is to the status of drug reviews. There's no provision in the bill to tell us what the change is going to be around section 8 so we know if we're going to get something better than what we've had. And there's no provision in the bill that talks about what the process will be to allow rapid funding decisions to be made.

Given that none of this actually appears as provisions in the bill, are you not concerned that, while the gov-

ernment says one thing, it doesn't put any of these provisions in the bill to ensure that these things happen?

Ms. Groetzinger: Indeed, it is a concern, as we've pointed them out. I understand that perhaps not every piece of legislation can have every single detail in it, and probably that would be unworkable. I would hope that this committee would take this on, to provide some amendments to the bill to include some of the issues that we've raised around appeal processes, about the definition of "breakthrough," and issues around interchangeability.

While I am not as concerned perhaps around some of the things around the citizens' council and the inclusion of a patient voice on the committee, I would actually be much more comforted if those were in the bill.

The Vice-Chair: Mr. Peterson?

1100

Mr. Peterson: Thank you for your comments. Part of the philosophy of this bill is to expedite the faster approval of drugs and to work more effectively with people by taking the decision-making out of government and putting it in the system. When I say that, I'm referring to the fact that on things like section 8, cabinet will no longer be approving the change of drugs. We're doing many of these things by taking it out of legislation and putting it into policy and regulation. That is the intent with things like the pharmacy council. I'm surprised that people would not see that as a more efficient and responsive way to do it, so that every time we want to make an amendment, it's not seen as a major change of legislation but rather a change of policy and a change of regulation, which from a government point of view is much easier to change.

Ms. Groetzinger: In terms of some of the changes—as you say, taking it out of cabinet, I think that's to be applauded. It actually will allow more transparency because the decisions of a civil servant can be put on a website, as opposed to those that are made in cabinet. Our major concern around the creation of an executive officer position is the lack of an appeal mechanism. I think the bill says that the executive officer may reconsider. I don't think it's actually good governance to have the position that made the original decision hear the appeal. I think there are other mechanisms that could be brought into that that would be much more comforting, and much more good governance, I believe.

Mrs. Witmer: Thank you very much for your presentation, but I think your presentation highlights what this government has been able to do, and that is a kind of a snow job on the people in the province of Ontario. People are very confused as to what is and what is not in Bill 102. Everybody really thinks these two councils are in there, and section 8, there's going to be a wonderful new mechanism.

The reality is that I think there's more confusion today than ever before. There is very little that is clear. There is a tremendous amount of power being given to an executive officer. There will be no transparency. There has been absolutely no transparency on the introduction of

this bill. That's why the public is totally confused. They don't know what's in here and what's not in here. The reality is there is little in here that is going to benefit you or anybody else in Ontario. Most of what happens is going to be in the form of regulation and the public will never see it before the regulation occurs. I would agree with you. We need to define breakthrough drugs. We also need to take a look at how the government will allow for rapid decision-making. We don't know. There's absolutely no process.

The public has been sold a bill of goods. There is nothing substantive here to demonstrate how any of this is going to happen, and I think they need to be ashamed of themselves.

Ms. Groetzinger: We're very aware that a number of policy changes are not in the bill.

The Vice-Chair: Thank you for your presentation.

CANADIAN PENSIONERS CONCERNED INC., ONTARIO DIVISION

The Vice-Chair: Canadian Pensioners Concerned Inc., Ontario division: You have the floor. You have 10 minutes. You know the rules. I guess you've been here many different times, so welcome again.

Ms. Gerda Kaegi: Thank you. I'm here with my colleague, Derek Chadwick. Given the shortness of time—I submitted my brief ahead of time, so I'm hoping you have it—I thought I'd just touch on the recommendations we have made and give a little bit of explanation.

We are very supportive of this bill, and I have read it very carefully. This covers some of the issues we've been fighting about for a number of years.

Let me go directly to our first recommendation and the issue of the formulary and what we call, and many others do, copycat drugs. We support the idea of the advisory committee to evaluate drugs, but hope it will base its recommendations on stringent, evidence-based criteria. New copycat patent drugs must meet new benefit requirements in order to be listed on the formulary. They have driven up the overall cost without really creating new treatments. There are many reports that have testified to this.

The listing of formulary drugs: We believe, as others have argued, that the decisions about listing on the formulary must be readily available to the public on a regular basis.

On recommendation 3 about the executive officer and appeals, we agree with the previous speaker. We support, in principle, the executive officer appointment. Ontario is the slowest of the provinces to approve and get drugs on its formulary. However, we believe that a special appeal board be established that would be composed of an external panel of experts, with very clear criteria for grounds of appeal against its decisions.

Focusing on part I of the bill: On the issue of interchangeability and off-formulary interchangeability, we strongly support this thrust. One of the key issues for us has been the question of evergreening. We believe that's

a good idea, including “similar” or “similar dosage”—those two terms. But in our recommendation 5, we argue that there must be a very careful definition of the meaning of “similar” to ensure that it achieves the intent of the legislation, so we’re calling for clarity on that.

On our recommendation 6, which deals with subsection 4(5), the role of the dispensing pharmacist, we’re a little concerned. We’ve heard the debates between the pharmacists—small independents, large and others—but also we’re coming as seniors. We have some concern about the use of the wording “may” dispense rather than “shall” dispense, if there is a generic available. We thus argue for the stronger word, “shall” dispense, with the protection that the physician may restrict any substitution based on the patient’s need. That’s the case at the moment.

On the issue of rebates, recommendation 7, the term “rebate” must be defined. We totally support the prohibition of hidden rebates, whether monetary or benefits in kind to wholesalers, operators of pharmacies or companies that own, operate or franchise pharmacies. We do not support under-the-table payments, and I mean under-the-table to the public, because we are paying for that.

Recommendation 8: A clear code of conduct should be established for drug manufacturers and those in the distribution and selling of prescription drugs that would clarify what is acceptable and unacceptable behaviour.

Part II, dealing with amendments to the Ontario Drug Benefit Act: Really, we have concerns with the principle. We’re being treated as consumers and taxpayers. Decisions for listing of drugs are to be made on the best clinical evidence available to meet the health needs of Ontarians. We’re citizens; we’re not just consumers and taxpayers. I really resent that reference to us, the public.

Our last recommendation, payment to pharmacies for professional services: We support your recognition, finally, of the additional role for pharmacists under this legislation through additional payments. I’m not impugning the integrity of pharmacists, but we believe that these payments must be for specifically defined services and, as with physicians, subject to surprise audits. Now, it seems to me there’s a potential for abuse, and I don’t believe that physicians or pharmacists would abuse, but unfortunately some do.

Quite frankly, I made a brief. I hope you will have time to read our brief.

The Vice-Chair: Thank you for your presentation. We have some time for questions. Mr. Peterson.

Mr. Peterson: Thank you very much for the clarity of your recommendations. Obviously the ODB affects substantially people you’re representing.

We envision three councils, including a pharmacy council to help us work with the pharmacists to better give care, to ensure that they get fairly paid for the services they’re providing and to work on other things, like the markups and the relationships; we also envision a drug advisory council which will help speed up issues, and we’ll be working with the executive officer to make

newer drugs faster to seniors. I think that your group has been extremely concerned that the new drugs are coming out faster. We’re also conceiving of another council that would allow us to handle appeals when a drug is being approved or not being approved fast enough. That would allow us to have a second look at decisions made, and these decisions would be open and transparent.

Does that seem to work within a framework that you could accept?

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Ms. Kaegi: Yes, indeed. It’s the appeal process that I did not see clearly in the legislation, and therefore I’m arguing that that has to be there. I see it as where you’d have a mix of people totally external but who are professional experts in their fields—pharmacists, academic researchers and so on.

So yes, I think the process planned for should be very good. I’m afraid as a political scientist, I know you can’t and don’t want to put everything in the bill. We’ll be watching very carefully as to how these committees are established and how they get appointed.

Mr. Peterson: It’s conceived that at this point—

The Vice-Chair: I’m sorry, Mr. Peterson. Your time’s over. Mrs. Witmer,

Mrs. Witmer: Thank you very much. I do appreciate your presentation. I can see you’ve put a lot of thought into it. You can watch what the government does, but the reality is, by the time they do it, you won’t be in a position where you can make any changes.

You talk about rebates and the cognitive fee. We’re hearing from the pharmacies that as a result of the lack of money that they’re going to receive, about 300 pharmacies are probably going to have to go out of business, some of them in towns that don’t have enough doctors, etc. How do you recommend that pharmacists would be fairly reimbursed in order that we can ensure there’s going to be access to pharmacists throughout the province of Ontario, particularly in rural and northern Ontario? Because without the rebates of \$500 million and with just the cognitive fee of \$50 million, there’s a huge gap there.

Ms. Kaegi: I also live in rural Ontario. I’ve had interesting discussion with my pharmacist, and he says quite frankly they don’t get the rebate. What really makes a difference to them is the quality of drugs they get and all the other things they sell in the pharmacy; that that isn’t the most critical thing. What I said to him—and I’ve spoken to one small independent in Toronto—is, “If your fees go up and if there’s recognition for this extra work and it’s negotiated with the pharmacists in some open way, would that satisfy you?” They both said yes. I’m saying that one is rural, small-town Ontario, 2,500 people. The other one is in the city of Toronto, a small independent pharmacist. So their feeling is, provided that extra recognition of their role is there, they have a belief that there is going to be a better time for them, a better situation for them.

Mrs. Witmer: We have financial analyses that prove otherwise.

The Vice-Chair: Sorry, Ms. Witmer. Your time is over. Ms. Martel.

Ms. Martel: Thank you for your presentation today. You focus on two points. Number one, the government says they're going to establish three councils, and they say that in all their promotional material, but none of this appears in the bill. I do not understand why the government can't put those provisions into the bill. We will have to move amendments in that regard since the government doesn't seem interested in doing that.

My second concern, though, has to do with your part II where you talked about the public as being seen as consumers and taxpayers. One of the concerns I have is paragraph 5, which says that the funding decisions "for drugs are to be made on the best clinical and economic evidence available."

I'll tell you my concern. We've got a lot of drug patients out there who can't get intravenous drugs like Velcade because the government, I think through the DQTC, has decided that's too expensive. The government says that under this bill people are going to get the drugs they need when they need them. But I don't know how people are going to get Velcade, Aviston or other drugs if one of the criteria is economic evidence, because they're expensive, but they're the last resort for many of these cancer patients.

Ms. Kaegi: I understand entirely, and that's why I wanted to change that economic concern that's all the way through the principles, beginning with the first principle, to meet the needs of the citizens of the provinces, not just as consumers and taxpayers. This province is worse than many other provinces. I'm hoping that if we can bring down the cost now of many of the drugs we're getting, we must be able to then put, on as other provinces have done, drugs that will be funded directly by the province.

We have pushed and we've been fighting this issue since 1989 or 1993—

The Vice-Chair: Thank you for your presentation.

ONTARIO HEALTH COALITION

The Vice-Chair: Now we have the Ontario Health Coalition. Welcome. I guess you've been here many different times. You know the rules. You have 10 minutes. If you wish, you can speak for the whole 10 minutes, or you can divide it between speaking and questions and answers. The floor is yours. Can you state your name, sir?

Mr. Eduardo Sousa: My name is Eduardo Sousa and I sit on the board of the Ontario Health Coalition. I'm also the Ontario regional organizer for the Council of Canadians. If there's time at the end, I'll leave further remarks until then, but at this point I just want to say that we support Bill 102. Certainly it could stand for a few improvements here and there, but overall we support the bill and what the government is trying to do through the legislation. I'll leave it there, and if there's time after Natalie speaks, I'll make a few more remarks.

Ms. Natalie Mehra: I'm Natalie Mehra. I'm the director of the Ontario Health Coalition. We too are speaking in support of this legislation, which is unusual for us, and are happy to do so. On the whole, there are some issues and questions that we have, as well as some suggestions and recommendations.

I want to open by noting that there are jurisdictions outside of Ontario that actually do a better job of negotiating prices with the drug industry and of being setters of prices rather than takers of prices. For example, the Australian government manages to negotiate an acceptable price with manufacturers and pay about 10% less than Canadians do for drugs. New Zealand achieved about 50% savings using coordinated bargaining methods. In keeping with those initiatives in other countries, and certainly the new initiatives in Europe to control the cost of drugs, we believe the same must be done here.

We recognize, of course, that there are serious ethical dilemmas that must be weighed carefully in dealing with public policy regarding access to medical treatment. We know there are numerous organizations and individuals advocating passionately for access to particular drugs and treatments that are not currently on the formulary.

We also want to take this opportunity to remind everyone that there are numerous organizations and individuals who have been advocating for particular non-pharmaceutical treatments and care, such as extensions to home care, improvements in nursing homes and access to a comprehensive range of hospital, diagnostic and community care. All this range of the public health system is important.

We're also very aware that the profit-seeking interests of the private, for-profit drug, both generic and brand name, and pharmacy industries are actively lobbying on this bill, so we applaud the courage of the government in grappling with the difficult questions that involve the balance of interests that this policy brings forward. Obviously, in such decision-making, it's necessary to balance the collective good, individual rights and the obligations of government and health providers to protect against harm.

Our approach to the bill is:

- We believe the pharmaceutical strategy must be developed under the principles of the Canada Health Act;

- We support access to drugs with proven efficacy and safety;

- We support access to needed treatments for those with rare and life-threatening conditions, and support democratic accountability and discussion in this process;

- We want to ensure the public interest in protecting the scope of the public health system, including non-pharmaceutical therapies, treatments and care, from being diminished by high drug costs;

- We want to protect against dangerous or unnecessary drugs; and

- We support any steps toward creating a national drug plan for all Canadians, accompanied by the appropriate regulatory regime.

We believe these principles or values should be embodied in the legislation.

Ultimately, we believe this government has successfully achieved a difficult balance regarding these values and provisions of Bill 102, specifically those regarding cost control and access.

We support the widening of the availability of generic drugs, allowing generic drugs that don't have an accompanying brand name drug on the formulary to be listed. We believe this could increase access to bio-equivalent generics and lower costs without harming patients.

We support the widening of what would be considered equivalent, i.e. a pill or a tablet. Again, we believe this will not be harmful to patients, but will lower costs.

In the section on conditional listings versus section 8, as others have noted, there are no details about this in the legislation. We believe the outcome of this initiative depends on what conditions will be placed on getting drugs onto the listings. These must be reasonably rigorous to protect patients, while allowing people with serious illnesses to gain access to life-saving drugs.

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We support the elimination of the rebates to pharmacies. We believe that the government should pay the actual transaction cost for drugs, not more than what the pharmacies are paying. We support the dropping of the price of generics. We support the decrease of the markup.

We support—again, not in the legislation—the creation of best practice prescription guidelines and the increasing representation of patients on councils regarding the formulary. But we think it needs to be specifically stated that any patients' groups that are funded by the drug industry or otherwise supported by the drug industry cannot sit on advice-making bodies for the government.

Additional comments: We know that the brand name drug companies are arguing that generic substitution is bad for health. We know that they're funding certain patient groups to repeat those claims. Medical experts have told us and we have done searches and found that all major credible studies show that this is untrue. Studies in BC of a wider substitution of generics in reference-based pricing show that there is no harm to patients.

Our recommendations:

Money being saved through these measures should be invested in health care and social programs, not used to fund tax cuts.

The creation of the executive officer: To the extent that the creation of this position is about negotiating better prices for drugs, we support it. However, we want to be clear that we believe the decision about what's on and off the listing is a political decision for which there should be political accountability. This provision needs to be clear that the minister or cabinet still maintain full political accountability for the decisions of what are on and off the formulary.

I think I'll end there and turn it over to you.

Mr. Sousa: I had some prepared text, but I think I'm just going to give you a bit of a personal story in thinking about this whole issue. My partner is a breast cancer

survivor. She's 25 years old, and she got cancer at 18. Because of the nature of the cancer and what she's had to go through, she's massively in debt. Her treatment has not been covered. She had to go to Montreal in order to receive further treatment. She is thousands of dollars in debt to pay for her treatment, and she's had to stop going to the University of Toronto. She's already in debt there as well, and part of that has been because of the cost of treatment. Although her case is very complex and this bill wouldn't necessarily completely address that, it would certainly help towards addressing the sort of situation that she and others are in. I thought I'd just throw that in there as well.

I hope that we go through with this.

The Vice-Chair: Thank you for your presentation. We have just two minutes. Mr. O'Toole.

Mr. O'Toole: Thanks very much for your presentation. A couple of things. My role here is to understand. There's a lot that's being talked about that's not in the bill, actually.

First of all, the starting point here is that drugs today aren't covered, basically, unless it's the Ontario drug benefit plan or Trillium. So they're not part of the health care system, and we're all saying they should be. I probably would agree as well, for the same reasons you've described. I think what this bill is doing is creating a two-tier system; even worse, not just generics but the actual brand name drugs. I think there are going to be fewer drugs available and certainly fewer stores.

The other one is the executive officer—

The Vice-Chair: Thank you, Mr. O'Toole. Ms. Martel?

Ms. Martel: Thank you very much. Let me raise two concerns.

Mr. O'Toole: There's no time here for so important a bill—

The Vice-Chair: Mr. O'Toole, please. It's time for Ms. Martel.

Ms. Martel: I would really hope that your girlfriend would be able to have her payments covered, except I look at section 16 in this bill, and I don't see anywhere where the government is making it clear that intravenous drug costs, for example, are going to be considered under section 16. So all those folks out there who have cancer and who are trying to access very expensive intravenous cancer drugs shouldn't look to this bill to provide that for them, because there's nothing in the bill that says that their cases are going to be reviewed or that there's going to be some exceptional circumstance that can apply to get those drugs, like there is for section 8 with oral drugs.

Secondly—

The Vice-Chair: Ms. Martel, thank you very much. Mr. Peterson?

Mr. Peterson: The government is trying to achieve more transparency and accountability by taking the decisions out of cabinet and putting them with the executive officer, whose decisions will be published. Do you see this as a good way of increasing accountability and transparency, by taking it out of cabinet?

Ms. Mehra: No. We believe that the decision about what's on and off the formulary should rest with elected political officials who should ultimately be responsible for those decisions.

The Vice-Chair: Thank you for your presentation. The time is over.

LOVELL DRUGS LTD.

The Vice-Chair: Now we have Lovell Drugs Ltd. Are they here with us? I think we have Rita? Okay. You have 10 minutes. You know the rules. You can speak for the whole 10 minutes or you can leave some time for questions. The floor is yours. Go ahead.

Ms. Rita Winn: My name is Rita Winn. I'm a practising pharmacist, and I'm the general manager and COO of Lovell Drugs.

Thank you for the opportunity to address the committee today. I have a keen interest in the subject of Bill 102, and my intention today is to give a realistic picture of the impact this legislation will have on communities and people throughout the province.

Our company is, first and foremost, about pharmacy and health care. In fact, 93% of our business is from prescriptions and over-the-counter medications. Half of our stores are located in medical clinics.

With roots dating back to 1856, Lovell Drugs is the oldest drugstore chain in Ontario. We're also one of the largest independent chains, still run by the family that helped to found the company. We operate only in this province, and we are a fixture in communities across eastern Ontario, particularly Whitby, Oshawa, Kingston and Cornwall. Lovell Drugs employs 150, including 30 pharmacists and 35 dispensary technicians.

If Bill 102 passes as it is currently written, it will wipe out 100% of our operating revenues—100%. Over time, Lovell Drugs will then simply no longer exist. I will eventually be forced out of business. For me and the 150 Lovell employees that I represent, this is a devastating prospect. But what is more distressing is the impact it will have on the thousands of Ontarians who count on us every day for good health and wellness and, in some cases, life.

I will take a few minutes to list the tangibles that will be taken away from our patients if Bill 102 passes in its current state.

Home infusion program: In the Kingston area, we provide home infusion to approximately 70 patients a week. This program shortens hospital stays, saving hospital dollars. If Bill 102 is implemented as planned without significant amendments, we will not be able to afford to provide this service. The current funding model for home infusion is broken and requires fixing. The proposed loss of the professional allowance will force us to close this part of the business. I understand today an announcement was made on the \$25 cap, but that wasn't in this regulation anyway, or in this bill. The net impact in our area alone will force 70 patients back into the hospital. Is this something the government is prepared

for? Increased patient load, in my mind, increases wait times.

Other services that will be affected by Bill 102 in its present state include the following:

- our methadone program: Lovell Drugs works with the Street Health Centre in Kingston to support methadone patients in a multidisciplinary program, the first of its kind in Ontario. Our program was used by the Ontario College of Pharmacists as the model for the standards of practice to deliver methadone to clinics.

- quick access to information and advice about important health topics, from asthma management to protecting yourself against West Nile virus.

- a medication reminder service to ensure patients take their medication as directed to optimize their treatment.

- pharmaceutical care services, from conducting detailed medication reviews to ensure patients' drug therapy is optimized, conducting patient medication reviews for physicians and providing referrals to other health care providers.

- in 2005, we held 150 clinic days, including such things as osteoporosis screening, heart health risk screening and asthma education. Lovell Drugs administered over 1,900 flu shots last year.

- special care as the result of excellent relationships that we have with physicians in the community, especially in the small clinics that we serve. That interaction is key in avoiding adverse drug events that can lead to more and expensive care.

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- disease-specific patient consultations such as asthma, diabetes, women's health and heart health.

- counselling on over-the-counter medication.

- disease education and prevention programs, including our very own Lovell Drugs heart health program, which gives patients at risk for cardiovascular disease special information on prevention and adherence to their medication.

- counselling on nutritional information for adults and infants.

- smoking cessation programs.

- specialty packaging, especially for seniors who are well enough to stay at home provided they have some help with their medications.

- specialty compounding.

- easy access to the pharmacy outside of regular business hours and on holidays.

- benefits from pharmacy's investment in pharmacist education programs.

- Free delivery service, which is essential to those seniors who live on their own and cannot get out, and those on social assistance who have no transportation.

As you can see, there are many services that we will be forced to review and either change or eliminate as a result of Bill 102. Many of these programs benefit very sick people and very old people. Many interact with us and count on us each and every day. What are they going to do if the care that they rely on every day is going to be interrupted or disappear?

The impact will be significant. Lovell Drugs isn't the only pharmacy that will be forced out of business. Bill 102 will impact every one of the approximately 2,800 pharmacies in Ontario, mostly the independent pharmacies and the smaller chains. Estimates based on the information from the Ontario Chain Drugstore Association and the Ontario Coalition for Pharmacy are that up to 300 pharmacies will be gone.

Over the course of the hearings, the committee may hear different figures being quoted regarding the financial impact on community pharmacy, particularly regarding the prohibition of manufacturers' rebates. It is worth noting that the reason different figures will be used is that the independent and chain pharmacies will be basing it on their own economic models. Rebates vary by pharmacy because they are negotiated between the manufacturer and the various pharmacies themselves. The negotiated rebates are not made public for competitive reasons. However, it is generally agreed by the OPA and the Ontario Chain Drugstore Association, which collectively represent all pharmacies in Ontario, that the \$500-million impact is, at minimum, a very realistic figure.

Throughout this consultation process, the committee will hear from many members of the pharmacy community. You will hear more from specific pharmacies about the actual impact of the provisions in Bill 102, and you will hear many solutions. The Ontario Chain Drugstore Association has developed a series of proposed amendments to Bill 102 that offers an alternative approach to ensure the economic viability of pharmacy but still maintain the principles intended in the government's efforts to reform the drug system: an open, accountable and transparent system.

I appeal to you on behalf of Lovell Drugs' 150 employees and the patients that we serve to listen to pharmacy's concerns and strongly consider them as you make your recommendations to the government on this legislation.

The Vice-Chair: Thank you very much for your presentation. We have two minutes left, so we're going to divide three ways. Ms. Martel.

Ms. Martel: Thank you for being here today. I'm going to focus on your \$25 markup cap, which—you're right—the minister just announced today. You may not have had a good chance to take a look at this, but what difference, if you can give this to us, will that particular change make in your bottom line?

Ms. Winn: I never looked at it specifically on its own; I looked at it as lump in that particular area of our business. It will have a positive impact but certainly will not replace the profit piece that we're going to be missing with the rest of the legislation. I would say it will be a good start, but it certainly won't replace the profit that we'll be losing.

The Vice-Chair: Mr. Peterson.

Mr. Peterson: You say in paragraph 6, "It will wipe out 100% of our operating revenues." Revenues is normally the top line of a financial statement. Do you mean the bottom line?

Ms. Winn: I mean the bottom line.

Mr. Peterson: You mean the bottom. We'll make that correction. Thank you.

The Vice-Chair: Mr. Chudleigh.

Mr. Chudleigh: Thank you for coming and presenting to the committee today. It's extremely helpful to have somebody with your experience and your size of operation to be sitting in front of a committee saying that you are going to go out of business if this bill passes. In your whole life, did you ever expect to be put out of business by a piece of government legislation?

Ms. Winn: Never. I love being a pharmacist, I love my job, I love my company, and that's why I'm here today.

The Vice-Chair: Thank you very much for your presentation.

Interruption.

The Vice-Chair: I want to remind the audience that there is no clapping, please. Thank you.

VILLAGE PHARMACY

The Vice-Chair: Village Pharmacy.

Mr. Dipen Kalaria: Good morning, committee members. My name is Dipen Kalaria, and my associate here is Bill Wassenaar. I am representing a pharmacist who works with HIV patients as a clinical specialist. Today we represent the Village Pharmacy as well as a group of pharmacists known as the HIV Care Pharmacists of Ontario. Together our members represent the pharmacists who treat and care for more than 50% of the sickest patients living with this disease in our province today. Of course, we're here to voice our concerns around many of the facets of Bill 102 as well as the regulations, but specifically for us it's the \$25 cap that will be a showstopper.

Today, the true economics of a pharmacy managing HIV patients and having a \$25 cap would simply mean that you would lose money on every prescription.

Mr. Peterson: Mr. Chair, we are amending the legislation to eliminate the \$25 cap. While we appreciate him addressing that, perhaps he has other topics—

The Vice-Chair: Mr. Peterson, he has the floor. You can ask questions when you have the time.

Mr. Kalaria: That was forwarded this morning?

Ms. Wynne: Yes.

Mr. Kalaria: Okay.

The Vice-Chair: You have the floor.

Mr. Kalaria: I'll admit that my presentation was mostly focused around that, unfortunately, but I can speak to some of the other things in the bill.

Specifically, one thing that has really bothered me since this whole thing was launched a month or so ago was the characterization of rebates as being hidden, non-transparent. They are simply volume rebates. The one thing that I think everybody needs to understand about them is that they do not affect the care or the health of Ontarians. Whether or not we receive a rebate for a given medication, we pick one medication from a list of

generics which is provided to us by the government through the formulary. So whether I get a rebate from one company or not, it would not make a difference to what the patient received. Even if the rebate was eliminated, the patient would still receive one of those five or six medications that are listed on the formulary. It has been characterized in some places as a hidden rebate that seems to compromise the care or the health of Ontarians, but it simply does not do that.

Another facet of this would be the 8% markup. It's very unclear in the legislation currently whether or not Bill 102 will be on the actual acquisition cost that pharmacists pay for medications or on the final cost, which is with the wholesaler markup. If it is with the wholesaler markup, what we'd be looking at, as some of the people here before me have mentioned, is a 2% margin for pharmacies and a 6% or 5.5% margin for wholesalers. I think I'm pretty safe in saying that there is no industry in the world that operates on a margin of 2% at retail when the wholesale margin is 5%. It's simply a flipped equation; it cannot happen.

Let me see if there's anything else besides the \$25 cap that I was prepared for.

I'd also like to urge the committee to consider that the pharmacy council is not yet in the legislation. We don't know what's going to happen. Section 8 has sort of been repealed, but as we've heard already, there's no provision made for it. It has simply been called section 16. Access to drugs for patients quicker is fine, but they still need to occur within the framework of the drug approval process.

I'm free to take some questions.

The Vice-Chair: Thank you for your presentation. Mr. Peterson?

Mr. Peterson: I didn't mean to interrupt you, because we're very interested in your views. We are listening. That's why we've made this change and we're having these committee hearings to look at other possibilities of change. We appreciate it.

The HIV area is probably one of the areas of hidden discrimination in our society. We're very pleased that you're giving so much of your time to addressing that area of great need.

One of the areas where people ask why we aren't putting more of this in the bill—it's because we want to keep the process open and accountable that we're not putting it in the bill. We want to put patients on the committee for drug evaluation. We want them to be part of the process and we want that process to be open and transparent, which it cannot be if it's going to cabinet and it's under government legislation. The last lady failed to understand that. If it's government legislation, it has got to be kept secret as part of cabinet confidentiality.

The members opposite don't trust that open and transparent process to be in regulations and policy. They think it's better to have it ensconced where it can be hidden in legislation. What are your views on this?

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Mr. Kalaria: Well, the concern is that the minister and the government want to involve pharmacy in this

process, but simply alluding to certain things, policy changes and so forth, doesn't give us a lot of comfort in knowing they're actually going to happen. So we would like to see the provisions for the citizens' council, as well as the pharmacy council, directly in the legislation.

The Vice-Chair: Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. I think what's happened, unfortunately, is there's a lot of confusion between what's actually in Bill 102 and what the government says is going to be happening in the way of policy changes. I think the fact that this morning the minister was forced to back down on the proposal regarding the \$25 is a good indication that if they actually had done good consultation before the introduction of the bill, if they had allowed people the opportunity to see the recommendations and respond, we wouldn't be in the position that we are today. So I applaud you for the work that you do. I think you talked about the need for an appeal process. Do you want to expand on that?

Mr. Kalaria: That is something that I alluded to. Currently, the bill does not provide for any type of independent appeal process. In fact, the only appeal to be made is back to that executive member who will have all the power to begin with. So we really would like a provision for an appeal process with an independent board placed in the bill, rather than waiting for that to potentially happen in the regulations or through policy.

The Vice-Chair: Ms. Martel.

Ms. Martel: I would think it was because of the lobbying that was done by HIV-care pharmacists in Ontario that we actually have a change. The government should have thought about some of these ramifications before they put them in the bill. Secondly, please do not be snowed over or snowed in, or whatever you want to call it—have a snow job done here by Mr. Peterson. You know what? You could put in the legislation that there'll be a pharmacy council, five reps from government, five reps from OPA. There it is in legislation. You can do the same with the citizens' council. This is not a problem and it doesn't have to be done by regulation. The sooner it gets in the legislation, then the more hope we'll have that it's actually going to be here, because I'm not prepared to trust the government on some of these issues; sorry.

Thirdly, with respect to the markup, it would be good if you could reiterate again the problem with the markup. I got some information from one of your colleagues, Mr. Somani, from the Village Pharmacy about three weeks ago and I read this into the record, but perhaps you could give us an example again of what this means and what the dilemma is, because I'm not sure all committee members understand that.

Mr. Kalaria: Okay. The current dilemma is that in order for a pharmacy to purchase medications, they can either purchase them directly through the manufacturer or through a wholesaler. Unfortunately, over the last few years, the manufacturers have made it increasingly more difficult to purchase from them. They have very high minimums—\$5,000, \$10,000, \$15,000, \$25,000 minimum purchase—so we have to basically acquire our medications through the wholesaler, who charges a 5% to

6% upcharge for the service. The government pays us the markup on the back price, and the back price is of course the best available price as published in the ODP formulary. That usually refers to the price from the manufacturer, which unfortunately is just not possible for most pharmacists to get. As a result, we collect the difference in markup of just maybe—well, right now it would be 3.5%, but with the new legislation, that would be 2.5%. Simply put, on expensive medications, this would just not be economically feasible for pharmacies to stock expensive medications. In some cases, a margin like that would just mean pharmacies going out of business, as my previous colleague here mentioned. I really do believe that pharmacies will close if that happens.

I think it was 20 years ago that the government decided that reducing the number of physicians in this province would save them money. You will have an exodus of pharmacies, and 20 years from now we'll be trying to replace pharmacists in this province, if this bill goes through as it is.

The Vice-Chair: Thank you for your presentation. Your time is over.

MAIN DRUG MART

The Vice-Chair: Now I'm going to call on Main Drug Mart. You know the rules. You have 10 minutes to speak. If you wish, you can speak all the time, or you can divide it between questions and answers and also your speech. Can you state your name, sir, before you start, please?

Mr. Nagy Rezkallah: Sure. My name is Nagy Rezkallah, and I am a pharmacist and co-owner of three Main Drug Mart stores in the Metro area that have 38 employees.

I am here as an Ontario citizen who cares not only for his own business but also for his fellow citizens. I understand that democracy brought me here to express my concern and I understand also that the same democracy is able to amend any given proposal.

Apart from filling and counselling on any filled prescription, we have other services that we provide free of charge, and those services are all supported by the generic allowance we get. For example: (1) diabetic education, one-on-one with glucometer use and managing diabetes; (2) blister pack or dosette for nursing homes, elderly and confused patients to make sure they take their medication correctly, which saves the taxpayers unnecessary expenses by avoiding hospitalization and home care. I brought one with me. You don't know it. This is how it's done. It takes at least 30 to 45 minutes to do one of those, and we provide those free of charge because I get my expense from the generic allowance. If I don't have that allowance, I'm not going to be able to do that anymore; there is no way.

Drug reviews, meaning we sit with the patients, we check all their medications and design an administration plan; also check side effects, drug interaction and drug duplication, which we have to correct. That arises from

the shortage of family doctors and more and more people with more prescriptions coming from walk-in clinics.

A pharmacist is the only health care professional available to help a patient with easy and free access for consultation, avoiding unnecessary doctor visits.

Once Bill 102 is passed with no change, I will have no choice but to do the following: (1) staff will be laid off; (2) the pharmacy will have to cut down its hours, leaving the patient with no health care except to visit more emergency rooms and doctors. Services will have to be cut back—for example, blister packs, which I showed you, which will lead to more hospitalization and home care visits. There will be less consultation with pharmacists and there practically will be no consultation at all. Patients will have less accessibility to expensive drugs, like HIV and cancer drugs—and I'm glad to hear that that has been solved this morning. Still, I will have to see the details of how it is going to be done, by removing the cap of \$25 on the prescription. But this is a very good step as a start.

Nobody can dispute that our government needs to control costs of medication. The majority of the money spent on ODB drugs, as I understand, comes from brand name drugs. I agree with Bill 102 to allow me, as a pharmacist, to switch prescription drugs from more expensive ones to less expensive generics.

If I may suggest, once a generic is available, delist all alternative brand names in the same category. This will save lots of money. Also, cut the cost by cutting the waste, and there are so many ways to do it.

I would like to stress that the generic allowance is also to compensate me for the markup I am not getting paid from the government and other third-party payers. I have two examples of that. This is how we get paid. For example, Lipitor. According to the May 28 Toronto Star, Lipitor is the number 1 drug dispensed in Ontario. A three-month supply costs me \$208. The ODB—the government—pays me \$217. That leaves me with a gross profit of \$9, which is a gross profit of 4.3%. Another example is Zyprexa, which is the number 5 dispensed drug in the province. The pharmacy only gets 1.9% in gross profit—not net profit; it's gross profit.

1150

I cannot emphasize more the importance of a generic allowance to compensate for all the unpaid markup. The generic allowance is not to make us rich; the generic allowance is to make us able to pay our wages, our rent, taxes, counselling and every single service that we give to the patient free of charge.

A dispensing fee of \$6.54, which is proposed to be increased to \$7, does not come close to matching even the rate of inflation in the last 16½ years. The markup of 8% that is going to increase to 10%: From the example of Lipitor and Zyprexa, it does not really exist in real life. We don't get 8% or 10%. How can we be in business? Because of the generic rebate that we get.

I appreciate you giving me the opportunity to voice my concerns. I trust you will take them into consideration. Thank you.

The Vice-Chair: Thank you very much for your presentation.

You have one minute, Ms. Witmer.

Mrs. Witmer: I hope that the government will seriously consider the impact that this bill and the policy intentions are going to have on people like yourselves who are doing an outstanding job of providing services to the people in this province, and I just hope they will listen. I wish they had listened before they introduced the bill—and certainly the consequences are going to be tremendous. Thank you so much.

The Vice-Chair: Thank you very much. Ms. Martel.

Ms. Martel: Thank you for being here this morning. I appreciate you listing those services that you provide as a result of the generic allowance. I think it is important for us to see where that money is going.

Secondly, I would agree with you, because I've heard from other pharmacists that in light of declining revenue in other areas in terms of dispensing fees and the actual costs versus what you are getting, the educational allowance has become part of a revenue stream in many pharmacies that allows you to survive. Is that true?

Mr. Rezkallah: Yes, absolutely.

The Vice-Chair: Mr. Peterson.

Mr. Peterson: Thank you for pointing out the exact details of the gross profits here. Basically, what you're detailing is how the gross profit has been eroded by the drug companies' increasing prices. The government could not respond to those increasing prices other than by delisting, so our hands were tied. Under this new legislation, we are trying to fix that gross profit so your gross profit will not be eroded.

Mr. Rezkallah: What I mean: I can take anything, like Zyprexa and Lipitor, but I am only in business because I'm getting the unpaid markup on those drugs from the generic rebate that I get—and this is my best store. This is the financial statement. Last year I had a profit of \$150,000—

The Vice-Chair: Thank you for your presentation.

Mr. Rezkallah: I believe that without the generic, I would have had a loss of \$80,000.

The Vice-Chair: Your time's over, sir.

Mr. Rezkallah: This is my best store.

The Vice-Chair: Okay. Thank you very much for your presentation. There is no more time left.

ONTARIO LONG TERM CARE ASSOCIATION

The Vice-Chair: I want to call on the Ontario Long Term Care Association to come forward. You have 10 minutes.

Ms. Nancy Cooper: Good morning. I am Nancy Cooper, director of policy and professional development at the Ontario Long Term Care Association. With me is Bill Dillane, president of OLTC.

We appreciate the opportunity to present to you today. OLTC represents the private, charitable, not-for-profit and municipal operators of 428 of the province's 630 long-term-care homes. Those homes care for 50,000 of

the 75,000 Ontarians in long-term care. This care includes ensuring that residents, who are typically in their mid-80s, safely get the 7.5 daily medications they now need to manage their complex medical conditions.

The critical role of pharmacies in this process is what brings us here today. We applaud the government's leadership in attempting to control escalating drug costs with Bill 102. We are concerned, however, over the potential of Bill 102 to impact the valuable and value-added service that pharmacies provide to long-term-care residents.

Our concern stems from two sources: first, subsection 11(2) of the bill, which states that, "The executive officer may pay the operator of a pharmacy an amount different from the amount provided for under section 6 in respect of a claim or claims under subsection (1) for prescribed classes of eligible persons, subject to any prescribed requirements." Secondly, government statements surrounding the introduction of Bill 102 clearly indicate that a new payment model for long-term-care pharmacies is a government priority. In the context of the proposed legislation, we understand that this could result in an entirely different pharmacy reimbursement model for pharmacists providing services to long-term-care homes.

In the combination of this bill and the government's stated policy priority, we fear either a reduction in the overall funding available to support the delivery of high-quality pharmacy services to long-term-care residents or a shifting of the costs of this service.

To understand our concern, it is necessary to view the current reality of pharmacy services in long-term-care homes. It is a reality that the existing compensation and operating framework encourages healthy competition and supports pharmacists to be active partners in resident care, provides pharmacists to enable the home to meet provincial regulatory requirements and national accreditation standards, and provides value-added services that advance the quality of resident care everywhere from reducing the risk of human error to reducing drug usage, including psychotropic drugs and chemical restraints.

Currently, this service in long-term-care homes is fully funded by the Ontario drug benefit program, or ODBP, with the exception of a modest \$2-per-month resident copayment.

The Ministry of Health and Long-Term Care does not fund pharmacy services as part of the care program that it defines through the nursing and personal care and the programs and support services envelopes, yet these services are an important part of the resident care program that homes are required to deliver.

All long-term-care homes must meet the over 400 service standards set out in the ministry's program standards manual, including providing pharmacy services that meet eight specific standards and 29 defined criteria. The program defined by these standards is significantly broader than simply filling prescriptions. It also requires that pharmacies provide services such as:

—clinical pharmacology, which includes participating with physicians, nurses and others as part of the interdisciplinary team;

—support for the home's therapeutic quality and risk management programs, including medication reduction programs;

—leadership in drug safety programs, including initiatives to reduce the risk of medication errors;

—maintenance of medical administration records systems;

—education for staff, residents, families and professionals; and

—safe and effective transmission and recording of medication orders and prescriptions.

These prescriptive requirements describe a comprehensive and valuable resident care program by anyone's definition. Yet they only begin to describe the added value that, in tandem with the current ODBP funding structure, fosters safe and effective resident care. It's that world of difference between being a service supplier and being a service delivery partner on the care team.

The current ODBP provides sufficient funding for pharmacies to deliver the complete program that homes require while encouraging them to become active partners on the home's care team. The beneficiaries of this funding model, with its inherent competitive focus, are the residents and the homes, as demonstrated by the following examples.

As I noted, there are 75,000 residents in Ontario's long-term-care homes, with each resident taking an average of 7.5 medications daily. This amounts to over 205 million medication administrations in a year. Yet in 2004, ministry unusual occurrence data showed that there were only 44 adverse drug incidents that resulted in the transfer of a resident to a hospital, for a rate of two millionths of 1%. Obviously, the goal is zero. Nevertheless, it is clear that the current program model provides strong support for the prevention of adverse drug incidents.

The sheer volume of this medication activity in long-term care alone suggests a high potential for human error, a risk that is actually enhanced by the care environment. Unlike hospitals, where the patient is normally in bed, a long-term-care resident could be anywhere in their home. They could be doing a therapy program, getting their hair done or visiting with family. The registered staff must not only find the resident but, while they are searching, they are also likely to be called upon to respond to a family question or to redirect a resident with dementia to find their own room.

The current program supports pharmacies as active partners in helping registered staff to effectively manage the risk for human error through drug safety programs and other initiatives.

In this context, you can see why we would be concerned with subsection 11(2) of this bill, particularly when government has indicated that long-term care is up first for potential major changes to our pharmacy service reimbursement model.

1200

As MPPs, you are all aware of the current funding circumstances in our sector and the need to provide more

direct nursing and personal care to residents. Shifting pharmacy costs to long-term-care homes would be unacceptable to OLTC, our member homes, staff, residents and their families. If this occurred, we would expect the government to fund homes for these costs.

We appreciate that there may be alternative reimbursement models that could also support the government's objective. In fact, we would be more than willing to work with government, pharmacies and others to explore these.

We don't believe, however, that a capitation model which also has the impact of removing healthy competition amongst pharmacies is one of those options. This belief stems from our experience in the recent past with respect to medical laboratory services. Under their previous funding model, medical laboratories provided phlebotomy as a value-added service to long-term-care homes. When government moved them to a capitation model, it was no longer possible for the laboratories to cover this cost. Homes and the ministry were left scrambling, and as a result the government had to end up funding homes to access phlebotomy services.

A similar example in the current context might be the medication carts that pharmacies have always provided to homes as a value-added service. This value is increasing through the pharmacy sector's commitment to invest in electronic records and smart technology. For example, many homes are now supplied with wireless electronic medication carts. These carts provide increased support in managing the risk of human error by making it difficult to distribute the next medication if the medical administration record for the previous one has not been signed.

The benefits that accrue to residents and staff from these advances in technology would likely not exist without the support provided by the current ODBP-funded pharmacy service program.

Today, we are asking for your support to ensure that this important legislation does not negatively impact access to quality pharmacy services in long-term-care homes. Specifically, we are requesting your support to ensure that government maintains an appropriate payment model that fairly compensates pharmacies for all the services provided to long-term-care homes and continues to encourage healthy competition amongst pharmacy providers to ensure value for this investment.

Again, thank you for giving us the time to raise our concerns with you today.

The Vice-Chair: Thank you very much for your presentation. There's not much time left, about 20 seconds. I guess we don't have time to ask questions. Thank you, again.

MOOD DISORDERS ASSOCIATION OF ONTARIO

The Vice-Chair: I want to call on the Mood Disorders Association of Ontario, if they're here. You know the procedure. You have 10 minutes to speak. If you wish, you can speak for all of them, or you can divide them

between speaking and questions and answers. The floor is yours. You can start whenever you're ready.

Ms. Lembi Buchanan: Mr. Chair, committee members, thank you very much for this opportunity.

My husband, Jim, and I are among the lucky ones. Innovative drug treatments have not only kept us alive but they have also provided us with a high quality of life. And for those of us who have been diagnosed with life-threatening illnesses such as bipolar disorder, also known as manic-depressive illness, and cancer, quality of life is everything. In our case, quality of life can be bought for an extra \$2, and I'll explain that later.

I'm presenting on behalf of the Mood Disorders Association of Ontario, which provides services to approximately 10,000 individuals across the province. Jim has been a director of the organization for many years, and I'm a member.

The Mood Disorders Association of Ontario supports the government's decision to reform the Ontario drug program to ensure its sustainability, and we have been involved in the consultations with the Drug System Secretariat from the start. We were extremely pleased when George Smitherman, Minister of Health and Long-Term Care, introduced the Transparent Drug System for Patients Act in the Legislature. However, we were deeply disappointed to discover that most of the proposed recommendations are not included in Bill 102, and Shelley Martel has already gone through that list.

There is no mention of a "citizen council." There is no mention that patients will have "an active role in both decision-making and policy setting" etc. I'm not going to reiterate them all.

What I would like to talk about is that there's no definition of "similar" when referring to active ingredients or dosages of medications. At the present time, generic drugs must have the same active ingredients in the same dosage as patented or brand name drugs. There is a grave danger by suggesting that drug products with similar active ingredients are as safe as drug products with the same active ingredients.

I am sure that everyone is familiar with Aspirin, Tylenol and Advil. You can come and see me later if you've had a hard morning, because these packages have not been opened yet. I'm sure everyone here is familiar with them. It's easy to suggest that they are similar since they are all painkillers. They even belong to the same therapeutic class of drugs. But they are not the same. They have different chemical structures. They work differently for each individual. They have different interactions with other medications. While one or two of them may be safe for an individual to take, another can cause harmful side effects or even death.

In recent years, Health Canada has approved three new antipsychotic medications for the treatment of bipolar disorder and schizophrenia. They are chemically distinct. They target different chemical imbalances within the brain, resulting in different clinical outcomes. Nevertheless, some provinces have decided that the three new antipsychotics are similar—as these are similar—since

they are in the same therapeutic class; and therefore they're interchangeable. As a cost-containment measure, the provinces have restricted access to the antipsychotic costing them the most money. A patient must fail first on the other two medications before a doctor can prescribe the costlier drug.

Restricting access without regard to the health outcomes of each individual patient is bad public policy. Preventing a physician from making choices based on a professional clinical assessment is unethical. If treatment fails, the chance of recovery for individuals with mental illnesses diminishes significantly.

If we were to take these drugs—let's say they all have to be prescribed by the doctor. If Tylenol is the most popular drug, for whatever reason, Tylenol is going to be higher on the list of the drug costs to the province. So the province can say, as some provinces have done with the antipsychotics, "This one is too expensive. We don't know whether it's more popular because it works better or people just take more of it, whatever reason, but we'll take this off the list, and patients have to try these two first." Of course, a child can't take aspirin because of Reye's syndrome, so we're left with one. What kind of health care system is this when we have three very good choices out there and we start taking one or two off? The difference in the price of these things is just pennies, as we all know. The difference in the average daily cost of the three different antipsychotics is just a little bit more than a cup of Starbucks coffee. So we're playing with people's lives with minimal-cost medications.

I would also like to point out that the word "same" already allows considerable leeway for pharmaceutical companies when producing generic products. For example, generic drugs must be effective within a 20% range of the original patented or brand name drug. This means that they may be 20% more effective or 20% less effective than the brand name.

My husband, Jim, doesn't have faith in generic products to begin with. He doesn't believe that they are as effective as the original brand name drugs. Whether or not Jim's position is reasonable, the key here is to ensure that he, like others with serious psychiatric illnesses, is compliant with his medications. If Jim believes that the original patented drug is better, than it is critical that he has access to it.

Fortunately, psychiatric medications are inexpensive when compared to the cost of HIV drugs and many cancer treatments. In fact, Jim's mainstay, Carbolith, is cheap. However, Carbolith, the brand name for lithium carbonate, is not included in the formulary because there are even cheaper substitutes. A 300 mg capsule of Carbolith costs nine cents, and the generic form only costs six cents. The difference works out to less than \$2 per month, and yet the Trillium drug program refuses to cover the extra cost.

Jim was diagnosed with bipolar disorder in 1973, when he was discovered on the roof of St. Patrick's Cathedral in New York City in a psychotic state, waiting for a helicopter to take him to God. At the time, Payne

Whitney, a leading psychiatric hospital in New York, was conducting clinical trials with lithium. Jim responded well to the treatment and has continued to take Carbolith for more than 30 years.

Regrettably, due to the severity of his illness, he has suffered a number of setbacks requiring lengthy hospitalizations. When he was hospitalized again in 2001, he refused to take the medications provided by the hospital pharmacy because the generic drugs looked “different.” This is not an uncommon reaction. Many psychiatric patients, like Jim, have been prescribed powerful psychotropic drugs that have caused harmful side effects. So it is hardly surprising that they view drugs that are “different” with suspicion.

According to the hospital report, the issue was eventually resolved after transferring Jim to the acute care unit. He had demanded access to his own medications and, when his behaviour became aggressive and threatening, Jim was designated as an involuntary patient and put under 24-hour surveillance. The routine substitution of a generic product for a brand name drug greatly exacerbated his condition, resulting in a longer hospital stay.

There is also a danger in suggesting that drug products with a similar dosage are as safe as drug products with the same dosage.

How much time do I have?

The Vice-Chair: You have 30 seconds.

Ms. Buchanan: So you have the information in front of you in terms of how just a very tiny, tiny amount—relatively tiny amount—of an antipsychotic can make a huge difference in whether he’s going to cause harm to himself or others because of his sleepwalking incidents.

The Mood Disorders Association of Ontario is concerned that the quality of patient care will be compromised by cost-containment policies that create a lower threshold for therapeutic substitution of drugs. Thank you.

The Vice-Chair: Thank you for your presentation.

I believe we’ve now listened to all the people listed for our morning session, so now we’re going to recess until 3:30 or right after question period. I’m going to ask the committee members to take their stuff with them, because it’s going to be a long recess. We’re not going to come back until 3:30 or right after question period, roughly about 3:30 to 4 o’clock. Now we are recessed.

The committee recessed from 1211 to 1532.

The Chair (Mr. Shafiq Qadri): Ladies and gentlemen, I’d like to call the committee back into session. As you know, we are here to deliberate on Bill 102, An Act to amend the Drug Interchangeability and Dispensing Fee Act and the Ontario Drug Benefit Act.

We’ll move immediately to our presenters. First of all, welcome to you all. Thank you for attending. There is an overflow room, apparently, next door—which is much cooler, I’m informed—for those who would like to view these proceedings. I would also respectfully request that our presenters, as well as all committee members, abide by the rules. We have, obviously, a great deal of interest in this bill, and we need to keep the timings very firm.

PHARMASAVE DRUGS

The Chair: With that in mind, I would invite our first presenters, from Pharmasave Ontario, Messrs. Cheung, Rajesky, Zawadzki and Sherman. I invite you gentlemen to please come forward. Identify yourselves, please, for the purposes of recording on Hansard, because everything you say, as you know, does become part of the official record. Your very firm 10 minutes begin now.

Mr. Billy Cheung: Hi. Thank you very much for this opportunity to communicate our concerns regarding Bill 102. My name is Billy Cheung. I’m a practising pharmacist as well as region director for pharmacy and operations for Pharmasave. With us today as well are Allan Rajesky, national director of pharmacy innovation; Peter Zawadzki, our manager of pharmacy innovation; and Doug Sherman, our general manager for Pharmasave Ontario.

First off, Pharmasave is made up of a group of independently owned stores that share the same name. We have 370 stores nationally and 130 stores in Ontario. We’re primarily located in rural and small communities. Our organization exists to ensure that independent pharmacy remains a viable and successful option for pharmacists. Each one of our stores is 100% owned by pharmacists who decided at some point in time to take a risk, start their own small business and build their own vision for how they want to practise pharmacy.

Pharmasave provides services to these pharmacists. We provide the tools and the training, and this helps our pharmacists differentiate how they provide patient care services in the community. As you can see from the sales mix on your slide there, our focus is pharmacy. We’re very pharmacy-focused. Most of our business comes from the pharmacy as well as the OTC side of the business.

We are a different type of drugstore. Most recently, we successfully published a heart health study showing that our pharmacists can decrease the risk of heart attack and stroke by 30% in the community through enhanced management of people’s heart health risks. We do thousands of health information clinics and presentations across Canada each year. Another example of our success as a unique pharmacy is that, just last week at the Drugstore Outstanding Service Awards, Pharmasave won five of the seven awards. Our focus is on enhancing patient care in the community.

In terms of our structure, we have no retained earnings. Pharmasave Ontario operations are all supported and funded by our member pharmacists. In other words, our operations’ support and training resources are all financially funded. Our national office is responsible for providing the development of programs and resources, and our regional office is responsible for the execution and assisting our stores in terms of providing these services to the community and to enhance patient care. We’re a very grassroots-driven organization.

As indicated, our model is based on pharmacy first. In terms of revenue, we generate our revenue through a

number of different areas from prescriptions: dispensing fee, markup, and manufacturers' allowances. As you're all aware, you'll see that the costs related to operating a pharmacy—things such as wages, rent and utilities, dispensing and operational costs—have continued to skyrocket and increase over the last 15 to 20 years. That being said, dispensing fee and markup have actually remained flat and, in some cases in terms of the markup, we've seen a decline in terms of that piece. What we're seeing as a result is that manufacturers' allowances have allowed us to subsidize our business to ensure that we can provide value for the money in terms of what the government spends, what patients spend and what third parties spend with respect to prescriptions. We've maintained our pricing because we've had those allowances in place.

The next chart is just another way to show how manufacturers' allowances have allowed us to fill that gap. Without that gap, what you'll see is the impact that we've seen on Pharmasave. We've done the analysis based on what we know of the current legislation and how it's written. What it means is it's a negative \$17.4 million to our bottom line. That represents 76% of our bottom line. As you might expect, it's very difficult for our company, our stores, to continue our operation in the way it is with that type of impact. In Ontario, a specific loss of \$159,000 per store is what we're seeing; again, the majority of their bottom line.

Even if we take the best-case scenario and take into account some of the things that have been in the proposed regulation, such as the rebate allowances, the ODB fee going up to \$7, the reduction in markup as well as the professional services fee and the generic pricing rule, we're still seeing a negative \$16 million for our stores. It's very significant. We've actually not even taken into account the markup cap of \$25 because we would assume that our pharmacies would not fill those prescriptions that we'll lose money on.

In terms of the actual impact on Pharmasave, we're going to see a number of different things occur: 20 to 30 Pharmasave stores are going to close in Ontario; job losses will occur in every single one of our stores; 10 to 15 staff will be cut at our Ontario office, and we only have 23; service hours will be reduced in most of our stores; and services and support to stores will be significantly reduced, which include things such as training, patient education materials as well as professional programs.

For patients, what this translates into is increased wait times to get their drugs and less pharmacy access, resulting in increased visits in walk-in clinics as well as hospital emergency rooms. There will be no access to high-cost drugs such as those for cancer and HIV, although we hear that that might have changed as a result of an announcement today. Copays will be charged, with absolutely no exceptions. Patients will have to go further to get their drugs through decreased accessibility.

We're going to see services offered by our Pharmasave stores that will decrease. These include things such

as home infusion, palliative care as well as long-term care. They will no longer make economic sense. There will be the elimination of patient education seminars, clinics, flu shots, blood pressure checks as well as extended pharmacist consultations due to the lack of staffing that we would have. There will be higher fees for anybody non-ODB. Our stores are going to have to figure out another way to make up some of those economic losses. Services usually covered, such as tablet splitting, delivery and compliance packaging, will have new or increased costs associated with them. The impact is dramatic. The net result is that independent pharmacy will have a very difficult time remaining viable with this new model that's being proposed, and patient care will be affected.

What we're saying is that Bill 102 does not allow the current model to evolve. It's expecting a complete change to the business as of October 1, 2006. It's very difficult, when a business is going to lose 76% of its bottom line, to suddenly change overnight.

1540

We fully support the recommendations and amendments put forward by the Coalition of Ontario Pharmacy, which you'll be hearing from, OCDA, CACDS and the Ontario Pharmacists' Association. We would really like you to seriously consider fixing Bill 102, looking at manufacturers' allowances to be allowed as well as written into the bill with a code of practice, and that the pharmacy council and citizens' council also have the ability to negotiate, this as well being written into the bill. We'd like you to fix Bill 102 to ensure the sustainability of community pharmacy and the pharmacists' ability to provide patient care.

Thank you. We'd be happy to take some questions at this time.

The Chair: Thank you, and with respect, we'll have about a minute for each side, beginning with the PC side. Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. I appreciate all the work that you've done on behalf of pharmacy and pharmacists in the province of Ontario. You've got some great data here.

I want to go into the copayment issue, because I don't think it was until just recently that patients became aware of the fact that this bill is going to have even more severe consequences than they had initially heard. Can you tell me what's going to change?

Mr. Cheung: With respect to the copayment, in some cases you have pharmacies that are compassionate for patients who can't afford the copayment, and they've been waiving some of those fees. What we see at this point in time is that, with the changes in this bill, pharmacies are going to have to charge those copayments, with absolutely no exception.

Mrs. Witmer: So no one will be exempt?

Mr. Cheung: No one.

Mrs. Witmer: And that could range in what size? What costs per prescription might that be?

Mr. Cheung: The copayment would include the \$2 copay that currently patients might not be paying—the \$6.11 copay that people might only be paying \$4.11 on at the current time—and any third party payers, differences in fees—

The Chair: Thank you, Mrs. Witmer. We'll move to the NDP side, Ms. Martel.

Ms. Martel: Thanks to all of you for being here. Earlier this afternoon, the minister said yet again in the Legislature that this bill is going to enhance pharmacy and pharmacists, especially in rural areas. He was on the public record again today. I've got in front of me your presentation, which talks about significant losses. What do you think about what the minister had to say?

Mr. Cheung: I agree that there are parts of it that are intended to enhance the role of the pharmacist. Our challenge is that we might not have pharmacists available to actually take on that type of role.

Ms. Martel: So you are pretty confident about the numbers that you've given to us as a committee, given your roles as pharmacists. Having looked at the bill, you are very confident that these numbers are the ones you're most concerned about if nothing changes.

Mr. Cheung: We know our numbers. We know our business. We've done the analysis. We have a significant concern regarding the devastation this can cause us in our business.

The Chair: Thank you, Ms. Martel. We'll move to the government side. Mr. Peterson.

Mr. Peterson: The rebates that you're talking about—people have said that they're within a certain range. What is your knowledge of the size of the rebates? Where do you fit in the supply chain? Are you the second-biggest, fifth-biggest, 10th-biggest buyer in Canada?

Mr. Cheung: We are currently the fourth-largest pharmacy chain in Canada. With respect, I can only speak to our business. Our business is made up of independent owners, so we don't have all the data from every one of our stores, but as I indicated, there is a loss of \$17.4 million as a result of these changes.

Mr. Peterson: But what percentage of purchases is that?

Mr. Cheung: It would range anywhere between 45% and 55%.

Mr. Peterson: Forty-five per cent to 55%?

Mr. Cheung: And that's not an exact number, because it could depend store-on-store, but it gives you a range there.

Mr. Peterson: Thank you.

The Chair: Thank you, gentlemen, for your deputiation on behalf of Pharmasave.

MEDICAL REFORM GROUP

The Chair: I now invite our next presenters, from the Medical Reform Group, Mr. Lexchin and Mr. Kalant. Gentlemen, please come forward. You've seen the protocol: 10 efficient minutes in which to make your pres-

entation. Please identify yourselves for the purposes of recording. Your time begins now.

Dr. Joel Lexchin: I'm Dr. Joel Lexchin. I'm an emergency physician at the University Health Network. With me is Dr. Norman Kalant, who's a retired physician from McGill. We're members of the Medical Reform Group, a group of about 200 doctors that has been active on health care issues for the past 25 years.

I'm going to address two issues. The first one has to do with the question of substitution that the bill deals with, and the second one has to do with the viability of the brand name pharmaceutical industry.

For the first issue, my background is quite relevant here. In fact, the background of the Medical Reform Group is quite relevant because we, as doctors, would not support changes to legislation that endanger people's health.

My personal background is that I am one of the authors of a couple of books of prescribing guidelines for doctors. One is called *Drugs of Choice*, which is for general practitioners. The second is *Drug Therapy for Emergency Physicians*, which is obviously for emergency physicians.

There's concern regarding the legislation, in terms of generic substitution going from "same" to "similar," that this would lead to problems with patients who are stabilized on one medication getting inadequate therapy is they're switched to something that is similar rather than the same.

Having written guidelines for doctors, I can say that in groups of drugs there is a fair amount of medical consensus that switches like these would not have any significant impact on patient health. That's not to say it would never happen, but it's very unlikely to happen.

You can look at wider instances of substitutions. In British Columbia they have therapeutic substitution. They take a category of drugs that are all considered basically the same in terms of safety and effectiveness, and the government will only pay for the least costly version in that group unless there's a genuine therapeutic need for a more costly version.

At least three or four studies have been done looking at the health outcomes based on therapeutic substitution—that is, actually substituting one drug for another—and there is no evidence from these studies to show there has been any negative health outcomes in patients as a consequence of this.

What Ontario is proposing in going from "same" to "similar" would be going from getting a pill to getting a tablet. The chances that this is going to have any adverse health outcome are quite minimal. As I said, this is speaking as a group of doctors and myself as somebody who writes guidelines for prescribing for doctors.

The other issue I want to touch on is the viability of the pharmaceutical industry; again, this is the brand name industry. There has been a lot of rhetoric coming out around this—how it would threaten investment in Ontario.

Just for a bit of historical context, go back 35 years to when Manitoba introduced its drug insurance plan and

formulary, and read the same kinds of threats being made in Manitoba: If Manitoba did this, the pharmaceutical industry would have to look seriously at whether it would supply drugs to that province.

Forward to the present time, whenever something comes up that the industry doesn't like, they make the same kinds of threats around pulling investment out of the country. Those threats are largely hollow. If you look at the profit rates of the pharmaceutical industry currently compared to all manufacturing industries—this comes from Statistics Canada data—what you see is that in the last year for which there were figures, which I believe is 2003, the industry was twice as profitable, as a return on shareholder equity, as all manufacturing industries.

So none of what has currently been done in Canada—federally in terms of price controls through the Patented Medicine Prices Review Board, provincially with the price freezes on the formulary here in Ontario and the bargaining that the government undertakes when it's going to list a new drug—has adversely affected profitability in the industry. There's no reason to think that what is going on would affect profitability. The industry is making these threats. Largely it's a hollow gesture.

Finally, there's the question the industry is talking about around research and development and how much it will or will not continue to invest in this province. For that, I'll turn to Dr. Kalant.

1550

Dr. Norman Kalant: A colleague and I have been studying the productivity of the R&D expenditures claimed to be made by the pharmaceutical industry. Before the patent law was passed in 1993, the industry argued that it needed more patent protection to increase its revenues and thus have more money for R&D expenditures. In fact, although R&D spending has increased subsequently, there has been no increase in the number of new drugs introduced by the Canadian industry.

We used a number of scientific publications and a number of patent applications as outputs of their research to compare the Canadian subsidiaries with their own parent firms in the United States. Our firms produced far fewer outputs per million dollars of R&D expenditure than the parent firms. This was not due to the small size of the subsidiaries and the low level of their R&D expenditures, since one company was an exception to the pattern, and that was Merck Frosst, which had an expenditure at about the same level as all the other subsidiaries and yet produced numbers of scientific publications and patent applications per million dollars of R&D comparable to its parent in the States.

To see if the R&D funds were being used to support research in academic institutions—universities and hospitals—we examined a random sample of scientific reports from scientists working in those milieus. Out of a sample of 100 publications, we found none that claimed to have support from the Canadian pharmaceutical industry.

So, if the R&D expenditures do not produce new drugs or new knowledge expressed as scientific public-

ations and patents, and they do not support academic research, where is the R&D money going? I think this is an important question that has to be answered in the Canadian context, and adds a reason to question the threat from the pharmaceutical industry that they will withdraw from Ontario if this bill is enacted. If they do withdraw, there would appear to be not much loss to Ontario.

Dr. Lexchin: That is the formal presentation.

The Chair: Thank you, gentlemen. We have 20 seconds per side. Ms. Martel.

Ms. Martel: Some other presenters have suggested that we need a definition for “similar” with respect to this bill. Can we get your view on that?

Dr. Lexchin: I would say that “similar” would be the same active ingredient in two different drugs with the consensus from the medical community that it produces the same clinical benefits.

The Chair: Thank you, Ms. Martel. The government cedes its time to you, Ms. Witmer—

Mrs. Witmer: No questions.

The Chair: Thank you, Drs. Kalant and Lexchin, for your deputation and your presence today.

PFIZER CANADA

The Chair: I now invite our next presenter, Monsieur Jean-Michel Halfon, president of Pfizer Canada. Monsieur Halfon, please be seated. You've seen the protocol. We invite any colleagues of yours to introduce themselves for the purposes of Hansard. I invite you to begin now.

Mr. Jean-Michel Halfon: Thank you very much. Joining me today are Guy Lallemand, VP of government affairs; Sean Kelly, Ontario director of patient access and health policy; and David Malian, director, stakeholder relations, for Pfizer.

Since 2001, as Canada's and the world's leading pharmaceutical company, Pfizer has been ranked the number one investor in pharmaceutical research and development nationally, and among the top 15 investors across all sectors. Last year, of Pfizer's total R&D investment in Canada, \$109 million of a total \$190 million was invested here in Ontario.

We believe that Bill 102 puts Ontario at a major crossroads. We believe the government must decide how it wishes health care decisions to be made: either as part of an integrated, broader life sciences investment and health strategy, or narrowly, within silos, driven by and focused on cost containment and cost containment only.

Our position on this bill is clear. We cannot support Bill 102 as it is currently written. We do remain very committed—and my company is very committed—to continue working with the government and others to change the bill so that it can create a vibrant life sciences sector in Ontario and result in healthier Ontarians.

Now I want to address the major specific concerns that Pfizer shares with Rx&D, the research-based industry association, on Bill 102. There are some goals—namely, building a more sustainable, integrated and transparent

health care system; improving access to medications; involving patients in decision-making; and encouraging collaboration amongst medical professionals—that are laudable and very important. Let me be clear: Pfizer is very supportive of these goals and wants to play a major role in achieving them. However, there are several provisions in Bill 102 and uncertainty surrounding many of the specifics of the reform package that we believe undermine these goals. As the bill stands today, some of our major concerns with the proposed legislation include:

- that a greater emphasis is placed on cost containment than on improved patient outcomes;
- the interchangeability amendments open the door to policies that reduce or may eliminate patient-physician choice in determining the most appropriate course of therapies for the individual needs of patients;
- competitive pricing agreements, modeled on the US Department of Veterans Affairs, could also eliminate physician and patient access and choice, a lack of choice that will impact the most vulnerable: the poor and the elderly;
- sweeping powers given to the executive officer to determine details of the new policies and to make access decisions in the “public interest” without appeal mechanism or appropriate checks and balances; and
- there has been no disclosure of the economic and health impacts of the bill.

Once enshrined in legislation, Bill 102 will have lasting negative implications for patients and investment in Ontario, along with unintended and unanticipated interpretations and consequences. That is why we believe we must very carefully examine, consider and change the bill appropriately. The government’s specific intentions on these initiatives must be made very clear. Given the magnitude and unprecedented way the bill is being rushed through for Ontarians, we believe we should take the time to get it right.

1600

We understand the government’s concern with rising demand for medicines and related costs to its drug budget. It should be noted, however, that over the last two years the growth of innovative medicines within the drug budget has slowed dramatically to only about 5%—5% in 2005, 8% in 2004, and 18% in 2004 for the generic industry. Investments in innovative medicines should only be a concern within the context of ensuring that the government, taxpayers and patients receive good value. That value comes from the treatment and prevention of illness—fewer and shorter hospital stays—keeping people well and productive contributing members of society.

When it is said that drug spending is too high, we need to ask some specific questions: Do we want to prevent heart attacks or treat them in emergency rooms? Do we want to help arthritis sufferers keep working and paying taxes or pay them a disability pension? Can home care be delivered without access to a range of innovative medicines?

We should not be so focused on the cost of health care only, but on the value of health. Let’s consider the cost of

disease and how to lower it by investing in health. That is done by recognizing our spending on medicines not as a cost we absolutely need to minimize, but as an investment that gives returns. Here Bill 102 falls short.

Ensuring the best use of medicines within the overall context of other health services cannot be done by any one part of the health care system in isolation. There is a better way than that outlined in Bill 102. It requires a focus on improving patient outcomes through integration, collaboration and innovation as partners. Pfizer, through its vast experience in disease management in Canada and abroad, can play and wants to play a very important role in making this happen within the context of a provincial health care system that ensures patients have access to the right medicines they need.

Pfizer has unparalleled experience in implementing major health care partnerships, and since 2001 we have sought to collaborate with the government of Ontario on a patient-centred, integrated, disease management partnership. While we have yet to gain a commitment from the government of Ontario, Pfizer has a track record of success in collaborating. For example:

In collaboration with the state of Florida, Pfizer implemented a first-of-its-kind disease management partnership. The Healthy State program reached nearly 150,000 high-risk Medicaid patients, resulted in improved outcomes for patients, and over two short years saved the state of Florida more than \$61 million. Similar disease management programs are under way with Pfizer and governments in Italy and in the UK, with the NHS.

In Ontario, we successfully collaborated with DaimlerChrysler, the Canadian Auto Workers and the Windsor-Essex County Health Unit on a partnership called Tune Up Your Heart. The objective of this program was to improve the heart health of employees through a worksite program consisting of education and medical interventions, including the appropriate use of medicines. There were dramatic results for the 373 employees who participated in the 12-month program. The average level of risk for a heart attack or stroke was reduced, and nearly half of the participants lost weight. To the benefit of the employer, and likely the employees, a third-party financial analysis found the program had projected discounted savings of more than \$2 million over 10 years.

Pfizer has also been very active in building Ontario’s biopharmaceutical sector. Just last month, Pfizer invited the leaders of Ontario’s biomedical community—

The Chair: Monsieur Halfon, with regret, the time has expired. On behalf of the committee, I would like to thank you for your presence, as well as your colleagues, Messrs. Lallemand, Kelly and Malian, and for your deputation as well as your written submission.

Mr. Halfon: Thank you very much.

APPLE-HILLS MEDICAL PHARMACY

The Chair: I would now invite our next presenters to come forward. This is Mr. Ben Shenouda of the Apple-Hills Medical Pharmacy group.

Mr. Shenouda, I believe you're coming from the next room, so please do so. Please be seated. Your time begins imminently. It begins now.

Mr. Ben Shenouda: Hi. My name is Ben Shenouda. I'm a pharmacist and I'm representing Apple-Hills pharmacy in Etobicoke.

I'll make it very simple. I'll take about two minutes to go through my papers here and then I will leave the rest of the 10 minutes for the committee to ask me whatever questions they see necessary.

I have here a financial statement for my pharmacy. I have three scenarios. The first is the current situation; the second one is when Bill 102 will be applied, and this is 8% on the wholesaler price to the pharmacy; and the third one is the 8% on the manufacturer price.

I'll go very briefly with the financial statement. Total pharmacy yearly sales are about \$1.2 million. The current markup is about 3.5% average. The generic rebate is about \$96,000, and this is calculated based on 40% out of 20% of the total sales. From this financial statement, the net profit after tax is \$32,000 and the return on investment is about 3% on \$1.2 million.

The situation when Bill 102 will be applied, as 8% on the wholesaler price to the pharmacy: This will give me the net profit after tax as \$11,000 and the return on investment on \$1.2 million as 1%. However, if the 8% will be applied on the manufacturer price, my pharmacy will be in the red zone and I will have to close.

I'm done with my presentation.

The Chair: Thank you, Mr. Shenouda. We will move to the government side. We have about two and a half minutes per side.

Mr. Peterson: Thank you for your presentation. Your analysis here indicates that your "average cost of tech filling Rx" is \$3. What do you mean by that?

Mr. Shenouda: This is the technical filling. This is including the depreciation of my computer, my printer, the cartridge, the label, and the vial for the prescription.

Mr. Peterson: So this includes a bundle of costs, not just a straight labour fee.

Mr. Shenouda: Yes, it is a bundle of costs. That's right.

Mr. Peterson: This is a fair amount of information to absorb quickly.

We have a question from Kathleen Wynne.

Ms. Wynne: Could I just ask a question on this? I've seen a number of pharmacies that have used this template, so I just have a question about it. When you calculate your receipts, you're just using your dispensary receipts? Is this your front store as well? What's in that first section?

Mr. Shenouda: The \$1.2 million, you mean?

Ms. Wynne: Yes.

Mr. Shenouda: This is basically the prescription.

Ms. Wynne: This is just the prescriptions.

Mr. Shenouda: Yes.

Ms. Wynne: Okay. And your expenses are everything?

Mr. Shenouda: Yes, because in my pharmacy I have a very small over-the-counter section, so—

Ms. Wynne: But those numbers aren't in here.

Mr. Shenouda: No, they are not here.

Ms. Wynne: Have you run the numbers with your total receipts?

Mr. Shenouda: Yes, we did.

Ms. Wynne: But you haven't brought that. So—

Mr. Shenouda: It wouldn't be relevant to this committee because what's happening is that the over-the-counter part of the sales is small enough that it wouldn't bring any significance to the figure.

Ms. Wynne: But then, do you discount your expenses for the over-the-counter part?

Mr. Shenouda: Yes. I did not—

Ms. Wynne: These are all your expenses, right?

Mr. Shenouda: I did not include the lady who is taking care of the over-the-counter. This is only people working for the pharmacy, for the dispensary—

Ms. Wynne: Except you've got your cashier.

1610

Mr. Shenouda: Yes. This is for prescription—

Ms. Wynne: You've included everybody who works for you. I guess the point I'm getting at is, I'm just not clear sometimes, when I look at these templates, exactly what expenses are included. So it would actually be helpful if you could give us, at some point, the total amount of your receipts compared with your total expenses, because you've given us your total expenses but we haven't got your total receipts.

The point here is that we are in no way interested in disadvantaging small pharmacies. That's not what this is about. We're trying to bring to the system some transparency, and we're trying to find resources to reinvest so people get the medications that they need. That's the intent of the bill. So if you could get that to us, it would be great.

The Chair: Thank you, Ms. Wynne, for your questions and comments. To the PC side. Mrs. Witmer.

Mrs. Witmer: Thank you very much. I really appreciate your coming forward. I think it's regrettable that independent pharmacists need to bring in their numbers, their financial statements, in order to demonstrate to the government that this legislation is going to put them out of business or drastically reduce their ability to provide services.

How long have you been practising as a pharmacist?

Mr. Shenouda: Seven years in Canada. In total, 23 years.

Mrs. Witmer: And have you ever experienced anything like this before?

Mr. Shenouda: No. I've practised in Europe before. I've practised in Third World countries. I've never experienced this before.

Mrs. Witmer: Well, I guess it's really quite shocking. The government didn't bother to do any consultation on the recommendations, and now we're hearing from hundreds of people like yourself who are really very concerned. You came to this country thinking that you

could have a good life for yourself and your family, and now we see this impact. What does the government have to do to amend this bill to allow you to continue to support yourself and your family?

Mr. Shenouda: Personally, I believe that the government has to check the right figures before they make any decision, because I think, from what we hear and what we talk about and what we know, as well, from all the meetings we did with our MPPs, the base of the information was not correct. So basically a decision had been taken on wrong information. That's why we see the concern about pharmacists. We see as well the contradictory effect. The intention is good, but the figures based on which the government had made a decision, are not accurate, and that's what we see as the problem.

Mrs. Witmer: So there's obviously a need for the government to take more time—not push, ram the legislation through—in order that people like yourself can continue to provide the health care services.

Mr. Shenouda: In my opinion, this is a very major change in the system, and any major change needs much more time and needs much more discussion to come up with a better system, not with another system which will show us problems in the short term or even long term and then we need to change it afterward.

Mrs. Witmer: I appreciate that. Thank you very much for coming forward today.

Ms. Martel: Thank you for being here today. Let me just look at your markup for a second and the three scenarios that you gave us. Current situation: 3.5% would bring you in about \$42,000. The next page: markup 8%, \$96,000; then, markup 2.5%. That, of course, goes back to the dilemma of, what is the markup based on?

Mr. Shenouda: Exactly.

Ms. Martel: So there's a significant difference from what you've got now. It could either go up substantially or it could go down quite dramatically, depending on what the government chooses to have the markup based on.

Mr. Shenouda: Yes. That's right.

Ms. Martel: Okay. So those figures are quite valid, because we know where the government is on that.

Now, you would know this morning that the government said there wouldn't be a \$25 cap, essentially, on very expensive drugs.

Mr. Shenouda: Yes, I'm aware of that.

Ms. Martel: Do you carry those in your pharmacy normally?

Mr. Shenouda: Not so often, although I have to bring to your attention here that that 25% cap will affect medication more than \$312.50, and this could be your Losec, if you have an ulcer, for three months' supply, having two tablets a day, or it could be your Actos if you are diabetic. It could be any of those expensive medications. So we are not here talking about HIV or MS patients. We are talking about patients with chronic disease. They can take this medication; any one of us can take it if we get any of those normal, you-see-every-day medications.

Ms. Martel: Let me ask you about your generic rebate, because you put a figure down right now as \$96,000. Can you tell the committee what you use that funding for?

Mr. Shenouda: I use this to fund my pharmacy, because there is a cost of operation. There are more than 150 medications on the list. The government pays basically zero on it. So I need to subsidize, if this is a valid point, the health care system with my generic rebate.

Ms. Martel: Do you run any heart-healthy programs? People coming into the store to get their—

Mr. Shenouda: I do what's called a medication management program. I get patients who are confused with their medication. I sit with them, I brief them about their medication, I advise them on how to use it, I check the drug interactions and all these kinds of things. I don't charge anything.

Ms. Martel: Do you have any equipment, for example, that you may have purchased for the pharmacy that allows you to do either your medication management program for patients or other things that you do for patients?

Mr. Shenouda: Other than my PC or computer, no, I don't have anything specific.

Ms. Martel: Thank you.

Mr. Shenouda: You're welcome.

The Chair: Thank you, Ms. Martel, and thank you as well, Mr. Shenouda, for your deputation on behalf of Apple-Hills Medical Pharmacy.

CANCER ADVOCACY COALITION OF CANADA

The Chair: I invite, on behalf of the committee, our next presenters: Colleen Savage, president, and Jim Gowing, chair of the board of the Cancer Advocacy Coalition of Canada. Please come forward. Your deputation time begins now.

Ms. Colleen Savage: Thank you for inviting us to come this afternoon. I'd like you to know that with me today is Dr. Kong Khoo, a medical oncologist from British Columbia, because Dr. Gowing couldn't overcome the transit system today. Dr. Khoo is vice-chair of the board. I think you have our document. I will cut through it pretty quickly because I'm pretty sure you will have some questions for us.

Cancer patients have asked us to let you know that they have less access to cancer drugs in Ontario than they would have if they lived in many other provinces, particularly British Columbia, where cancer outcomes are the best in the country. Bill 102 and its related package of policy framework and regulations will help to address that problem. We do stand by our earlier commentary, when this bill was first introduced, that we are greatly encouraged to see Health Minister Smitherman talk about improving access to important new cancer drugs and important new drugs for all diseases. We are pleased with the promises we hear. We are, of course, worried about whether those promises become reality in the way that we hear the promises.

I want to make sure that you understand, and I'm willing to spend a minute of this precious time telling you, that we have had probably the best consultation process I've ever been involved with. We have ready access to the minister, to the deputy minister, to Helen Stevenson, any time we want. They have been open, responsive and candid to our every question. The long, long list of questions, of course, means that we aren't done, but I certainly can't complain at all about the responsiveness of that team in meeting with us whenever we want to.

I'm going to cut to page 2, where we get right into the issues that are still of some concern to the Cancer Advocacy Coalition. The first is section 16, the exceptional access mechanism. We haven't got a read yet on how rigid or flexible that system is going to be, so we have some suggestions. We believe that the new process should not limit the number of drugs that are available for exceptional access. We believe that oncologists are qualified and knowledgeable about cancer drugs and can easily figure out what a patient needs because they know their patients well. Oncologists are very concerned that if untrained individuals are going to be making decisions about exceptional access, we need to know who those people are and what guidance they are following.

When all other treatments have failed, a cancer patient is in dire need of a new choice and cannot wait for an answer. Please make sure people understand that. There's no delay that's acceptable; there's no indecisiveness that's acceptable; it simply has to work. Our oncologists have suggested that the best thing for them would be an online application, a simple one-page form where they can insert the information about the patient, click and submit and get an instant answer, "Yes." That would be a nice world, right? We're not that naive, so one of the conditions that we're happy to recommend to you and we believe oncologists would be happy to accept is that that instant answer, "Yes," be followed two months later by a requirement for the oncologist to respond to the ministry, "That treatment worked," or, "It didn't." If it did work, that's a good enough reason to continue it. If there's no evidence that it worked, that's a good enough reason to stop the exceptional access.

1620

One of the examples that has been brought to our attention is that when asking for a renewal of a section 8 in the past, if the treatment had worked and the patient's condition improved, then that new health status would be reason to cut off access to the drug that provided the improved health status. We've mentioned this to Helen Stevenson, and I'm sure she's going to take care of that little detail.

I need to point out to you that Ontario does not pay for many cancer drugs that are proven effective and are widely used elsewhere. Apparently, cost is the deciding factor. The only condition that should apply to the use of a cancer drug is whether it is effective.

I'll take a minute to talk about conditional listing during the review process as well, because one of the

features that has been described to us is that the ministry will enter into written agreements not only about the pricing and other details with the manufacturer, but for surveillance of treatment outcomes, because of the relatively new use of these new drugs in a real-world market. We think that's a great idea. We encourage it. We also think those same kinds of phase 4 studies could be applied to all drugs accessed through the exceptional access mechanism. That kind of information is extremely valuable to oncologists.

On therapeutic substitution, we have the minister's word that he has no intention of permitting therapeutic substitution at the pharmacy. We believe him, we trust him, he's given us his word, and we'll let the matter drop there. However, we see an unusual situation in competitive agreements that might in fact create therapeutic substitution done by the ministry. The way that would work is that the ministry contracts or tenders out an entire group of same or similar drugs and allows only one supplier. If that were to happen with cancer drugs, I can tell you that cancer patients and oncologists would be deeply upset. But I wanted Dr. Khoo to describe to you in greater detail on this particular point why it's so important.

Dr. Kong Khoo: Therapeutic substitution in cancer is not feasible. Most of the drugs we use, although they can be similar—they're analogues of each other—have differing enough effectiveness in evidence-based studies for the different applications that substituting one directly for another would not be evidence-based and not implementable.

In Alberta, they've decided for a class of cancer drugs called aromatase inhibitors to only fund one, but the evidence exists best for the other two in other situations. So I think for cancer in particular this process will not necessarily work most of the time.

Ms. Savage: Dr. Khoo has the pleasure of working in British Columbia, which has the best access to cancer drugs in the country. If you'll bear with me a minute, I want him to explain to you how that has happened there. Maybe Ontario can learn from the west coast.

Dr. Khoo: We undertook an evaluation, a survey, of what drugs are available. We took 20 of the newest drugs that represent the standards of care. They actually represented 24 individual drugs or indications. BC funded and fully paid for 21 of those 24 drugs. Other provinces funded as few as four. There's this huge discrepancy across the country. Each province has different mechanisms for vetting and evaluation. They come to different conclusions, often from the same evidence.

I think there needs to be a major change in this. Some of this will come from the Canadian strategy for cancer control. But I think some of the process exists within the jurisdictions of how drugs are vetted and evaluated.

Ms. Savage: I'll just move quickly along, because I can see everybody looking at their watches.

We anticipate three types of appeal decisions that we would draw your attention to. The first is the appeal for an exceptional access. I would remind you that a quali-

fied practitioner has to be the person who hears and reviews that kind of appeal. If any of our oncologists, for example, were to be turned down for an exceptional access cancer drug and wanted to appeal, first of all, could they; secondly, who would be the practitioner or the staffer who heard that appeal, and are they qualified to do so?

Secondly, I have to tell you that the patient advocates who have been in this building through the last several months have told me on more than a few occasions that they get no response from the ministry when they write letters of complaint. They want some reassurance of a more respectful response to their concerns. They want to know how they will know that any kind of appropriate investigation or follow-up will take place at all when they write as citizens to complain about drug decisions.

Thirdly, the matter of any rejection of the initial drug submission: We just want to see the citizens' council used in a constructive way here. It's not clear to me what the citizens' council is really supposed to do, but I would like to suggest that that's a valuable asset to add as the third element to a drug review, the first being the clinical evidence and the second being the cost-benefit analysis. That third element of social values, citizen expectations—

The Chair: Thank you, Ms. Savage and Dr. Khoo, for your deputation on behalf of the Cancer Advocacy Coalition of Canada. The committee thanks you for your presence as well as your written materials.

Mr. O'Toole: Chair, on a point of order: I just wonder if I could clarify if you're supportive of Bill 102?

The Chair: Mr. O'Toole, I believe that is not a point of order.

GLAXOSMITHKLINE

The Chair: I will now proceed to invite our next presenters: Mr. Paul Lucas, the president of GlaxoSmithKline, and other colleagues. Gentlemen, please be seated. I invite you to begin your deputation. As you've seen the protocol, there are 10 minutes in which to make your full presentation, which begins now.

Mr. Paul Lucas: Good afternoon, Mr. Chair and members of the committee. Thank you very much for this opportunity to speak with you today. My name is Paul Lucas, president and CEO of GlaxoSmithKline.

As one of Ontario's leading health care companies, GSK plays a vital role beyond the sale of innovative medicines. We are committed to investment in R&D, innovation and the economy. One of our three manufacturing facilities located in Mississauga produces and ships \$2 billion of product, which represents almost 25% of total Canadian pharmaceutical shipments. This facility produces over 75 different products that are exported to over 70 countries worldwide. These product mandates sustain, and have recently added, many high-value manufacturing jobs in Ontario.

Last year, GSK invested almost \$140 million in research and development in Canada. More than half of

this was invested in Ontario, including \$21 million in direct payments to Ontario universities and hospitals. We are among the top 15 contributors to R&D in Canada, across all sectors.

With limited resources in the public sector, GSK has maintained a commitment to investing directly in Canadian research talent. As a partner in R&D, we enable scientists and physicians to conduct their important discovery and development work here in Ontario. This is costly work, but it pays off when Ontario patients benefit from new treatments and cures. I cannot imagine where we would be today without 3TC, co-developed by GSK and Shire BioChem here in Canada. This medicine is now the cornerstone of HIV/AIDS treatment, and is considered by many to be the most important discovery in Canada since insulin.

We continue our search for the cures of tomorrow. GSK invested \$3.75 million in the Structural Genomics Consortium at the University of Toronto. This basic research initiative will provide important structural information for over 350 proteins that will be made available to scientists worldwide. It is just one of a number of investments in Ontario—one that this province also supports—that we believe will contribute to the discovery of new products for unmet medical needs.

Our investments serve as a catalyst for other investments, many of which are matched by federal and provincial governments. So we are not simply a supplier of a commodity; we are a partner in providing health care solutions that will benefit patients and Ontario's thriving knowledge-based economy. In short, we are investing in Ontario's future.

Investment in research and development results in earlier patient access to new medicines through clinical trials. Canada—and Ontario in particular—is among the top three trial sites for GSK globally. There are more than 150 clinical trials running in this country, involving 23,000 patients in over 1,400 centres, including GSK trials for exciting new products Tykerb and Cervarix, just two examples of major innovations in the area of breast and cervical cancer that are accessible to Ontarians. We have only been successful securing these trials within our global company because we've been able to demonstrate, until now, that this is a jurisdiction that supports research and innovation.

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Despite the years of work to create a vibrant biopharmaceutical presence in Ontario, Bill 102's sole focus on cost containment undermines this effort. This legislation wrongly targets the innovative industry through cost control measures and transfers much of the savings to an unregulated sector, where generic prices are some of the very highest in the developed world. How will this strategy find new cures, provide access to breakthrough medications, improve the health of patients in Ontario and benefit our economy? When patient outcomes are compromised, how does this cut costs in the long term?

We have a few specific requests to the government for amendments which could greatly improve the legislation.

(1) Therapeutic substitution: While the government statements say therapeutic substitution is not the intention of the changes, the wording of the legislation is otherwise, requiring pharmacists to substitute “same” for “similar” medicines from what is prescribed. The bill does not take into account the value of incremental improvements in medicines for individual patients based on their unique needs, and reduces access to innovative treatments based on cost alone. We need to ensure that Bill 102 values the innovative industry and protects the integrity of the patient-physician relationship, rather than allowing the government to alter the prescribing decision based solely on cost.

(2) Price freeze: Bill 102 proposes a continuation of the price freeze on the provincial formulary which has been in place since 1994, and a rollback of any price increases taken in the private market. No one likes to see price increases, but inflation has increased by at least 25% over that period of time and Canadian prices are already 9% below the international median for innovative pharmaceuticals. Many people are not aware that GSK and the innovative industry prices are regulated by a federal agency, the PMPRB. So we are not asking for any special dispensation, but only to have fair compensation for our products that is in line with the annual increase in CPI. This would put our industry on par with other government programs that allow for annual increases, such as tuition, rent and other areas of health care.

(3) Off-formulary interchangeability: We are asking for off-formulary interchangeability to be delayed until the actual benefits and impacts are evaluated. While we would welcome reforms resulting in employer cost savings, there is currently no evidence indicating that OFI, as outlined in Bill 102, will achieve those savings. In fact, since the prices of generic drugs outside the provincial formulary are not regulated, there is no guarantee that patients or payers will receive lower prices through off-formulary interchangeability.

Most people would agree that medicines and vaccines have transformed health care, reducing death and disability across most diseases. Those innovations have occurred through incremental steps, not major leaps. Bill 102 does not recognize the value of incremental innovation in medicines, even though this is the method of progress of all technologies.

Like you, we want Bill 102 to work for the benefit of patients and to preserve the great progress we have made in developing Ontario as a centre of excellence in research and development. Clearly, this proposed legislation is not aligned with Ontario’s innovation agenda and will have the opposite effect by restricting patient access to the medicines they need, eroding biopharmaceutical innovation, and putting future research and development at risk.

Our treatments save lives and ultimately save the government money, so long as the drug budget is not reviewed in isolation. Innovative medicines are both effective and cost-effective. In a province that claims to embrace innovation, cost containment instruments must

be replaced with innovative approaches to pharmaceutical care that look at spending on medicines not as a problem but as an opportunity: an opportunity to leverage the spending on pharmaceuticals to drive economic growth and improve access to the treatments that patients in Ontario need.

We have been partners in the past and we continue to be partners today. A recent example of GSK’s partnership with hospitals, community physicians and allied health professionals is our chronic disease management initiative called PRIISME. Through this program, we are seeking ways to collectively improve the management of chronic diseases in asthma, COPD and diabetes. The results of this initiative have demonstrated a reduction in ER visits, hospitalizations and unscheduled doctor visits. That’s good for patients and it’s good for the government’s bottom line.

I would ask you to seriously consider the amendments I’ve outlined to Bill 102 so that we can continue to be partners in the future. Thank you.

The Chair: Thank you, Mr. Lucas. We have 20 seconds per side. Ms. Witmer.

Mrs. Witmer: Thank you very much, Mr. Lucas, for an excellent presentation. Are you going to leave a copy of those amendments with us?

Mr. Lucas: I can, yes.

Mrs. Witmer: We’d really appreciate that. I guess, basically, you’re telling us that this bill is going to have a huge impact on innovation in this province and also make it harder to attract investment.

Mr. Lucas: Absolutely.

The Chair: Thank you, Ms. Witmer. Ms. Martel.

Ms. Martel: Thank you for being here. One of the new powers of the executive officer is to negotiate agreements with manufacturers of drug products. Has the government given you any idea of what that process is going to look like?

Mr. Lucas: No, not really.

Ms. Martel: What have they told you in this regard?

Mr. Lucas: They’ve told us that it really is along the lines of the Veterans Affairs model in the United States, which is basically a program of therapeutic elimination and restriction of access—

The Chair: Thank you, Ms. Martel. We’ll move to the government side. Mr. Peterson.

Mr. Peterson: You had an innovative product for treating diabetes, I believe, called Avandia, which we were not able to purchase from you or work on an educational program with you under the old legislation. This new legislation contemplates that. Is it a good idea for us to include that in this new legislation?

Mr. Lucas: We believe that it’s a great idea to negotiate agreements that are going to benefit patients and patient outcomes, but not to base that negotiation on price alone.

The Chair: Thank you, Mr. Peterson. Thank you to you, as well, Mr. Lucas, and to your colleagues from GSK for coming forward. Please feel free to leave the written submission.

COALITION OF ONTARIO PHARMACY

The Chair: I would now invite our next presenters: Mr. Rajesky, of the Coalition of Ontario Pharmacy. Mr. Rajesky, you've seen the protocol: 10 minutes in which to make your full deputation, and any colleagues you may have with you, please have them identify themselves for the purpose of Hansard recording. Your time begins now.

Mr. Allan Rajesky: Thank you very much. My name is Allan Rajesky. I'm director of pharmacy innovation for Pharmasave National. To my immediate right is Gersh Sone, who is the CEO of the Canadian Association of Chain Drug Stores, and on the end is Art Ito, who is the director of pharmacy services for The Bay/Zellers Pharmacy.

As I said, I'm Allan Rajesky and I represent the Coalition of Ontario Pharmacy. We are a non-partisan group of pharmacies, pharmacists, patient advocates and health care groups. Our members include all sizes and types of pharmacies—small, medium and large pharmacies, independent drugstores and chain drugstores, owner-operated pharmacies, franchise pharmacies, company-owned pharmacies, pharmacies in grocery stores, pharmacies in department stores and stand-alone drugstores. We represent more than 80% of the drugstores in Ontario.

Our members include, at one end of the scale, the Independent Pharmacists Group and the Independent Pharmacists of Ontario, and, at the other end of the scale, the Canadian Association of Chain Drug Stores and the Ontario Chain Drug Association. Most of us are members of the Ontario Pharmacists' Association. The OPA and our coalition play different but complementary roles. The OPA represents about 60% of pharmacists and is the voice of the profession. Our coalition is focused on the operational side, not the professional side—that is, the business side of pharmacy. We represent more than 80% of them. In fact, that is how the coalition came into existence. The announcements of April 13 showed a lack of understanding of the business side of pharmacy, a lack of appreciation for what it takes to keep community pharmacies sustainable.

We are a health care profession, a healing profession, but we can't heal if we're not in business. Patient care will suffer if pharmacies close. Patient care will suffer if pharmacies reduce their hours or lay off employees. Patient care will suffer if pharmacies cannot afford to provide special services like delivery, tablet splitting, health days—the ones most of us offer as part of our current offerings to the community. Patient care will suffer if pharmacies, especially pharmacies in rural and northern Ontario, can no longer afford to stock high-cost drugs like those used to treat cancer, MS or HIV, although it sounds like this may have been resolved today with the elimination of the markup cap.

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All in all, patient care will be cut if the government cuts community pharmacy, and that is what this legislation is doing: It cuts community pharmacy. The package of reforms announced on April 13 will take about

\$500 million out of community pharmacy, and that's a conservative estimate. It's also a net figure; that is, it takes into account the new investments that were announced as well.

The largest impact—not the only, but by far the largest impact—is the elimination of manufacturers' promotional allowances. This is what the ministry is terming "rebates." Some of you may be thinking that \$500 million is an unreasonable figure. Some of you may have been told that our figure is wrong, but the people who say that are not in the business of pharmacy. We know our business and we know our stores. All the members of our coalition have looked at these changes. We know our costs; we know our revenues; we know how much we receive in promotional allowances. So every member of the coalition knows very definitely what impact these changes will have.

Five hundred million dollars is a very conservative estimate, but don't just take our word for it. I invite you to consider what the minister and the OPA have said about the impacts, particularly the manufacturers' allowances.

Before I mention the numbers, I will point out that the pharmacy market is larger than the prescriptions paid for by the Ontario drug benefit, or ODB. ODB accounts for about 40% of pharmacy sales. The minister looks at ODB sales because that's all the government pays for, and says that eliminating promotional allowances will save \$210 million—\$210 million, only looking at 40% of our business. The OPA looked at only ODB sales and said that eliminating promotional allowances will save \$253 million—\$253 million, again only looking at 40% of our business. Even using these numbers, when you extend them to 100% of the pharmacy business, you can see that our conservative estimate of \$500 million is pretty close to the mark.

I've heard some MPPs talk about whether promotional allowances are a good or bad source of revenue. In our view, that misses the point. The point is, you can't remove one of our major sources of revenues and not replace it. Otherwise, patient care will suffer. You can't take half a billion dollars out of community pharmacy and not replace it. That means taking an average of \$150,000 out of each store. The biggest impact will be on the 750 independent pharmacies. The biggest impact will be on stores in northern and rural Ontario. As many as 300 pharmacies will close. The government knows this.

On May 5 the director of the ministry's Drug System Secretariat admitted that drugstores will close. I was there. He told me. Last Friday, a Liberal MPP admitted that drugstores will close, once again. There will be other impacts on patients—too many to list—from longer wait times to no service on evenings or weekends to lack of access to certain drugs or services. Patient care will suffer. Communities will suffer.

Our message is simple: A cut to community pharmacy means a cut to patient care. The government cannot cut our funding without replacing it. However, none of the new funding is included in the bill. On the other hand, the major cut to our funding is in the bill. Moreover, the new

funding is not sufficient to offset the cuts. The net effect will be a cut of some \$500 million. You will hear later from the Canadian Association of Chain Drug Stores, the Ontario Chain Drug Association and the Ontario Pharmacists' Association. We support all of their proposed amendments.

We specifically urge you to amend the bill to allow for the continued investment of manufacturers in pharmacy, using promotional allowances while making it more transparent. We also urge you to include the composition and duties of the pharmacy council and the citizens' council in the legislation, giving these councils the ability to negotiate; draft language has been circulated. We urge all MPPs to defend community pharmacy. Thank you.

The Chair: Thank you, Mr. Rajesky. We'll have about a minute or so per side, beginning with Ms. Martel of the NDP.

Ms. Martel: Thank you for being here. I want to see if you can clarify something for us. Mr. Shenouda—I think you were here for his presentation—used this, and now there are questions being raised about why total receipts and total costs are not included, so it might make these figures illegitimate, is the nice way to describe it. Do you want to comment on the use of these spreadsheets, because I know the coalition has been using them, and the figures that appear? I know they're going to be different from one pharmacy to another, but how they appear and why they're relevant.

Mr. Rajesky: I don't have all those numbers right in front of me. What I can say is that when we're looking at the numbers, we're looking at just the impact on pharmacies. So what are the pharmacy revenues; what are the pharmacy costs? The front store, other things don't necessarily come into play with this because you still have to fill your prescriptions no matter what you're selling in the rest of your store. So when we're looking at costs, when we're looking at revenues, we're looking at the pharmacy side specifically.

Ms. Martel: Are you concerned that, even with the other part of the business—because you're talking about small stores, so we're not talking about Shoppers selling everything under the sun; my community pharmacy is mostly selling medication, not a whole bunch of other things—that even with the sales from the other part of the business, that there could be a significant impact on—

The Chair: I'll have to intervene there, Ms. Martel, and give it to the government side.

Mr. Peterson: Thank you for coming and thanks for making this presentation. Do your numbers include all of the private plans and the OTC—over-the-counter—sales and costs?

Mr. Rajesky: We're not talking about over-the-counter when we're talking about the impact of the costs and revenues. We are including impacts that will have waterfall effects to private payers as well.

Mr. Peterson: Your organization—we're kind of confused in the government because we have the OPA and then we have yourselves. What is the difference in your representation of pharmacies?

Mr. Rajesky: You'll probably find that the amendments that we are requesting are the same with both groups. The OPA has been directly with the government. We've been working on the public relations and with the government as well. We're working with the pharmacy and the operational side of the business in mind, and OPA is working primarily on the pharmacist/professional side as well.

Mr. Peterson: We're—

The Chair: Thank you, Mr. Peterson. I'll offer it now to the PC side.

Mrs. Witmer: Have you had an opportunity to have a meeting with the minister or Mrs. Stevenson? We've heard how very much available they are. I just wondered: Have you made a request and have you had a meeting?

Mr. Rajesky: We've made a couple of requests. Our original one was denied. We hear there may be an opportunity to meet on Friday. There are certain restrictions on that meeting, so we need to review those and see if we're able to meet those requirements. But we may have a meeting coming up. As of yet, we have not been granted a meeting.

Mrs. Witmer: I guess if I take a look, OPA represents pharmacists, and about two thirds of the pharmacists belong to OPA?

Mr. Rajesky: About 60% of all pharmacists, which include industry pharmacists, hospital pharmacists, yes.

Mrs. Witmer: Okay. If take a look at this coalition, how many of the pharmacies/pharmacists do you represent?

Mr. Rajesky: Fairly close to 2,500 of the 3,000 pharmacies, or close to 85%.

Mrs. Witmer: So this is a substantial group, and as of yet you've not had a meeting with the Ministry of Health or a representative.

Mr. Rajesky: No. It has become a substantial group because everyone has the same concerns, analyzed their businesses and realized that this bill is not sustainable for our companies or for the continuation of patient care and the way we provide today.

The Chair: Thank you, Ms. Witmer. Thank you to you as well, Mr. Rajesky, and to your colleagues on behalf of the Coalition of Ontario Pharmacy.

GREEN SHIELD CANADA

The Chair: I invite now our next presenters, Messieurs Garner, Chiles and Clitherow of Green Shield Canada. Gentlemen, you've seen the protocol for 10 minutes, the time for which begins now.

Mr. David Garner: Good afternoon and thank you. My name is David Garner. I'd like to introduce Vernon Chiles, to my left, a pharmacist and vice-chair of the board for Green Shield Canada, and to my right, Richard Clitherow, Green Shield's vice-president of the Health Solutions Group, which has primary responsibility for government-oriented initiatives.

I'm going to start my submission to the committee with an introduction of Green Shield for some back-

ground. Following this, I'll outline our involvement with the Drug System Secretariat and their research. I'll then finish with Green Shield's position with respect to certain aspects of the proposed Bill 102 and regulatory changes.

Green Shield was formed nearly 50 years ago by pharmacists as a not-for-profit corporation and pioneered the pay-direct drug plan in Canada. To this day, 50% of our board is comprised of representatives from the pharmacy community and more than 50% of our claims are processed for the purchase of drugs.

We operate coast to coast to coast in Canada, although the majority of our business is here in Ontario, where we are headquartered.

Our customers represent a diverse group of employers and associations ranging from large industries such as General Motors of Canada, DaimlerChrysler Canada and the Ford Motor Company of Canada to many other corporations and small businesses across the country.

In addition, we provide services to the Canadian Automobile Workers, the University of Toronto and other learning centres and public organizations, such as the cities of Windsor and Sault Ste. Marie.

We also provide outsourcing service to other similar organizations in our business such as The Co-operators, and of course we have a contract with the Ontario Ministry of Health and Long-Term Care for the Health Network System, supporting the Ontario drug benefit and Trillium programs.

Our mission statement commits us to enhancing the common good in the administration of health and social service benefit plans with quality, efficiency and with service excellence. It also commits us to seek out innovative ways to broaden the availability of these services and to continuous improvement.

Examples of this would include our advocacy activities and most recently the introduction of health benefit programs specifically targeted to individuals who are unable to obtain these benefits elsewhere.

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We do consider ourselves as the specialists in the field of health-care benefit administration.

I'd like to talk a little bit about the drug system in Ontario and the input that Green Shield Canada was able to provide to the Drug System Secretariat. Drug benefit plans sponsored by employers, associations and others provide a level of coverage for prescription drugs and requisite products to approximately 45% of Ontario residents. These plans include both active and retired workers.

There are a number of different plan designs, and these are funded in a number of different ways. However, there is a common challenge that exists with all of them, and that is that costs are becoming too onerous. Our customer costs have been rising at nearly four times the rate of inflation, and it is becoming increasingly difficult for plan sponsors to sustain the level of benefits and in fact to sustain the plans themselves. This obviously could have a direct and negative impact on both access and quality of care. I'd like to add that this pressure and

challenge is not unique to us; it prevails in all industry sectors and has a significance not only to the sustainability of the health care plans but in some cases to business survival.

It's our belief that the solution may only be found in a revamped drug system for Ontario, built upon collaboration between public and private sectors to harmonize the approaches to access, affordability and quality of care for all the residents of Ontario.

Over the summer and the fall of 2005, we had an opportunity to meet with Helen Stevenson and members of her team from the Drug System Secretariat to provide our input into what we believe could bring about a process to meet the objectives I mentioned a moment ago, those being access, affordability and quality of care. We were also able to bring representation from our largest customer contingent, the auto industry: General Motors, DaimlerChrysler, Ford and the Canadian Auto Workers.

I'm pleased to confirm to the committee that a constructive, open and frank dialogue ensued, where all parties were able to freely discuss not only the challenges and problems that exist in each constituency today, but also suggest alternatives to improve the current situation, with examples of ways in which both the public and private systems could interplay for the common good.

I will now summarize for you the areas that we identified as being priorities to achieve these goals.

There is a need to harmonize the public and private drug plans to accomplish five desirable outcomes:

- firstly, the optimization of health outcomes;
- secondly, the effective management of costs and the prevention of waste;
- thirdly, to provide access to drugs for the more than 10% of Ontario residents who lack a plan;
- fourthly, to provide access to citizens with high total drug costs, such as catastrophic coverage; and
- fifthly, to provide equitable and compassionate access to expensive drugs for rare diseases or other high-cost drugs relative to the ability to pay.

All of this should be accomplished through a combined public and private financial model that will achieve coordinated and stable funding.

Continuing with our list of priorities, we feel we should strive for a unified public and private medication management strategy toward patient care, cost efficiency and safety. In other words, the right therapy provided to the patients for the right condition, in the right quantity, for the right period of time.

We should review drug costs and purchasing policies to ensure that they would benefit public and private sectors equally. This would include a broader selection of interchangeability products than that which currently exists in Ontario.

We should conduct an in-depth review of the role of the pharmacist in the compensation model to protect and enhance the services available from the health care team's most accessible member. There are no wait-time issues at the pharmacy, but are we using this underutilized resource appropriately? Should we considering a

suite of services with appropriate compensation aimed at enhancing medication management?

Lastly, we need to ask ourselves: Are we optimizing information technology to its fullest to achieve efficiencies? In our business at Green Shield Canada, we have been able to use technology to greatly facilitate assessment and approval, exception processing and the monitoring of patient treatment regimes. We need to coordinate public and private service delivery to achieve optimal health outcomes, pricing and reimbursement alternatives.

Moreover, Green Shield Canada is a strong advocate for speedy implementation of electronic health record strategies, such as the Emergency Department Access to Drug History viewer, implemented in 2005 with the assistance of Green Shield; as well, the All Drugs All People repository, referred to as a drug information system; and electronic prescribing.

By now, I'm sure you're able to see how some of our objectives are aligned to the proposed Bill 102 and other changes. Nonetheless, I will now speak to those aspects of the bill affecting Green Shield Canada and its customers which we feel competent to address.

Let me start with the role of the pharmacist, a member of the health care team who is underutilized and often unappreciated and has a somewhat unusual compensation arrangement that does not cover all of the professional services rendered by the pharmacist.

It is time to make a change, and Green Shield Canada is supportive of the initiatives included in Bill 102, provided:

—that the pharmacists' role is enhanced and the sustainability of their service is not affected during the transition or thereafter;

—that compensation be harmonized between public and private sectors, removing the necessity to charge more in one sector and to make up for it in the other; and

—that both public and private sectors are engaged with the profession of pharmacy to support medication management services that will bring about improved patient outcomes and safety, while being identifiable and measurable such that they are saleable in the private sector.

Next, I would like to indicate our support for the proposal to create channels for improved transparency and decision-making and for greater and more diverse participation, dialogue and consultation with Ontario residents and patients, and hope that this will also extend to private plan sponsors. This is long overdue and will go a long way to seeking solutions to the problems at hand and in the future.

However, I would be remiss if I did not mention a note of concern with respect to the very broad terms of reference that are proposed for the executive officer. One of the reasons that this reform will be successful will be improved transparency, which has to include an ongoing partnership and dialogue with, amongst others, private sector health care providers and sponsors. We encourage the establishment of this function in such a way as to

ensure that the necessary degree of collaboration is maintained between the public and the private sectors.

The subject of off-formulary interchangeability, or OFI as it has often been referred to, is an important measure as well. Most provinces already have broad interchangeability. Having said this, Green Shield implemented enhanced generic substitution, similar to OFI, at the request of the automakers in January. I'm happy to report to the committee that after overcoming some expected challenges, the change has been accepted by the physicians, pharmacists and patients, and has provided considerable savings without compromising patient safety or efficacy.

Another aspect of the bill which we support and are encouraged by is the process to facilitate faster access to new medications. While not dealt with as yet, we are also a strong advocate of comprehensive catastrophic coverage. The approval process for new medications and catastrophic coverage will also be closely coupled; so too will be the necessity for the public and private sectors to work closely together to make sure this is a success for all stakeholders.

Lastly, since all of our customers have expressed difficulty with sustaining their health plans due to escalating costs from increased utilization and high drug costs, we will advocate on their behalf for any measure that deals with policies to control costs, provided that the quality of patient care and service is not compromised.

It's worthy to note that many plan sponsors of private plans are becoming increasingly frustrated, and it is not out of the realm of possibility that you could see health plans significantly scaled back or even abandoned. You can imagine the kind of dilemma that would produce. It is better, we believe, that we come together now to preserve what we so richly cherish.

On behalf of my colleagues joining me here today and the entire Green Shield organization, I'd like to thank this committee for giving us the opportunity to share our views.

The Chair: Thank you, Mr. Garner. On behalf of my colleagues, I would like to thank you for your deputation on behalf of Green Shield Canada.

CANADIAN MENTAL HEALTH
ASSOCIATION,
ONTARIO DIVISION

The Chair: I now invite our next presenters: from the Canadian Mental Health Association, Ontario division: Michelle Gold, senior director of policy and programs, and colleagues. Ms. Gold, your 10 minutes begin now.

Ms. Michelle Gold: Hello. My name is Michelle Gold. I'm senior director, policy and programs, with the Canadian Mental Health Association, Ontario division. With me is Heather McKee, community mental health analyst. The Canadian Mental Health Association is a provincial organization committed to improving services and support for individuals with mental illness and their families and promoting mental health for all of Ontario.

We have 33 branches providing community mental health services throughout Ontario.

We're pleased to see that the government's proposed reform of the provincial drug system incorporates a number of the elements that we addressed in our submission last fall to the Ontario drug benefit review. Our submission was based on input we received from CMHA branches, from people who are on the front line providing community mental health services to people with serious mental illness.

Access to psychiatric medications is a key part of recovery from mental illness for many people. One important lesson from the research is that with psychiatric medications, one size does not fit all. A reformed drug system must ensure access to a variety of psychiatric medications, even for those of limited means. It's a fact that people are hospitalized because they discontinue necessary medications they cannot afford.

People with serious mental illness also have high rates of physical illness, such as diabetes and heart disease. They require access to a range of drugs for these and other physical conditions.

1700

CMHA Ontario supports much of the government's plan to reform to the drug system. However, we are proposing several amendments to existing sections of the bill, as well as recommending expanding certain sections to deal with several omissions.

Bill 102 introduces the position of the executive officer of the Ontario public drug programs. The considerable authority of the executive officer includes the power to designate products as interchangeable and to list and delist products from the formulary. The role is extensive, yet many of the details are not spelled out in the legislation, such as what constitutes credible information for decision-making. Also, the justification for formulary decisions in a publicly funded system must be evident and transparent.

We are recommending that paragraph 3 of section 6.01 regarding the principles be amended to say, "The public drug system will operate transparently for all persons with an interest in the system...."

CMHA branches tell us that their clients are currently forced into using older medications because newer, more effective drugs are not yet covered by the formulary. We caution that any initiatives that restrict access to newer-generation medications ultimately end up costing the health system more. The proposed act currently states that the executive officer may list a drug product in the formulary when they consider it to be in the public interest, but there is no definition provided as to the criteria for "public interest." This has the potential to create undue hardship.

We recommend that the section be expanded to include a definition of what constitutes "public interest."

Regarding interchangeability, CMHA Ontario supports legislation that ensures that decisions about specific medications are made by health care providers in consultation with patients. "One size does not fit all" is particularly true for psychiatric medications. People with

mental illness need to have access to appropriate medication. They respond differently to different medication, even within the same class of drug. For example, a person with schizophrenia may exhibit significant side effects with one type of atypical antipsychotic but benefit from a different one.

As currently written, the act allows for therapeutic substitution, wherein drugs with similar ingredients are interchangeable. However, there must be some allowance for physicians indicating "no substitution," based on the clinical response of the patient. There are differences amongst individuals in their physiological makeup. For example, research is finding differences in the response to medication between men and women, and often we see clinical trials being repeated to adjust for gender differences.

We recommend that clause 1.1(3)(a) be amended to allow for "no substitutions" on the advice of a prescribing physician.

One of the key issues that CMHA branches identified with the current drug system is the difficulty for people with mental illness accessing medications through the limited-use and section 8 individual clinical review process. People with mental illness find the process to be difficult, time-consuming and bureaucratic. While they wait for approval, people are forced to pay out of pocket, often at the expense of cutting back on food. Others go without necessary medication entirely, with the inevitable impact on their mental health.

Timely access to medication is absolutely essential. For example, for a person with psychosis, delays in medication treatment are associated with poorer outcomes.

We recommend that section 25 be expanded to provide that the executive officer consult with physicians in determining an appropriate time frame for deciding on special cases, and that the requirement of timeliness be added to the legislation.

Lastly, we do support the involvement of consumer and patient representatives in drug funding decisions. In separate documentation, the Ministry of Health and Long-Term Care has referred to the creation of a citizens' council. We stress the importance of having people with mental illness be considered for positions as consumer representatives. Medication is a very common treatment for people with psychiatric disorders, but as a result of stigma and discrimination, people with mental illness are often excluded from decision-making processes and they're not allowed to speak for themselves. It's essential that their voices and their issues be heard equally in any process of consumer representation and public involvement.

We recommend that paragraph 2 of section 6.01 be amended to say, "The public drug system will involve consumers and patients in a meaningful way."

I'd like to thank you for the opportunity to speak to you today on behalf of the Canadian Mental Health Association, Ontario division.

The Chair: Thank you, Ms. Gold, and to your colleague. We have about a minute or so left per side. Mr. Peterson.

Mr. Peterson: Thank you very much for the great job your organization is doing in getting rid of the stigma and negative impact of mental health issues. I have worked very closely with Sandra Milakovic in Peel. She's just a wonderful representative for you. I enjoyed giving out hugs with her at the subway station.

I can assure you that when a doctor now puts "no substitution" on a prescription, there will be no substitution, and that "similar" and "same" still do not allow for chemical changeability. It will have to be exactly the same; it will just be the form. But due to the psychological nature of some of the people you're dealing with, it's very important that that be clearly understood in part of our legislation. We are also trying to take the decision-making for breakthrough drugs out of cabinet to make it faster.

Do breakthrough drugs affect people with mental health issues, and is there a faster way we could work with you to help people in those categories?

Ms. Heather McKee: Yes. Certainly that is important. I think there are a number of medications, for example, that are now available in the United States but haven't—

The Chair: I'll have to intervene there. Thank you, Mr. Peterson. We'll go to the PC side. Mr. O'Toole.

Mr. O'Toole: Thank you very much for your presentation on behalf of the vulnerable client group you represent; I think you make the case very well. We heard earlier this afternoon from the Medical Reform Group, Dr. Joel Lexchin and Dr. Norman Kalant, both of whom said that substitutions don't constitute a significant problem. We did hear again this morning from the mood disorders group, as well as another group—I think it was the MS group—who were very concerned about this substitution issue. So I commend you for bringing that up. I think it's very important as you've described it here and as it was described.

Even though that one group, as doctors, is saying there isn't really a problem, do you consider this to be pretty serious? I've heard it from others. What would you like to see put in here? You've got an amendment to section—it was 6.3, right?

The Chair: I'll have to intervene there, Mr. O'Toole, with respect. Ms. Martel.

Ms. Martel: Thank you for your presentation. I'll probably make more comments than ask a question. It would be great if there was a process for breakthrough drugs. Breakthrough drugs aren't even defined in the legislation. That's the first problem. The second problem is that the new section 8 process, whatever it is, is also not outlined in the legislation, so we don't know if it's going to be better or worse than the current section 8 process. Thirdly, there is no provision in the legislation either to establish the citizens' council or the committee to evaluate drugs or the pharmacy council. So while these are all good ideas, not one of those provisions actually appears in the bill. Of course, as you pointed out, there's no definition of "public interest" in the bill even though, in at least four different sections of the bill, the executive

officer can make significant decisions—delisting, listing, interchangeability.

I appreciate your amendments; I think those will be very important to us. But there's so much that's not in the bill that the government has promised, and it makes me wonder why some of these things, which are very easy, don't even make their way into the legislation if the government is intent on actually implementing them. Thank you for your presentation today.

The Chair: Thank you, Ms. Martel, and thank you to you as well, Ms. Gold and Ms. McKee, for your presentation from the Canadian Mental Health Association, Ontario division.

ROBARTS RESEARCH INSTITUTE

The Chair: I would now invite our next presenter, Mark Poznansky, president and scientific director of Roberts Research Institute.

Mr. Poznansky, as I'm sure you've seen the protocol, your 10 minutes begin now.

Dr. Mark Poznansky: First of all, thank you for giving me the opportunity to present this afternoon. I believe the deliberations you are undertaking and the decisions that will subsequently be made may have profound implications for the future health and wealth of this great province—perhaps more than most can predict.

Let me start by saying that I understand many, if not all, of the issues surrounding Bill 102. I don't want to respond on behalf of the pharmaceutical industry or, in fact, any other industry; they're more than capable of speaking for themselves. I'm also quite sure that patients' interests are clear. They simply want access to the best medicine and at the most affordable price, and certainly the ministry is acutely aware of the cost issues and the incredible pressure their budgets are under. My issue is quite different.

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I want to talk about our children and our children's children and the lives they will lead, their standard of living, which also translates into the quality of health care they will be able to afford. Many of the most advanced western countries have embraced the innovation agenda and made major headway in converting their economies from those that are based primarily on resources and manufacturing to industries that are part of the knowledge-based sector. It is discouraging, but not surprising, to realize that a number of countries have now surpassed Canada in that respect; I refer to Ireland, Sweden, Finland and even tiny countries like Israel and Singapore. The United States and most parts of western Europe also seized these opportunities some time ago.

Globalization is not so much a threat as a fact of life, and there are not many who believe that Canada's extensive automobile industry will survive globalization and the movement of those jobs to lower-cost centres such as Mexico, India and China over the course of the next decade. We live today with huge surpluses as a result of the current price of oil, but how long will that

last as we've seen the commodity price index slowly erode over the past decades? Surely it is our responsibility to plan for the time when we are making fewer cars in Ontario and the price of oil has stabilized or decreased. So it seems clear that if Canada, and specifically Ontario, is to prosper, we must succeed in the innovation game; that is, the knowledge-based industries.

Outside of the IT centres in Ottawa and Kitchener-Waterloo, it is safe to say that we are doing poorly. My expertise is in the area of the life sciences, medical devices, biotechnology and pharmaceuticals. In order to produce a significant impact in these areas, we need huge investments, not in the tens of millions of dollars but in the hundreds of millions. This will likely require dollars flowing from major corporations and major investment houses. While there are some in Canada and Europe, and even some in Asia, it is safe to say that the vast majority of any such investment will have to come from south of the border. In order for those funds to flow, those investors will have to have confidence in our technology, in our management and in our public policy. They will have to have a strong perception that their investments are solid.

Make no mistake about it: Bill 102 is not seen to be friendly to those who might seek to invest in Ontario in the area of innovation in the life sciences, and here we speak about the biotechnology industry and the pharmaceutical industries, which now are more and more very much the same.

Returning to the issue of perception, I'd like to recount a very telling story of an event I recently experienced. I was down in Boston, seeking an investment from a major biotechnology company seeking to do a deal with a small Ontario firm. They loved the technology but in the end passed on the investment, citing concerns over the issue of patent protection. They did not have confidence in Canada's patent policy and in fact questioned whether Canada had any patent policy at all.

Now, we might laugh at their mistake. We might even say, "Typical American ignorance about Canada." The fact of the matter is, we have pretty good patent protection. But perception is often reality, and if we allow the Americans to have that perception in this case, then the laugh is on us, because at the end of the day we are the ones who walk away from the table without the investment.

Bill 102 is about price and accessibility of drugs for the people of Ontario, but it is also about perception, and in the long term it might be that the cost of that perception may far outweigh any cost savings. There is a very strong perception out there—and this goes beyond the walls of the pharmaceutical industry—that Ontario is not a friendly environment for the patented medicine drug companies. Traditionally, it has been very difficult to get new patented medicine onto the Ontario formulary. There have been drugs discovered and developed in Canada that did not gain access to the Ontario formulary until they had long since entered common use across the United States and many Canadian provinces. Bill 102 only strengthens that negative perception.

So those of you who are in support of Bill 102, please understand the downside. Please understand the potential ramifications. You may save dollars—you may save hundreds of millions of dollars—but at what cost, especially at what cost to the future and especially to our children's and their children's future?

This bill will make the establishment of a strong, innovative life sciences industry in Canada even more difficult. Major corporations in the life sciences will shy away from making any major investments in Ontario, and raising significant capital from major investment houses will be similarly difficult. Its passing, especially in its current form, will only add to the perception that at least in this sector, Ontario is not a good place to invest. So please examine the bill carefully, not just from the point of view of current drug prices but from the point of view of the future and the future of life sciences investments in Ontario.

Just to show you the growth of this industry, I show you a graph of the growth of the biotechnology industry in revenues in the United States. These are revenues that are not accruing to Canadian companies. Thank you.

The Chair: Thank you, Dr. Poznansky. We'll move to the PC side. Ms. Witmer.

Mrs. Witmer: Thank you very much, Mark, for coming today. I really appreciate your presentation. This is a little different than what we've been hearing, but I think it's absolutely necessary that this be very seriously considered by the government. You referred to my community, Kitchener-Waterloo, where we have been successful and people have been able to take risks, but certainly I think the facts illustrate that if the government moves ahead with Bill 102, as it currently intends to, we are going to lose out on any future investment in this province. Is there anything within the bill that could be changed that would change the investment and innovation climate?

Dr. Poznansky: I've gone through the bill and I recognize the issues of cost containment; I recognize the issues of the pharmacies. But what concerns me most is the overall tone of the bill in terms of the areas of innovation, specifically patented drugs. I think that simply has to be altered. It should be altered on a bipartisan basis, because we're not just dealing with the cost of drugs here; we're really dealing with the future of this province.

The Chair: Thank you, Mrs. Witmer. Ms. Martel. A minute per side.

Ms. Martel: I'm quickly searching through the government background paper that talked about the investment that they wanted to make with companies. I think it's \$30 million; I could be wrong. That's obviously not in the bill; that's in the government background papers; but do you want to comment on what, if anything, that will do to the situation to make it more positive?

Dr. Poznansky: Thirty million dollars, to an industry, is a minute drop in the bucket. We just raised, through one of our companies, \$24 million US. This is a small,

tiny company in London, Ontario, with 15 employees. So if you talk about a \$30-million investment, you're talking about—I hesitate to say it—very small peanuts.

The Chair: Thank you, Ms. Martel. Mr. Ramal.

Mr. Khalil Ramal (London–Fanshawe): Dr. Poznansky, first I want to congratulate you on your event yesterday. It was a very successful one.

Secondly, you talk about perceptions. You built all your arguments on perceptions. In your own opinion, how can we change that perception in order to attract more formulas to be patented in Ontario? As we mentioned, the patent issue is not a provincial one; it's a federal one.

Dr. Poznansky: The earlier governments, and I won't say what colour governments, in both Ottawa and Toronto in the middle and late 1990s talked about the innovation agenda and the future wealth of this country. We've heard much less about innovation, both from Ottawa and Toronto, over the course of the last year or two. It's almost as if the innovation agenda was last year's agenda, and now we have to deal with issues like children and taxes and the military—which are important, okay? But how can we have a culture where innovation is last year's agenda? Innovation has to be inculcated into everything we do if we're going to go forward successfully.

The Chair: Thank you, Dr. Poznansky, for your deputation on behalf of Robarts Research Institute.

MERCK FROSST

The Chair: I'd now invite our next presenter, Mr. Gregg Szabo of Merck Frosst, to come forward. Mr. Szabo, as you've seen, 10 minutes' protocol, beginning now.

Mr. Gregg Szabo: Thank you, Mr. Chair. Dear committee members, on behalf of Merck Frosst Canada, we appreciate the opportunity to provide input to those who may recommend amendments to Bill 102. This is a significant and highly complex piece of legislation that has the potential to have major impacts on Ontarians' ability to access needed medications and on the province's ability to attract investment in research and development.

Merck Frosst is a research-driven pharmaceutical company that develops and discovers medicines and vaccines across a broad spectrum of therapeutic areas. Recently, Merck scientists developed a vaccine with the potential to dramatically reduce the incidence of cervical cancer, and our research pipeline includes some exciting new medicines in the areas of cancer, Alzheimer's, diabetes and AIDS.

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Merck Frosst's Canadian headquarters in Kirkland, Quebec, is home to one of only 10 worldwide research facilities. Our investment in R&D in Canada over the last 10 years is over \$1 billion, and our company is consistently ranked among the top 20 R&D spenders in the country.

Canadian scientists at Merck Frosst have developed a number of important advances, including Singulair, a pill

for the control of asthma, which can help free people, especially children, from the difficulties of dealing with inhalers.

Merck Frosst also contributes to the development of science in Ontario through extensive support to institutions such as the University of Waterloo, the University of Toronto and, notably, the Robarts Research Institute.

Merck Frosst recently invested in the new MaRS centre. As part of this investment, we have established an on-the-ground business development presence actively working here to identify new partnership opportunities that may result in more commercialization for Ontario companies and promising innovations for patients.

Over the past few years, our health care system has been increasingly stretched by a growing and aging population. Merck Frosst is committed to working with government and other stakeholders to ensure changes which will make the system more effective and sustainable.

In getting started today, we want to recognize that there are promising elements around Bill 102. We are pleased, for example, that discussions have referenced the need for more patient involvement and an enhanced role for pharmacists in patient counselling. However, we believe that the inclusion of patients on the committee to evaluate drugs and the creation of the citizens' council should be outlined explicitly within the legislation.

The elimination of cabinet approval for drugs receiving a positive recommendation is also a welcome change. In addition, the elimination of limited use and the return of section 8 to its original intent for exceptional cases will mean reduced paperwork for physicians and pharmacists, and is another positive step forward.

I will focus today on three of our major concerns with Bill 102 as it currently stands. The first is access to medicines; the second, therapeutic substitution; and the third, the impact on innovation, jobs and investment.

We are concerned that Bill 102 will not do enough to improve access to medicine in Ontario. While there has been a commitment to additional spending to cover growth in the program, there has not been any obvious resource commitment towards adding new drugs to the formulary. Over the last two years, Ontario has only listed 15% of the drugs approved for use in Canada, while Quebec, by comparison, has listed 55%.

Ontario is also a participant in the national Common Drug Review, or CDR. Since its inception a couple of years ago, CDR has actually rejected 100% of new drugs that represent first-in-class or new therapeutic options.

Although relatively unknown, these facts are astonishing. The seniors of Ontario and patients covered under the Trillium program need to be reassured that changes to their drug system will ensure access to new innovative therapies.

We would like to see this legislation amended to provide for clear benchmarks on access so that patients in Ontario can quickly and reliably benefit from medicines deemed to be safe and effective for use in this country. Specific and measurable targets on the number of new

medicines to be listed and timelines for listing would be a welcome step towards achieving this goal.

Bill 102's commitment to review breakthrough drugs more quickly is a positive step forward. According to the Common Drug Review definition of "breakthrough," however, very few drugs qualify for faster review. We would support a more inclusive definition of "breakthrough" to ensure that innovation is encouraged and Ontarians have rapid access to substantial improvements in therapy.

Another serious problem with Bill 102 is the broadening of the definition of drug interchangeability. The bill gives the executive officer the power to allow the interchangeability of products with the same or similar active ingredients. This is causing a great deal of concern, as it could mean the substitution not just of a generic version of a drug which has come off patent but of an entirely new drug within the same therapeutic class. Different drugs work in different ways for different patients, and it is vital that the province not adopt a one-size-fits-all approach when it comes to medicine.

Advances in medicine have not come overnight. Medicines first introduced are gradually improved upon by subsequent drugs within the same category. The introduction of multiple medicines in specific therapeutic categories paves the way for incremental improvements in science and patient outcomes, and the result is better drugs and better health.

In the case of AIDS, for example, we've developed medicines which have effectively turned what was considered a death sentence into a chronic, manageable condition. Since the introduction of the first antiretroviral 20 years ago, dozens more medicines of this type have been developed, and the result is that AIDS patients today can receive treatment from more effective medicines with fewer side effects.

Furthermore, because patients react differently to different medications, it is essential that doctors have a range of choices available in case patients develop resistance or need to switch medication due to toxicity.

Therapeutic substitution glosses over the differences between various medicines within a class and serves as a barrier for patients and a disincentive for the introduction of innovations within the same class. An amendment should be made to clearly define and prohibit therapeutic substitution and all related practices that go by other names, such as reference-based pricing, maximum allowable cost (MAC) pricing, New Zealand-style pharmacare, or US Department of Veterans Affairs-style restrictions.

I want to turn my attention now to the impact on innovation, jobs and investment. The future for Ontario is the knowledge-based economy. It is one of the reasons the government has focused on education as a key component of its strategy. We need, however, to ensure that there are vibrant companies to employ these bright minds that we are developing. Companies like Merck Frosst are the future homes to many young scientists. In order to have a strong life sciences sector, we need to ensure, in addition to its already strong health research

infrastructure, that there is a strong local market for the goods and services that are delivered.

While spending on medicine within the health care budget is rising, it is important to see this within the broader overall framework of the health care system. Effective use of medicine can reduce other health care costs by a factor of 7 to 1 by avoiding more invasive procedures, reducing and preventing hospital stays, and keeping people healthier. For certain disease areas, the introduction of new medicines over the past decades has led to a decline in hospitalization rates of between 30% and 75%. Increased drug spending in Ontario is driven by demand from a growing and aging population, not increased drug prices. Prices in Ontario are limited by the Patented Medicine Prices Review Board and average 9% below the international median. In addition, prices have been frozen for over 12 years. According to Statistics Canada, over the same period, prices of food in Ontario have risen 28%; shelter, 29%; and transportation, 56%.

We believe it is critical that the legislation be amended to allow mechanisms for reasonable price increases. This is imperative to allow Ontario to remain competitive not only with other jurisdictions in Canada but with jurisdictions around the world.

By creating the new Ministry of Research and Innovation and taking the role of minister, Premier McGuinty signalled to the world the importance of innovation to Ontario. However, a greater alignment of health and industrial policy is required in order to create an enabling environment for health innovation. It is our fear that, if unamended, this legislation will only serve as a disincentive for further investment in the province by the life sciences industry at a time when the global growth in the sector is increasing. Countries—not just the United States and the UK, but emerging economies like India and China—are fiercely competing for their stake in this critical new knowledge economy.

On behalf of Merck Frosst Canada, I would like to thank the members of the committee for listening to our concerns. We hope that continued consultation and dialogue will produce changes in Bill 102 for the benefit of patients while ensuring ongoing investment in innovation.

Thank you very much.

The Chair: Thank you, Mr. Szabo. Thirty seconds each. For the NDP, Ms. Martel.

Ms. Martel: Thank you for your presentation. What would be a more inclusive definition of "breakthrough," in your opinion?

Mr. Szabo: I think we have to look at a definition that would allow for substantial improvements and not just limit it to therapies and diseases for which there is no existing therapy: substantial improvements in issues of efficacy, tolerability; even quality of life I think would be very important to patients, physicians and pharmacists.

The Chair: Thank you, Ms. Martel.

To the government side.

Mr. Peterson: We have had extensive consultations with you, and you told us early in the process that you

didn't want therapeutic substitution or reference-based pricing. That's not included in this legislation, due to the comments of the brand industry. We thank you for those comments.

We're not going to be allowing, if a new—drugs have to stay the same. They cannot—similarity is to envisage a—

The Chair: I have to intervene there, Mr. Peterson.

To the PC side.

Mr. Cameron Jackson (Burlington): Thank you, Gregg, for your presentation. Are you concerned that this legislation offers no other areas of reform, such as prescribing guidelines or health outcomes, efforts that would help, as you've made the point? But weren't you concerned that this legislation doesn't deal with any of that?

Mr. Szabo: I'm certainly not an expert in exactly what the legislation deals with on that topic, but I do recognize that those are very important aspects. We believe in appropriate utilization of medication. We believe in disease management partnerships amongst a broad range of stakeholders to ensure better use of drugs in Ontario.

The Chair: Thank you, Mr. Jackson, and thank you to you as well, Mr. Szabo, for your deputation on behalf of Merck Frosst.

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PELLOW PHARMASAVE

The Chair: I invite our next presenter, Rosanne Currie of Pellow Pharmasave. Ms. Currie, as you've seen, you will have 10 minutes for your deputation, which begins now. Please begin.

Ms. Rosanne Currie: Hello. My name is Rosanne Currie and I'm pharmacist and owner of two rural pharmacies in southwestern Ontario: Pellow Pharmasave in Walkerton and Lucknow Pharmasave in Lucknow. I have provided a map to you in case you're not familiar with the geographical location.

I have spent my entire career in Walkerton, the community where I was born and raised. I chose the career of pharmacy, specifically community pharmacy, because of my passion to help people. I feel that as a community pharmacist I am a very accessible front-line health care professional and a valuable member of the team.

I am here today to share with you the negative impact that Bill 102, under its current form, will have on my business. Most importantly, I am concerned about the negative impact that this bill will have on my patients. One thing I am that proud about practising in an independent pharmacy is the high level of service that is provided to my patients. The patients in my community rely heavily on our expertise, and not only ask us questions about their medications but also their medical conditions. They come to us for support and reassurance, and even the odd hug. We promote health and wellness and aim for disease prevention. I fear I will not be able to continue to provide the current level of service that is

offered if Bill 102 goes through without any amendments.

The compensation by the Ontario government to pharmacies has been flat over the last 16 years, as mentioned by the coalition. There is no doubt in my mind that the funding we have received from the manufacturers has enabled my pharmacies to provide the patient care services over these last number of years. I am thankful that we have had this source of funding and support, as it has allowed me to take my practice to the next level. With this extra source of revenue I am able to have staff in place to support my patient care initiatives. In fact, I have won several awards across Canada for my service levels and patient care. I won the first-ever Commitment to Care Award for patient care in 1993. I shared the OPA Pharmacist of the Year Award with the other Walkerton-area pharmacists for our contributions during the Walkerton E. coli crisis. I received just last week the DOSA award for owner-manager of the year. I am also very proud to say that my pharmacist in Lucknow will be the recipient of the Pharmacist of the Year Award for Pharmasave at the end of this week. These awards are the result of a lot of hard work and commitment to a profession I am very proud of.

While compensation from the government has remained flat, there have been dramatic cost increases to run our businesses. For example, we need to stock more expensive medications; our staff do deserve pay increases; we need to hire trained technicians and pharmacists and continue to upgrade knowledge and skills; technology has advanced, necessitating updating of hardware and software programs; and we have needed to enhance security systems, let alone the rising costs of rent and utilities and insurance.

The cost of carrying drug inventory in a pharmacy places huge cash flow demands on us. Between my two pharmacies, I have over \$330,000 of inventory sitting on my shelves that I get return on only when I receive a prescription for these medications. As I mentioned earlier, medications are becoming more expensive. And I understand that today Mr. Smitherman announced a renouncing of the \$25 cap. The other thing we need to consider is that if a medication expires on our shelf, we are stuck with that loss, unlike in other businesses where, if a product is expiring, they can blow it out at a reduced price. We can hardly do this with prescription medication.

The transparent Bill 102 is supposed to be for the patient. I feel that in its current form it will be very detrimental to patient care. The reason for this is that if the pharmacy is no longer financially viable, I foresee that staff will be laid off; there will be reduced store hours; we will need to reduce our inventory levels, so patients will have a delay in receiving proper treatment; and not carry expensive medications, because we would be losing money. Staffing levels that are cut within the pharmacy translate to increased wait times for patients and reduced services. Regretfully, I may even need to close my pharmacies if they are no longer a viable business. Between my two stores, we employ 16 full-

time employees and eight part-time employees. Six of these employees are the breadwinners of their families.

As we are front-line health care professionals, many patients seek our advice on a daily basis on prescription medications, but also on health issues, including information on over-the-counter medications, herbal medicines and alternative treatments. Time and time again we hear from our patients that we take the time to listen to their concerns, educate them and assist them with solving their problems. I had a patient recently thank me over and over again for my caring and taking the time to get her back on track with managing her medical conditions. She had fallen through the cracks of the Ontario health system because she currently is an orphan patient without any family physician.

We will no longer be able to provide these services. More people will be referred to the emergency department, and we know that these systems are already taxed. Currently, the emergency department refers people to our pharmacy for advice on various issues.

At my pharmacies we offer valuable clinics throughout the year on topics such as diabetes, arthritis, heart health and osteoporosis. We've held very successful flu shot clinics at both of our stores, with over 400 people attending this past fall. I might add that I lose money on these clinics because it costs me more to provide the service than what the government reimburses me—not a very good business decision, I might add, but I continue to offer this service because I support the initiative. This is a service that I will need to eliminate.

The valuable role pharmacists have to play as front-line health care professionals is testimony in the Walkerton E. coli tragedy. I can't begin to tell you the impact that we had during this tragedy. When pharmacies have reduced staffing, resulting in reduced services, reduced hours of service, or have to close as a result of Bill 102, I wonder how people will cope with the next pandemic. We know that it's just a matter of time. Where will people go for assistance?

Another aspect of my business is that we provide extensive services to our nursing homes and residential lodges within our communities. In addition to supplying these facilities with medications, we are active members of multidisciplinary teams and make recommendations to drug therapy. We perform quality assurance audits, we are an active member of infection control, we prepare so that flu outbreak plans are in place, we provide in-services to staff and families on health-related issues and offer after-hours emergency services, just to name a few. There is talk within the bill that there may be changes within this model as well. If this new model is not viable, I will not be able to provide these valuable services to the elderly in my community.

Another service that we have been able to provide to our customers is home visits. It is not uncommon for our pharmacists to do home visits after business hours, especially if a patient has been discharged from the hospital with a complicated medication regime. Within the current system, oftentimes there is lag time between

the nursing agencies' coming into their homes. We often get called after hours to provide emergency services; in fact, I was called to my store twice this weekend. We follow up on drug therapy. We provide community seminars, pill splitting for the elderly, multi-dose packaging to improve adherence, medication wallet cards and delivery service. I will not be able to provide these services if I reduce my staff or decrease store hours of operation as a result of Bill 102.

In January, my husband and I purchased the building beside our current location in Walkerton in the hope of expanding our pharmacy and the services we offer. We wanted to expand our floor space and provide a more wheelchair-accessible environment, more privacy for our patients and a better work environment for our staff. With Bill 102, we need to rethink these plans.

The impact of pharmacies closing in rural communities: People will need to travel farther to a pharmacy. This will be very difficult for the elderly patient who already has transportation issues. Patients may not receive medication in a timely fashion. Another important point to keep in mind is that we do live in a snowbelt area, so it's not uncommon for highways to be closed.

Small-town pharmacies rely on a large percentage of their business to be generated from prescriptions. I know this topic came up earlier today. We do not have large front-shop retail sales volume or corporate drug plans to generate viable business. Whom will these people turn to now: their family physician, which we now have a shortage of? The emergency room? Is this cost-efficient? Rural communities are struggling to keep their merchants' core viable with the arrival of the big box stores.

Dear committee, please be careful in the full consideration of Bill 102. If passed in its present form, community pharmacy services will change drastically. The pharmacy retail business, especially in rural communities, will be decimated. I trust that the underlying goal of this government is not to remove the entrepreneurship from pharmacy and destroy another staple in these small towns. Please ensure that patient care services are protected, and the viability and sustainability of rural community pharmacies. Pharmacists are the most trusted health care professionals.

I am familiar with the amendments that the coalition is putting forth. I support the amendments presented by the coalition. Thank you for your time.

The Chair: Thank you, Ms. Currie.

You have 20 seconds each. To the Liberal side.

Mr. Peterson: You would be a model pharmacist in terms of providing the extra services, and we are going to be allowing you to bill for those fees. We would welcome someone like yourself to the pharmacy council, as we go forward, to make sure that pharmacists are included as front-line health care workers. Thank you for the example you've set.

The Chair: Thank you, Mr. Peterson. To the PC side.

Mr. Jackson: This would have a devastating effect for the community as well as your business.

Ms. Currie: Yes, it would.

Mr. Jackson: Where would the nearest pharmacy be outside of these two communities?

Ms. Currie: It depends on the impact that this bill would have on the neighbouring communities as well. I'd suspect that people would have to travel 20 to 30 minutes to the nearest pharmacy.

The Chair: Thank you, Mr. Jackson.

Ms. Martel: We hope you have an opportunity to participate in the pharmacy council if the government put the provision in the legislation.

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Ms. Currie: That's right. That's a concern we have.

Ms. Martel: Yes. Secondly, can you talk about your own pharmacy in terms of your business that's storefront and not generated by prescriptions? Can you give us an idea of that breakdown?

Ms. Currie: In terms of the ratio, I would say 80% of the business is generated by the prescription revenue, 20% by the front shop.

Ms. Martel: So this has a big impact.

Ms. Currie: It sure does.

The Chair: Thank you, Ms. Martel, and thanks to you as well, Ms. Currie, for your deputation on behalf of Pellow Pharmsave.

CANADIAN TREATMENT ACTION COUNCIL

The Chair: I would now invite our next presenter, Mr. Rosenes, vice-chair of the Canadian Treatment Action Council, and colleagues, and if you may, identify yourselves for the purposes of Hansard recording. Mr. Rosenes, welcome. As you've seen the protocol, your 10 minutes begin now.

Mr. Ron Rosenes: Thank you very much to the members of the standing committee on social policy. My name is Ron Rosenes. I'm the vice-chair of the Canadian Treatment Action Council, and to my right is Louise Binder, who is the chair of the Canadian Treatment Action Council. We very much appreciate the opportunity today to present to the committee. We're here on behalf of our organization, the Canadian Treatment Action Council. We are a nationally elected NGO that gives policy advice and does advocacy on systemic access-to-treatment issues for people living with HIV and AIDS. We are also a member of GRIP. This is an acronym that stands for Get It Right for Patients, an advocacy coalition of 10 disease groups that you'll be hearing from shortly who believe in the importance of the right drug for the right patient at the right time.

We've been pleased as a member of the GRIP coalition to have had several meetings to bring our specific concerns to the Drug System Secretariat. Many of you probably know a fair bit about HIV/AIDS, particularly the fact that treatment requires a combination of antiretroviral drugs, as well as treatments for side effects, toxicities and opportunistic infections. This

results in very complex polypharmacy and the need for very individualized treatment strategies.

Clearly, HIV has always been an expensive disease to manage in the drug system, and as consumer advocates, we have always acted responsibly to provide the government with advice on cost savings. Therefore, we'd like to say that CTAC supports the overall intention of this broad legislative and regulatory initiative, in particular the intent to increase access through savings to the system and to include a role for patients in both the drug evaluation and policy committees that will be established through the legislation.

There have been, however, a number of areas of particular concern to us as representatives of the HIV/AIDS community, first and foremost the wording in subsection 1.1(3), which expands the ability of the government to designate as interchangeable not only drugs that are the "same" but drugs that are also designated as "similar." This language, as originally proposed, is so broad that it could create significant health and safety risks, in our opinion, for people with HIV due to the high potential risk of drug reactions and also drug-drug interactions.

Additionally, the potential to develop resistance to HIV medications is very high and must be carefully monitored at all times by the physician. In our discussions with the minister as part of the GRIP coalition, we were able to explain the potential health and safety risks of the language being written so broadly. As a result, the minister has agreed to amend the definition to limit the definition of "similar active ingredients" to "binding agents and fillers."

We expressed our concern at the proposal to add section 3 of the bill, which would expand the ability of the pharmacist to interchange drugs that had "similar" active ingredients even where the drug was not designated as interchangeable, and we are pleased that the minister has agreed to remove section 3 and to restore the original subsection 4(5) in the Drug Interchangeability and Dispensing Fee Act.

The other area of particular concern to CTAC is with regard to consumer expertise on the committee to evaluate the drugs and on the policy advisory committee that is also being contemplated. While we are pleased to see the addition of two patient representatives on the committee to evaluate drugs and to the policy committee, we strongly recommend a formal selection process as well as a formal accountability mechanism to be developed to ensure that those patient representatives get input from relevant disease groups for which drugs are under consideration by the committee to evaluate drugs.

We recognize that many aspects of this legislative reform will be dealt with by regulation and policy guidelines, and we are pleased that the minister has agreed to continue to consult on an ongoing basis as these are being developed.

Thank you for your attention. We're pleased to answer any questions that you may have.

The Chair: Thank you, Mr. Rosenes. We have about 90 seconds or so per side, beginning with the PC side.

Mr. Jackson: Thank you, Mr. Rosenes. Is it possible to find out where this wording is? We're pleased that the minister treats you with that kind of respect, but he certainly doesn't with this committee. I wonder if we could get a copy of these amendments that the minister has agreed to. Mr. Chair, could I ask you to formally request that?

The Chair: You can. I will direct legislative research and any others who need to participate in that. Or is it to the—

Ms. Wynne: Mr. Chair, the amendments will be introduced at the time that has already been established by the subcommittee. If the minister has had a conversation—

Mr. O'Toole: Take your own time. Thanks.

Ms. Wynne: Mr. Jackson is asking for something.

Mr. Jackson: This isn't the first time this has come up in the short time that I've been on the committee. There are several of these issues. I think that the sooner we can get them, Mr. Chairman, the better. It's a request for information. I don't expect our deputants to have that answer. I'm pleased that they were getting a straight answer, but we certainly would like to have any of these as soon as possible. I think it's the decent thing to do for everyone else. Thank you, Mr. Chairman.

The Chair: Thank you, Mr. Jackson. We'll try to process that. Ms. Martel.

Ms. Martel: Thank you for your presentation. I just have to say on the record that I would appreciate that information as well. The minister made it public this morning that he was going to make a change and get rid of the 25% cap. That was fine to make public. We didn't see that until after we started the committee, but now we find out there are some more amendments, obviously, and some commitments that he's made. I think the committee has a right to get that. So this has nothing to do with you folks, but it is a matter of—

Mr. Rosenes: We appreciate that. We also appreciate the fact that the timelines have been very tight for us as well. We've had to exert our own pressure to make sure that our voice is among those voices being heard. We may be privy to some information here that's not in front of you yet, but it's still, to our minds as well, a work in progress.

Ms. Martel: We appreciate that.

Mr. O'Toole: Mr. Chair—

The Chair: Thank you, Ms. Martel. I would just like to advise the committee with regard to the question of amendments. As you're aware, June 6, 12 noon is the amendments deadline, and clause-by-clause consideration will be that same afternoon.

Mr. O'Toole, do you have a point of order, an actual point of order?

Mr. O'Toole: Yes, Chair. My point of order would be, if there are reports or consultations, or reports of those consultations, how come the members of this committee don't have them? When we have the minister making announcements outside of this process, it's making a complete sham of these professional people

who are coming forward to us. I'm asking for those reports on those consultations to be tabled with members of this committee, including the amendments or proposed amendments.

The Chair: Ms. Wynne, would you care to reply?

Ms. Wynne: Yes. Mr. Chair, when legislation is in the process of being amended, there are public hearings going on, and the people who have been consulted with by the ministry before the bill was written continue to be talked to. The ministry has relationships with those groups of people, and it's an ongoing process. I think it's a sign of strength that those discussions are ongoing. All of that—what we're doing here and the conversations with the ministry—is what feeds into the final amendments that come forward according to the subcommittee report.

That is absolutely the way it works. When those amendments are ready—and I assume that when the NDP and the Tories have their amendments ready, they'll bring them forward at the same time.

Ms. Martel: To the same point, if I might, I think the issue here is that the minister thinks it's okay to make some of his changes public, which he had no trouble doing at the media availability at 8:45 this morning. He was quick to tell all the media that he was going to make this particular change with respect to the 25% cap. That was fine to relate to people. Now we find out this afternoon that he's made agreements on other things that somehow or other are not public information, and that's what I resent about what's going on here.

Yes, we will all bring forward our amendments, but yes, it's also clear that the minister picks and chooses what he wants to make public. I guess he was trying to get something back in terms of the negative perception that's been out there with respect to this bill, so he makes the announcement that he does this morning. And that's okay, but now we find that other commitments have been made, but we can't get copies of that. That, for me, is what the issue is; that's what I disagree with.

1750

The Chair: Thank you, Ms. Martel. As Chair of this body, I can only say that the parliamentary assistant to the relevant minister has heard these remarks, and it is at his leisure what to do with it.

Mr. O'Toole.

Mr. O'Toole: I'm also just putting on the record at the indulgence of the Chair here that the Coalition of Ontario Pharmacy today made it very clear that they have been unable to meet with the minister. So what is the price of admission? Do you have to buy a fundraiser ticket? That's the implication. It's Let's Make a Deal. Do you understand what I'm saying?

Mr. Rosenes: May I please respond to that?

Mr. O'Toole: I'm not really posing it to you; I'm posing it to the Chair.

The Chair: I'll ask you, sir, to bring your remarks to a close within 30 seconds, please.

Mr. Rosenes: I would just like to emphasize and make sure that everyone understands that both Louise Binder and I are volunteers who are elected by a national

constituency to do our best to make our voice heard from our community, and that is all we have done. We have sought, as community members, to get a meeting with the Drug System Secretariat, and we are simply appreciative of the fact that we have been able, and not without a lot of asking, to get our voices heard.

The Chair: Thank you, Mr. Rosenes. Thank you, members of the committee, for your questions and comments on these issues.

GET IT RIGHT FOR PATIENTS COALITION

The Chair: I would now invite on behalf of the committee our next presenters, Mr. Frank Viti and Louise Binder of the Get it Right for Patients Coalition. I invite you to please begin.

Ms. Louise Binder: Thank you very much. My name is Louise Binder. I'm the chair of the Canadian Treatment Action Council and I am a member of the Get it Right for Patients Coalition. I'm also a woman living with HIV/AIDS. I repeat what my colleague indicated, which is that all of my work is done as volunteer work. I don't belong to any political party, and I didn't buy any tickets for anything.

Just so you know, the Get it Right for Patients Coalition is a 10-member organization. That 10-member group came together in a very short period of time as a result of this particular legislation because we, like all of you in this room, are concerned that Ontarians deserve a drug system that will give patients better access to the drugs they need and also give taxpayers better value for the money we spend. While we are certainly concerned about all of the other stakeholders in this process, by far our greatest and really our sole concern is with patients.

We became a unifying voice to protect the interests of the current legislation where we see it as a good piece of legislation, and also to take a look at Bill 102, which, in a number of ways, we also think has very many benefits for patients in this province, although it certainly isn't without the need of some changes to it.

We're very pleased to see the end of generic rebates. That's been a problem for a long time in this province. We're also very happy to see the streamlining of the section 8 process, which has held up a lot of important drugs that people have needed and has wasted a lot of doctors' time in filling out unnecessary paperwork for those patients. We're actually quite in favour of the creation of an executive officer, rather than the cabinet process that was previously in place, to make decisions about these drugs. Most of all, perhaps, is the inclusion of the patient voice in the committee to evaluate drugs and the creation of a citizens' council, also an opportunity for patients to have a voice.

We're also very pleased to see more of a recognition of the role of our pharmacists. They certainly do have an important role, greater than the counting of pills. They're very, very knowledgeable experts on medications. Certainly, we're glad to see them have a greater role.

There are two primary concerns that we do have with this legislation. They deal with the "interchangeability"

language in the legislation and some aspects of concern around the accountability of the executive officer. I'm going to allow my colleague Mr. Viti to take us through those two areas.

Mr. Frank Viti: Specific to interchangeability, the Get it Right for Patients Coalition was highly alarmed by the initial language in Bill 102 that would, we felt, expand the interchangeability to include similar drugs, not only same-to-same drugs. We also were concerned about the new dispensing powers that would be extended to the dispenser, or pharmacist, which we felt would allow automatic switching of drugs, even when they were not designated as interchangeable and were similar. So that has caused us a lot of concern over the last two weeks.

Once again, we have concern with an issue specific to what accountability or re-review process exists when the executive officer has deemed a drug not to be listed on the formulary.

With those two areas of concern, we engaged in a comprehensive discussion with the minister and members of his staff. We want to thank, first and foremost, the minister and every member of his team for finally listening to the patient voice. As patients, we have only come together as a coalition recently. We were welcomed, and they have been listening to our issues and concerns.

Moving forward, we believe that the Get it Right for Patients Coalition and the minister, as of today, have an understanding—we don't have any documents, but we have an understanding—that the minister and his team are committed to protecting patients' health and that there will be some changes in terms of interchangeability. We are confident that the current DIDFA legislation will protect patients when drugs, on the rare occasion, are deemed similar, and that the no-substitution clause will end up protecting, on most occasions, patients' health.

We have helped the minister think through a mechanism that will work to have a re-review of a negative decision specific to the executive officer not listing a drug. We will continue to work with his team specifically toward a process that we're confident will protect patient health.

Finally, we want to outline four specific detailed recommendations for your committee to consider that we think would make Bill 102 a very strong piece of legislation, and which would not in any way compromise health outcomes. We'd like to take you through these four very detailed recommendations.

First and foremost, an amendment, subsection 1.1(3.1), which defines similar active ingredients for the purposes of interchangeability in subsection 1.1(3): We would recommend strongly the adoption of these new definitions of interchangeability. Basically, the bottom line is that no interchangeability for same-to-same and same-to-similar drugs without the no-substitution protection will be protected. No substitution when chemical entities are not the same would also be protected.

The second issue, the deletion of section 3: Louise, maybe you can take us through it.

Ms. Binder: One of our concerns was that it appeared that the legislation, at first reading, was going to give an opportunity for pharmacists to automatically interchange a drug for another drug that was similar but not the same. In discussions with the minister, we explained the potential safety and health outcome risks, particularly for some very serious disease groups that use a lot of different medications, and where those medications are actually somewhat similar but have a very different interaction with patients. The minister, as I understand it, is considering the removal of the section in Bill 102 that was going to expand the pharmacists' interchangeability powers back to the original language in the legislation. So we're very pleased to see that, because we think that's a much better protection for patients.

Mr. Viti: Specific to section 6 of the bill, we wanted to have some clear language that says that nothing should be construed as allowing therapeutic substitution within Bill 102. We'd like to see in section 6 an amendment that states clearly that the act, or DIDFA, should never be construed to permit therapeutic substitution.

Finally, on breakthrough drugs.

Ms. Binder: Breakthrough drugs are very important for illnesses that are life-threatening or for very serious chronic and debilitating illnesses. At the moment, we really wait far too long to get breakthrough drugs approved for reimbursement in Ontario.

The proposal that we have made to the minister, and which is being considered, is that breakthrough drugs will be defined as those drugs which demonstrably improve serious health outcomes. We'll include in that definition demonstrable quality-of-life indicators, so that people can in fact go back to work and be fully functioning members of our society, our community and our economy. That is language which I believe you will see coming forward through regulation and we would strongly recommend that that kind of language be accepted by your committee as something the minister should adopt.

1800

Mr. Viti: Finally, we just want to acknowledge the minister and his team's invitation to help him through the regulation policies and procedures process over the long term. As a coalition of patient organizations, we accepted the minister's invitation.

The Chair: Thank you. We have minimal time for each side, beginning with Ms. Martel.

Ms. Martel: You said that the definition of "breakthrough" is going to come by regulation. I wonder if you'd like to see that in legislation.

Ms. Binder: I would certainly always, of course, prefer to see as much in legislation as possible, for obvious reasons.

The Chair: To the government side.

Mr. Peterson: You have indicated that you are happy that the rebates are being eliminated, even though many pharmacists came through and said this is a death knell of their industry. Would you expand on that for me?

Ms. Binder: Yes. I don't think that the issue of rebates is the appropriate way to respond to dealing with the generic drug industry in its relationship with pharma-

cists. Why is it that we, in this country, pay the highest generic drug prices of any other industrialized country?

The Chair: To the PC side.

Mr. Jackson: I'm fascinated that anywhere from a quarter of a billion to half a billion dollars in cuts will be experienced, predominantly by the innovative research drug manufacturers in this country. They've been hugely helpful to the AIDS agenda and the changes there. Much of the new, innovative drugs will move to other jurisdictions, hopefully in Canada, where we can put clinical trials in place. Are you not concerned about that aspect of the impact of this legislation?

Ms. Binder: I'm not convinced that that is going to be the impact of this legislation. There's not very much R&D done in this province right now and I'm not convinced that that is actually going to be the impact.

The Chair: Thank you to you both, Ms. Binder and Mr. Viti, for the deputation from Get it Right for Patients Coalition.

CANADIAN AUTO WORKERS

The Chair: I'd now invite, on behalf of the committee, our final presenter of the afternoon, Canadian Auto Workers: Mr. Paul Forder, director of government relations for CAW, and colleague. Gentlemen, your time begins now.

Mr. Paul Forder: Thank you very much, Mr. Chairperson. We do appreciate an opportunity to come before this committee. We wish Dwight Duncan wouldn't have the temperature so warm in here. We're not going to tax your patience. We know you've heard probably about everything, but we do want to lend our support, very publicly, to the government and this bill, this initiative, especially as we see the baby boomer bulge moving through the system. This is an initiative that is long overdue.

I'm not going to read our submission. You have it. We can go through it. I'd rather point out a few points. With me is our researcher, Corey Vermey, who's on the health file for the Canadian Auto Workers. We have a lot of experience in negotiating drug plans. It becomes increasingly more difficult as we move through this modern day of globalization, trying to ensure that coverage is there for people in their twilight years. We see this initiative as very positive, very helpful and very timely.

The real issue here for us is we've had an experiment since 1993 with the big three, General Motors, Ford and Chrysler workers, together with our partner, Green Shield, a not-for-profit organization. We've moved into a conditional formulary plan and we have had no problems whatsoever. You've heard from Dave Garner, the CEO of Green Shield today, and I just confirmed with him again: absolutely no problems. Where a physician demands a particular drug, it's not questioned and it's accepted. But for the most part, our people want a drug that will do the job and at the same time don't want to have it enormously costly for even those who are covered, because there are only so many dollars to go around when you're trying to expand the plans and

you're trying to negotiate collective agreements with our employers, and that's just since 1993. So we see this as very positive, very similar to where the government is moving and we think it makes a lot of sense.

We want to stress the awareness program: promoting appropriate use of medication. In our organization, together, again, with Green Shield, we've created what we call the medication awareness program. What that does is absolutely fascinating. I was in charge of the retired workers' department for several years at the CAW. We would bring in pharmacists and we would tell people to bring all of their medication to their physician. It was absolutely mind-numbing, the drugs they would have. They would bring in satchels of drugs, many that were incomplete prescriptions that demanded that they use all of the medication in order for it to be effective, conflicting drugs prescribed by different physicians—they'd been travelling or on vacation or in Florida. It was just an absolute nightmare, a chemical disaster walking with our seniors.

We tried to emphasize that they carry this card with them all the time, wherever they go, so that whatever happens to them, they can turn to any physician, any health care specialist, and he or she will know what kind of medication this person is on and they'll be able to appropriately assess it and not prescribe conflicting drugs. That has got to speak well for enhancing the health of seniors, retired workers, where this program is in effect.

We don't see any value in trying to play footsie with those who would rather spend all their money promoting name brand drugs. It doesn't make any sense to us, because when you spend more on name brand promotion than you do on research and development, that says something about how inadequate the system is. We think it's an appropriate step to move in this direction. It will save many dollars for the health care system. This is the fastest-growing expenditure now, as we all know, in public and private health care, and you've got to get control of it. We salute the government for taking this initiative. Of course, we would like to see a national pharmacare program where people down the road would never have to pay for a drug, and that's something we'll continue to push for in the future, as a trade union concerned about all people having access to medically necessary drugs to enhance their lives, protect their lives and ensure that their standard of living and health is maintained always.

Mr. Corey Vermeij: If there are specific questions—I know there are a number of nuances that are probably not captured in our submission in regard to comments made today by the minister, the issue of interchangeability being one of those elements.

I was just in attendance at a national pharmaceutical strategy stakeholders' consultation being held today, and in the room were a number of the larger Ontario employers—Inco and Canada Post being two that come to mind—and a number of other representatives from the Ontario Federation of Labour and ourselves. It's clear that there is considerable effort under way nationally that

has flowed from the Romanow report, the Kirby report, the federal-provincial-territorial first ministers'-deputy ministers' efforts to move forward, and we applaud Ontario because you have a piece of legislation before us that is very much keeping in step with, if not ahead of, the national pharmaceutical strategy. So I think that's to be noted. It's not the complete answer, but it is a very significant answer to the rising costs of drug spending and the sustainability, which is a question we have to answer if we're going to also answer the question of access for those who are not under public coverage, who are paying out of pocket and those particularly who do not have unions that can bargain fairly significant benefit packages, including drug coverage. That's a significant number of people in Ontario, and we don't lose sight of their interests either.

The Chair: Thank you, gentlemen, for your deputation. About a minute per side, beginning with the Liberals.

Mr. Peterson: Thank you very much for making your presentation. This whole drug reform was driven by two things: First, the industry asked for reform; the rebates had gotten so large that they say it's unwieldy. Secondly, we needed to contain some of the costs of the medical system so we can maintain one tier. Everyone knows that one of the great reasons for investing in Ontario by the automobile industry is the inexpensive nature of our health care system. It's so much less expensive than other jurisdictions.

Your organization and many organizations have gone for generics first. Can you explain that policy to us?

Mr. Vermeij: It's very clear that the US auto manufacturers have claimed that their health care costs as a component part of an automobile is US\$1,500. The comparable cost in Ontario is, I believe, \$125 per vehicle. So it's an enormous differential. Even as the exchange rates have worked against the provincial industry—

The Chair: With apologies, I will have to intervene there. To the PC side.

Mr. O'Toole: Thank you very much. Just a couple of things. Everything I read about today as one of the competitiveness issues is the more recent discussion in the auto sector, problems with pensions and hangover liabilities of the benefit plan. In fact, UAW, your partner in the States, just passed a resolution to diminish services to retirees. I can tell you, having worked for 12 years in personnel with General Motors in Canada, that they will be doing exactly the same thing. Governments delist stuff like chiropractic, like physiotherapy, like optometry. It goes onto the employer's cost of benefits and, as such, they're becoming unaffordable. In fact, your competitiveness was recounted today by the Robarts Research Institute, which said that the auto sector is no longer competitive. If you're reading anything, irrespective of what you've said, this is a serious challenge. The costs of drugs are going up, regardless if they're generic or name brand. I'm surprised at your support for this legislation. I'm shocked.

The Chair: Thank you, Mr. O'Toole. The floor is now Ms. Martel's.

Ms. Martel: Thanks for being here today. I have this question. One of the other goals that the minister has stated on different occasions about the bill is to find cost savings so that these savings can be reinvested back into the Ontario drug plan, but I note that in the legislation there is no provision to say that any savings that are achieved will be reinvested into the drug plan, which of course makes me concerned that the money is going to go to the consolidated revenue fund. Do you think that if the government meant what it said, we should be seeing an amendment that says, "Cost savings from this bill are going to be reinvested into the Ontario drug plan"?

Mr. Forder: I wouldn't suggest that every time a government initiative makes a saving, it has to be redirected

back into that particular program. All kinds of funds are collected and should be appropriately earmarked for the need. That's how I'd deal with that one.

Mr. Chair, could I respond to Mr. O'Toole's comment, briefly?

The Chair: Mr. Forder, I'd like to inform you that your time has now expired. You're welcome to confer with him privately afterward. I'd like to thank you on behalf of the committee for your deputation from the Canadian Auto Workers.

If there is no further business from members of the committee, this committee stands adjourned until 9 a.m. on Tuesday, May 30, in this room.

The committee adjourned at 1813.

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Vice-Chair / Vice-Président

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Mr. Tim Peterson (Mississauga South / Mississauga-Sud L)

Mrs. Maria Van Bommel (Lambton–Kent–Middlesex L)

Mrs. Elizabeth Witmer (Kitchener–Waterloo PC)

Also taking part / Autres participants et participantes

Mr. Cameron Jackson (Burlington PC)

Mrs. Elizabeth Witmer (Kitchener–Waterloo PC)

Clerk / Greffier

Mr. Trevor Day

Staff / Personnel

Ms. Lorraine Luski, research officer,
Research and Information Services

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