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Mardi 30 mai 2006

Standing committee on social policy

Comité permanent de la politique sociale

Transparent Drug System for Patients Act, 2006

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

Chair: Shafiq Qaadri
Clerk: Trevor Day

Président : Shafiq Qaadri
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 30 May 2006

Mardi 30 mai 2006

The committee met at 0901 in committee room 1.

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.

ONTARIO PHARMACISTS' ASSOCIATION

The Chair (Mr. Shafiq Qaadri): Ladies and gentlemen, colleagues, I'd like to call this meeting of the standing committee on social policy to order. As you're all well aware, we're here to deliberate on Bill 102, An Act to amend the Drug Interchangeability and Dispensing Fee Act and the Ontario Drug Benefit Act. On behalf of all my colleagues here at the Legislature, I'd like to welcome you.

I'd now formally like to welcome our first presenters of the day. They are Mr. Marc Kealey, CEO of the Ontario Pharmacists' Association, who's joined by his colleague, Deb Saltmarche, vice-president, professional affairs. I would respectfully remind all those who are listening that the 10-minute rule is in force. Any time remaining afterwards will be distributed evenly amongst the various parties. As there's an extraordinary interest in this bill, as you can imagine, the timing, as I say, will be very strictly enforced.

Just to inform the audience, there is an overflow room next door. Your 10 minutes begins now.

Mr. Marc Kealey: Good morning, Mr. Chair, members of the committee and guests. My name is Marc Kealey and I'm the CEO of the Ontario Pharmacists' Association. I'm joined here this morning by my colleague Deb Saltmarche, who's our vice-president of policy and professional practice at the Ontario Pharmacists' Association, and she's also a pharmacist.

Yesterday, this committee heard the facts from individual front-line pharmacists across Ontario. One by one, they put their businesses on hold for a day and came here to tell you what will happen to them and their patients if Bill 102 goes through in its current form. Let me summarize what they said: People across Ontario will find pharmacies reducing their hours, laying off staff and cutting the patient care services they provide. Some people will be without a health care provider in places where the only health care provider, or the most accessible health care provider, is a pharmacist who is forced out of business.

On April 13, when I participated in Minister Smitherman's announcement of Bill 102, I warned that this situation could occur. Let me quote my own words from that day: "We do have cause for concern on the future sustainability of pharmacy."

At that time, we at OPA chose to emphasize both the dangers of Bill 102 and the successes and advances it contained for the pharmacy profession in this province, and let me say why.

For the first time, the bill brings pharmacists recognition of their professional skills and abilities and their capacity to serve in new ways as front-line health care providers and be reimbursed for doing so. That represents a tremendous step forward for pharmacists, and there needs to be recognition and support for making this happen in Bill 102. In fact, our association has been fighting for 16 years to realize these goals.

Since the introduction of Bill 102, we have been insistent and relentless in our demands that the government provide clarity and transparency in its assessment of the impacts of Bill 102 and address the concerns we have raised from the start about the sustainability of our profession.

The litany of heartfelt reports and pharmacy-by-pharmacy analysis you heard yesterday and will continue to hear today demonstrates that those concerns have not yet been addressed. Instead, they have escalated from concerns to fears to warnings of dire consequences. In the absence of clarity and understanding, what we've seen fill the vacuum is fear and apprehension. We've seen from some quarters unsubstantiated and exaggerated claims about the impacts of Bill 102, numbers not backed up by facts, and tactics that generate noise but not solutions.

OPA's approach to Bill 102 has been to work within the process in good faith to achieve the government's stated objective: to ensure the sustainability of the drug system for all Ontarians. I know this is a goal that crosses

partisan lines. For that reason, OPA comes here today to the members of this committee with solutions that will fix Bill 102. Other presentations yesterday, today and on June 5 are spelling out problems. We're here to share with you amendments to the bill that represent our answers.

The situation we face, as you have heard, is that this bill threatens the sustainability and financial viability of pharmacy. Specifically, OPA calculates a real-world net loss of $269 million to pharmacy in Ontario. We base this calculation on the proposed elimination of rebates at a rate of 60% from generic manufacturers, coupled with the 20% level of reinvestment in professional allowances proposed by the minister at our annual general meeting on May 13.

As individual pharmacists have described to you, a loss of this magnitude means anything but business as usual. It means across-the-board reductions in the services pharmacists provide or it means non-sustainable pharmacies. Non-sustainable pharmacies mean patient access to medications is put at risk, and frankly, in 2006 in the province of Ontario this is an unacceptable proposition.

Bill 102, as I noted on April 13, proposes to reimburse pharmacists for providing value-added professional services. But community pharmacies are businesses, and those businesses must remain viable if the pharmacists who run them are to deliver these services to patients and ensure access to medications.

We are here today with this committee and the government to provide specific amendments to Bill 102. Our aim is to enable further improvements through the regulations and to ensure we have both a sustainable drug system and continued access to pharmacists' services and medications for patients. We want to assist the government to meet its patient care objectives: improved health care outcomes and increased accessibility of health care services.

I want to elaborate our proposed amendments this morning with reference to four key issues: ensuring immediate and long-term sustainability; entrenching the pharmacy council in Bill 102, as well as OPA's role; clarifying and making transparent certain crucial issues for pharmacists in the wording and intent of the bill; and defining the regulatory process and fully engaging OPA as a partner with the government in the regulations.

To ensure sustainability, we propose amendments to Bill 102 to define and differentiate rebates and professional allowances and to institute a robust code of conduct. The provision of professional allowances by generic drug companies and their acceptance by community pharmacists must continue, because it provides the financial basis for the provision of many professional services and supports the nuts-and-bolts infrastructure of community pharmacy, and frankly, this drives efficiency in the health system. The abolition of professional allowances is not adequately compensated by other measures in Bill 102, and this unbalanced equation is, in our opinion, the Achilles heel of otherwise progressive and useful legislation by this government. We further propose that no limit be placed on the level of investment permitted under the code of conduct governing professional allowances.

0910

There's a clear choice here: The only alternative to this approach that will ensure continued access to pharmacists' services is a further increase in the dispensing fee to nearly $11.

In the regulations, we have specified amendments to remove the $25 cap on the markup in order to ensure patient access. We were pleased to learn from the minister yesterday that this amendment is now advocated by the government. We also seek to ensure that the negotiation of reimbursement and dispensing fees is addressed in the regulations in a manner supportive of the sustainability of pharmacy.

On the pharmacy council and the role of the OPA, we propose that Bill 102 be amended to entrench the council and to define it, and to include in its duties the definition and implementation of professional services. We propose amending the bill to recognize OPA as the exclusive agent for pharmacists in Ontario and to specify that all fees and other components of reimbursement shall be determined through negotiations with the Ontario Pharmacists' Association. The composition of our organization, as evidenced in the broad-based nature of our board, enables us to be truly representative of pharmacists and pharmacy. And at these hearings, you are hearing pharmacist after pharmacist steer you toward OPA for the well-considered solutions that our amendments to Bill 102 represent.

Certain crucial issues for pharmacists must be addressed by clarifying and making transparent the language and intent of Bill 102 through further amendments we propose.

On interchangeability, we are calling for a definition in the Drug Interchangeability and Dispensing Fee Act, of DIDFA, of "similar" drugs; for the listing of off-formulary interchangeability, or OFI, drugs in a part of the formulary; and for a delay in the implementation of the changes on interchangeability to ensure the indemnification of pharmacists.

We are seeking clarity on the process for defining exceptional access and conditional access drugs and assurance that these medications will be listed and reimbursed appropriately.

Finally, our amendments call for defining the regulatory process and fully engaging the OPA as a partner with the government in developing the regulations associated with Bill 102. To date, the draft regulations, time and consultation plan are unknown. These regulations cover the dispensing fee and the reduction on the markup. As a result, in spite of our best efforts, we have yet to establish a full sustainability evaluation of the impact of the regulations associated with the bill.

These amendments represent OPA's solutions to the problem with Bill 102 that we and so many individual pharmacists have identified. We will be submitting our detailed amendments by Friday. We ask that this com-

mittee move forward to accept and implement what we present as carefully considered and workable solutions that will fix this bill. We wish you luck in your deliberations.

The Chair: Thank you, Mr. Kealey. I would like to thank you on behalf of the committee for your deputation on behalf of the Ontario Pharmacists' Association. Should you have any written materials, please feel free to leave those as well with the committee clerk.

GREG STREPPEL

The Chair: I would now invite our next presenter, Mr. Greg Streppel. I invite you to come forward. I understand you'll be using PowerPoint, so I'll give you a moment or two to set that up and then we'll begin.

Mr. Greg Streppel: Good morning. Thank you for your presence here today. My name is Greg Streppel. I'm a community pharmacist with a practice in Elmira, Ontario. I'm going to discuss my pharmacy and the services we provide, my concerns regarding Bill 102 and the impact I believe it will have on my pharmacy and my clients, and some suggestions for the committee.

I am one of the co-owners of Woolwich Centre Pharmacy. We're an independent, patient-focused pharmacy. We service a largely rural community about 15 minutes north of Kitchener-Waterloo. Our clients include the usual walk-in folks from the immediate community, five retirement and group home residences, rural people, including a large Mennonite community, and the physicians and other health care providers in our community. We employ one full-time pharmacist and five part-time technicians. We don't sell perfume, potato chips or soda pop. The services that we do provide include prescriptions and OTC medicines, with the appropriate counselling for those products. We also provide, at no cost, first aid, wound management and herbal remedy counselling, clinical services such as diabetes and insulin management for our retirement home clients, medication review and drug concern resolution for all our clients, and referrals to other health care providers when appropriate.

Other services that we also provide at no cost include dossette and compliance packaging, blood pressure monitoring, glucose monitor teaching, rural delivery, a drug information service for health care professionals in the community, our annual flu and West Nile disease prevention campaigns and smoking cessation guidance.

Minister Smitherman has stated that Ontarians have not received good value for the drug budget expenditure. I can't imagine this statement reflecting pharmacy services. No other profession is more accessible and provides so much for so little.

My main concerns with Bill 102 have to do with the very specific ways in which it will intend to decrease compensation to pharmacists, namely, a reduction in the allowable markup from 10% to 8% and the elimination of generic allowances.

While the reductions in revenue are spelled out very clearly, the bill's promise to protect pharmacies from drug price increases from companies and the promise to pay pharmacists for cognitive skills are largely undefined. This makes most independent pharmacists very scared due to the uncertainty.

Another aspect that worries me is that the bill is meant to save public money by governing how prescriptions for Ontario drug benefit clients will be handled. The truth is that we can't have one drug price for a senior and another drug price for other folks who don't access the Ontario drug benefits, so the consequences of the bill go far beyond seniors and people who receive social assistance.

Additionally, other insurance payers will follow the precedent set by the ministry. They will say, "If government is only paying so much for this, then that's all I'm going to pay too." We have ample evidence of this already in practice.

What this means for our clients and patients is that, in order to try to be viable, we'll have to reduce our hours of operation, lay off staff and reduce or eliminate many of the patient care services that we provide, which are substantial. This will result in poor outcomes for our clients and patients.

In its current form, the bill will make my practice nonviable. Many other independents are in the same position. If a lot of us close, what you'll see is a shift of clients to high-volume, low-service pharmacies. That will leave many patients under-serviced and overburdened to access their medications and timely drug information. This will in fact result in greater long-term costs, not savings, because with less access to pharmacists, patient visits to physician offices, clinics and hospitals will increase. Greater costs will also result from the suboptimal drug management of chronic diseases like diabetes and asthma. You'll see those costs accumulate not in the next year, but maybe in two years, five years, 10 years. Also under in this scenario, another consequence will be the net migration of pharmacists out of Ontario to other jurisdictions. This will exacerbate the current pharmacist shortage.

I have some suggestions to make to the committee. I would like to see the committee urge the ministry to work with the OPA to clarify and define unclear aspects of the bill, which are causing so much uncertainty. I would also like you to urge the ministry to ensure that pharmacies are viable. We have families to support, and our work has value and deserves fair compensation. Lastly, I would like you to urge the ministry to develop better physician education initiatives to improve prescribing patterns. One such initiative that we could borrow from is called the therapeutics initiative, located in British Columbia. It has provided evidence-based best-practice information for drug utilization to physicians and pharmacists in that province for 10 years.

Thanks for your attention. I can answer any questions.

The Chair: Thank you, Mr. Streppel. About a minute each side, beginning with the Conservative side.

Mrs. Elizabeth Witmer (Kitchener–Waterloo): Thank you very much for coming here from Elmira. You must have fought the traffic, as I did, this morning.

I do appreciate the presentation you've made. You focused, in your suggestions, on number 3, the improvement in prescribing patterns. That is one of the things that is totally lacking from the bill. You feel that it is an initiative that could have an impact on—

Mr. Streppel: Yes. We've seen this in other provinces, in British Columbia and Saskatchewan, where there have been initiatives that have tried to improve prescribing patterns by providing unbiased information to physicians. I think physicians are dealing with life and death situations every day. They probably don't have as much time as we would all like them to have to know drug therapy to its best extent, and they receive a lot of biased information. If we could have some kind of initiative to provide them with unbiased information, make a selection that economically makes sense and is in the best interests of patients also, that would work to some degree to alleviate the increase in the drug budget, which we all know is unsustainable.

0920

Mrs. Witmer: And we've heard that from a couple of people.

The Chair: Thank you, Mrs. Witmer. We'll now offer the floor to Ms. Martel of the NDP.

Ms. Shelley Martel (Nickel Belt): Thank you for being here this morning, Greg. If I can paraphrase you correctly, you've said that the reductions in revenues are spelled out clearly in the bill but the new compensation package is not defined. It's kind of like buying a pig in a poke, because you know what you're losing, but you have no idea of how you're going to gain what the government promises to give you.

There's a $50-million package out there essentially for cognitive services. I don't know how that's going to be divvied up. There are lots of pharmacists out there. I'm not sure how far $50 million is going to go to actually pay for the services you do. When you're providing cognitive services, I assume you're going to need someone else in your pharmacy to carry on your other work while you're trying to provide cognitive services to some of your patients.

So in terms of what you see, what are your concerns? The government is saying, "Don't worry. We appreciate the role of pharmacists," but the bill is essentially null and void in terms of what that new compensation package is going to be.

Mr. Streppel: It hasn't been spelled out clearly. There's quite a big shortfall with the reduction in allowances. The reduction in allowances is not currently being made up with the cognitive services package, the money has been earmarked so far. Also, the dispensing fee increase is inconsequential. So there's a big deficit there, and there's also no way to know at this point how that money is—

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

Mr. Tim Peterson (Mississauga South): Thank you very much for your presentation. I compliment you on the full range of services that you're providing at your pharmacy. As you know, through these cognitive services, we want to remunerate those, and we take seriously your suggestion that those be better defined. Mr. Kealey, the CEO of OPA, whose organization I think we've met with over 30 times, also has pointed this out to us, and we'll work on this.

We also have gone forward with giving you a full 8% markup. That 8% markup was previously met by price increases, and we intend to restore that for you as well as increase your fee with the cognitive services. As well, we're talking about an education allowance. What is the volume of the rebates that you've been looking at for your pharmacy?

Mr. Streppel: The volume of rebates probably approaches between 5% and 10% of our revenue.

Mr. Peterson: That's on your total revenue?

Mr. Streppel: Yes.

Mr. Peterson: Do you want to keep that information confidential, or can you be a little more specific for us?

The Chair: Thank you, Mr. Peterson. Regrettably, that question will have to remain rhetorical for now.

Thank you, Mr. Streppel, for your presentation and your audiovisual support.

MAIN DRUG MART GROUP

The Chair: I'd now like to welcome to the committee Mr. Maher Mikhail, manager of Main Drug Mart. Mr. Mikhail and colleagues, please come forward. As you've seen the protocol, you have 10 minutes in which to make your presentation, which begins now.

Mr. Maher Mikhail: Honourable members of the social committee—Chair, Vice-Chair and committee members—good morning. My name is Maher Mikhail. I am accompanied by Mr. Gendi, the executive director of Main Drug Mart Group in Toronto.

I am an independent Ontario pharmacist, a Toronto community pharmacy owner, and the executive vice-president of the Main Drug Mart Group, which represents 60 stores in the GTA. I would like to begin by elaborating a little bit on the pharmacy profession.

I love my job and I enjoy every minute of my professional career. My profession is unique: I'm a professional and an entrepreneur as well.

Pharmacy has dramatically changed over the past 25 years, from the 1980s, the time when we were expected to decipher physicians' writing, type labels, count pills, and manually write insurance and ODB claim forms.

These days, more is expected from pharmacists. We keep up with the latest developments and updates in the pharmaceutical and medical fields through continuing education. We guide patients and lead them to learn better control over their health. We educate patients on how to use their medication and devices for a better quality of life and control over their health issues.

Pharmacists are one of the most publicly trusted professions in the world. In an optimal situation, a pharmacist detects, predicts and prevents problems with patients' medications and therapies before they happen. Phar-

macists intervene on their patients' behalf. They are the link between the patient and their physician.

Pharmacists are at the very front line of the health care system. Patients come to us when their doctors are not available or accessible. They come to ask for our advice instead of going to walk-in clinics or emergency rooms.

Patients know that we are always available and accessible. We don't have secretaries to take phone calls or screen phone calls. We don't hide from intruders in back rooms. Because our position is front and centre, pharmacists are more exposed to all kinds of dangers, including drug addicts that come into the stores, shoplifting and sometimes scary hold-ups. No other profession in the health care system is as exposed to these kinds of dangers as pharmacists.

My pharmacy is open seven days a week. I keep the pharmacy open on weekends for the sake of the patients. However, as most pharmacies find, I don't recover my weekend opening expenses. As pharmacy manager, I have one day off, and during that day I'm still on call and in touch with work.

As a health care professional, I feel it's my duty to stock my pharmacy shelves with all kinds of medication so that patient treatment is not compromised by lack of supply. I use my operating line of credit and pay bank interest to stock up on expensive medications for serious illnesses like HIV, cancer and MS so that I may dispense the medication immediately to customers in need of these medications. I buy shelf-stock-size medication, sometimes a 100-tablet bottle to dispense a 14-tablet prescription. I may be lucky and consume it all before it expires. Some expired medications might be credited by manufacturers for part of the purchase price. The non-returnable ones cost me even more money to destroy through the biohazard waste system.

Bill 102, thankfully and finally, recognizes my professional services other than dispensing prescriptions and will reimburse me for those cognitive services that were never recognized before.

Sixteen years ago, the Ministry of Health was paying a dispensing fee that's almost the same as it is today: $6.54 per prescription. It seems that everyone is getting a raise—everyone, that is, except the pharmacists of Ontario.

The Ministry of Health demanded that my claims be submitted electronically, but I had to buy the equipment and upgrade to keep up with the sophisticated equipment of the government's offices, and I was still getting a $6.54 fee. I invest time in senior citizens' homes, educating them about medical conditions that concern most of them, like osteoporosis, diabetes and hypertension, and I am still getting $6.54 per prescription. I have a free delivery system to deliver medications to my senior citizen patients, those with critical illnesses and physically challenged patients, and my dispensing fee is still $6.54.

Bill 102 is proposing to eliminate the actual source of income, the generic inventory allowance, now known as the "nefarious rebate," that we earned from the generic manufacturers for the past 16 years. It was what kept pharmacists going, improving and advancing our profession to serve the public and to close the growing gap between what ODB has been willing to pay and the actual cost of providing services.

An example of this gap is the attached list of 13 pages of generic and brand name medications, in alphabetical order, which was supplied to us by the provider of the dispensary system computer software, ProPharm, showing the formulary ODB prices and the actual acquisition cost based on the wholesaler price list. Please review.

0930

Bill 102 is proposing to increase the dispensing fee after 16 years by 46 cents to $7, which is well below the actual cost of filling prescriptions.

Bill 102 was formulated without proper consultation with our OPA. As a result, it proposed first to decrease our markup from 10% to 8%, with a $25 cap. Thankfully, the ministry realized, and announced yesterday morning, May 29, that the $25 cap is not realistic. In light of that, please fix the rest of the bill.

The viability of my pharmacy is in jeopardy with all those proposals in Bill 102. I may have to take dramatic steps backward: reduce/eliminate my services, reduce hours of operation, reduce my staff and charge extra for non-ODB services—that is, if I manage to stay open.

Pharmacists are only expecting to be compensated fairly in a democratic and free society as dedicated health care professionals and Canadian entrepreneurs.

I'm here today because of our great country's democratic political process that allows me to express my concerns as a Canadian citizen. I am also confident that through the same true democratic political process, this bill can and should be amended to be fair and efficient.

Finally, I would like to emphasize the acceptability of inventory allowance in any and all kinds of businesses and trades, and to emphasize the fact that there is no business anywhere in the world that doesn't allow or keep reasonable margins in order to survive.

Please, honourable members, protect your health care system. Our aging society relies on it. Help our Ontario pharmacists to stay loyal to Canada and Ontario. We don't want to lose our pharmacists to the south, where, in light of what's happening now, it seems more appealing.

Thank you very much for listening.

The Chair: Thank you, Mr. Mikhail. We'll begin with the NDP.

Ms. Martel: Thank you very much for your presentation.

Can I look at your 13 pages, so I'll be clear how this works? Can we just deal with the first one, Aldomet? The ODB price: $15.89 per 100 capsules or pills.

Mr. Mikhail: Yes.

Ms. Martel: And the wholesale price: $20.41?

Mr. Mikhail: Yes.

Ms. Martel: So this would reflect a loss essentially through the whole piece. Am I correct?

Mr. Mikhail: That is correct. This is what we have been getting and this is the price difference. Manu-

facturers submit increased prices to the government. The government doesn't allow it, the ODB doesn't allow it, but the manufacturers go ahead and increase the price anyway, and it's up to us to dispense the medication at a loss or not. We request acquisition costs from the government.

The Chair: Thank you, Ms. Martel, with apologies. I'll have to offer it to the government side now, Mr. Peterson.

Mr. Peterson: Basically, what eroded your 8% markup was the fact of the manufacturer increasing prices and the government not being able to stop it. Is that correct?

Mr. Mikhail: That's correct.

Mr. Peterson: Our only alternative in past legislation was to delist the product because of the way the legislation was written.

Mr. Mikhail: Delisting products is not really a very healthy idea.

Mr. Peterson: That's why we could not eliminate it. The only way we could stop price increases was to eliminate the product. You can imagine the uproar we'd have with patients if we started eliminating the products they've been on. Under the new legislation, we are planning on restoring that 8% markup, and with negotiations through the council for the evaluation of drugs and working with the pharmacy council, ensuring that the 8% becomes a guaranteed markup to you, an improvement of your markup. Do you think pharmacists will trust us to do that?

Mr. Mikhail: If they stay open, if they are still operating a pharmacy, they may trust you to do that, but what we are seeing are a lot of closures coming up, a lot of changes.

The Chair: Thank you, Mr. Peterson and Mr. Mikhail. To the PC side.

Mrs. Witmer: Thank you very much for your presentation. I guess the government's been so successful in sowing the seeds of confusion that you've stated here, "Bill 102 ... is recognizing my professional services"—the cognitive services. I noticed that the OPA says the bill brings pharmacists recognition of their skills. The reality is, folks, there is nothing in Bill 102 that is going to compensate pharmacists for cognitive services.

Mr. John O'Toole (Durham): It's not in the bill.

Mrs. Witmer: It's not in the bill. I think people need to remember that this is simply a promise. There have been so many broken promises on the part of the government. They've taken away the rebates through the professional allowances, but there's no guarantee you're going to get any additional money.

Mr. Mikhail: It's not clear in the bill, and we are waiting—

Mrs. Witmer: It's not there. They've done a good job; even OPA says they're being recognized. Well, not in the bill.

The Chair: Thank you, Mr. Mikhail. Your time has now expired. Thank you as well for your written material.

NOVOPHARM LTD.

The Chair: I'd now like to welcome, on behalf of the committee, Mr. Allan Oberman, president and chief executive officer of Novopharm, and colleagues. I invite you, as you speak, to please introduce yourselves for the purposes of the permanent record, Hansard. I invite you to now begin.

Mr. Allan Oberman: Good morning. My name is Allan Oberman, and I'm the president and CEO of Novopharm Ltd. I'd like to introduce two of my colleagues who are with me today: Terry Creighton is vice-president of government relations, and David Windross is vice-president of external affairs. David also happens to be a pharmacist.

I want to thank the members of the committee for the opportunity to present to you and to respond to the policy issues of Bill 102.

Novopharm is Canada's oldest generic pharmaceutical company, founded by Dr. Leslie Dan in 1965. Our vision is to be Canada's leader in affordable health care solutions. We employ approximately 1,500 people in highly skilled, well-paid scientific positions, most of which are located here in Ontario. We research and develop many new generic products per year, while currently manufacturing over 220 generic medications in over 700 dosage forms.

The medications that we make are generic versions of brand products once the brand's 20-year patent expires. They are equivalent to the brand product in every way in terms of purity, quality, effectiveness and safety. In fact, we make significant investments in clinical studies to prove to Health Canada that the product is equivalent. The only difference is price. Generic medications are priced much lower than the brands, due to extensive generic competition and government pricing regulations.

In the year 2000, Teva Pharmaceutical Industries, a publicly traded, Israeli-based company, acquired Novopharm. This merger made Teva one of the 20 largest global pharmaceutical companies and the largest generic manufacturer in the world. Teva believed, at the time, that Canada was a good place to do business. They had faith in our highly skilled employees and our affordable cost structure. They chose Canada because the regulatory environment was generally supportive of the generic drug industry and we had excellent proximity and access to the US market.

Since becoming a part of Teva, we have invested hundreds of millions of dollars in research and development and capital expansion. We have increased our manufacturing output by over 400% and made significant investments in new buildings, laboratories, equipment and technology, and in our people. We've become a major exporter of pharmaceuticals to the United States and are now starting to export to Europe. In the last three years, we have added over 700 highly skilled, well-paid jobs in research, engineering, production and management.

You know, Canadian manufacturers are often maligned for not making the investments in capital and innovation that will increase their profitability and scale

to effectively compete on a global basis. The investments that Novopharm and Teva have made in Ontario over the last three years have lead us to the point where we can say that we operate one of the largest and most efficient pharmaceutical manufacturing companies in Canada.

A healthy domestic generic industry is very important because we develop and produce essential medications for Ontario's residents at the lowest possible cost. Over the last few years, Ontario has become a global centre of development and production for the generic drug industry. We now rival the brand industry in terms of employment, with over 7,500 employees in Ontario, and we far exceed the brand industry in terms of production levels and new product introductions and in the volume of pharmaceutical exports.

The policy changes in Bill 102 will have a significant impact on Novopharm and the entire Ontario generic drug sector. We understand that the government has attempted to find a fair and balanced way to reduce the costs of the ODB program and to introduce transparency. The government has recognized that generics are a way to provide the best possible pharmaceutical care at the lowest possible cost.

We generally support the intent of the bill, but there are a few key areas where we have concerns. Some of these concerns will be better addressed by the CGPA, the association representing the generic manufacturers, which is scheduled to be in front of you next Monday.

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Today, Novopharm would like to point out two fundamental concerns. First, unilateral price reductions of generic pharmaceuticals, and second, off-formulary interchangeability.

The Minister of Health has announced that Bill 102 will lead to savings of over $269 million for the ODB through a variety of measures. One of those measures is to reduce the price of generic medications to 50% of the brand price. This represents a price decrease of between 21% and 29% depending on the generic medicine. At the same time, over the last 13 years our industry has essentially lived under a price freeze where increases have not been permitted while costs such as wages, electricity, fuel and property taxes, to name a few, have risen dramatically.

Furthermore, Canadian generic prices are already fair and reasonable when compared to other countries. Last year, Professor Joe D'Cruz of the Rotman school of business at the University of Toronto released his study which clearly and unequivocally demonstrated that Canadian generic prices are on par with the United States. This was the most comprehensive study ever completed on thousands of generic medications. The price reduction proposed by the Ontario government will make generic medicines in Ontario much less expensive than anywhere in the world, thereby threatening the continued viability of the generic manufacturing base.

The Ontario Ministry of Health is a participant in the national pharmaceuticals strategy, which has directed the PMPRB to conduct an international pricing study of generic medications. We question why the Minister of Health has unilaterally decided to reduce generic prices without waiting for the results of the study. The unilateral reduction is not based on any proper jurisdictional comparison. Why has he not chosen 55% or 60% or another figure?

Currently, the ODB has a graduated, two-step pricing model for generic medications. When a new generic is introduced in Ontario it is priced at 70% of the brand. The generic price falls to 63% of the brand for the second and subsequent generic entrants.

In this way, the government has provided an incentive to the generic manufacturer who invests in research and development to bring a new product to market quickly for the benefit of all Ontarians. This approach enables the government to benefit from competition between generic manufacturers and pay even lower prices when more than one generic is available. We believe this model makes sense.

The Premier himself has taken on the role of the Minister of Innovation and Development because he recognizes the importance of innovation in the life sciences. When the MARS complex opened across the street last fall, Premier McGuinty said in his remarks, "If we want a culture of innovation, we need to support the risk-takers."

The government has proposed eliminating this two-step pricing policy for generics and replacing it with a flat percentage of the brand price. This will affect the speed at which generics are developed and brought to market because there will no longer be any incentive to be first to market. There will no longer be an advantage to make the investments to speed the introduction of new products. The government will end up paying higher prices for brand products even after their patents expire, because the proposed generic policy will result in there being fewer generic alternatives.

In many other jurisdictions around the world the investment in R&D and innovation is rewarded. On average, generic manufacturers spend 15% of their sales on research and development. Innovation should be rewarded by allowing a higher price for the manufacturer that is first to market. As a comparison, the United States government rewards the development of a first-to-market generic by allowing a 180-day exclusivity period at a higher price for that generic. It's good public policy to have a two-step pricing model for generics.

We encourage the minister to leave the current system of first generics at an initial price of 70% of brand to ensure future generic investments and innovation. As we look to the future, the products that will be coming off patent over the next 10 years will be extremely expensive to develop and we may not be able to produce generic versions at a flat 50% of the brand price while still recouping our costs.

We would recommend that the government retain a pricing model that supports innovation and research and development of generic products.

I ask the committee to direct the Ministry of Health to ensure that the new pricing model for generics continues

to encourage innovation and reward risk-taking. As taxpayers and as patients, we all benefit from a healthy generic pharmaceutical industry.

Our second key message to this committee is not to be taken in by the erroneous claims of the brand companies relative to off-formulary interchangeability. OFI, as it is known, will simply allow pharmacists to substitute generic versions of brand products that have long passed the period of patent protection but simply aren't listed on the formulary. OFI will therefore allow private drug plans and cash payers to take advantage of lower generic pricing. Most of the generic medications subject to OFI have been in the marketplace for many years. The government is merely acting to eliminate a bureaucratic problem that was never the intention of the legislation when it was initially written.

Finally, private payers will be able to take advantage of lower-priced generic medications that have been available for many years, and pharmacists will be able to use their professional judgement to substitute these medications without having to bother the physicians, who are already overworked.

In summary, Bill 102 is an important blueprint for the entire drug system, and it is essential that the government consider all the various components of that system. We believe that a drug plan that offers the best access to generic medications at fair prices compared to the rest of the world and encourages innovation and research will ensure an affordable and sustainable program for the citizens of Ontario. Thank you.

The Chair: Thank you, Mr. Oberman, for your deputation and written material submitted on behalf of Novopharm.

DONNIE EDWARDS

The Chair: I would now invite our next presenter to come forward: Mr. Donnie Edwards. Mr. Edwards, as you've seen the protocol, you have 10 minutes in which to make your presentation, which begin now.

Mr. Donnie Edwards: Thank you, Mr. Chairman, committee members and guests for allowing me the opportunity to present my expert commentary on Bill 102. My name is Donnie Edwards. I am the pharmacist manager at Boggio IDA Pharmacy, a busy, innovative, independent pharmacy in Port Colborne. I have been in practice for 18 years. We have a staff of 35 employees, including six pharmacists and eight technicians.

Port Colborne is a community of approximately 25,000 people with three community pharmacies, 10 family physicians and a 60-bed general hospital with 25,000 emergency visits per year offering a complex continuity of care. Unfortunately, there are a large number of citizens without a family doctor, and those who have a family doctor are waiting a minimum four weeks for a visit. Our small, busy emergency room has a typical four- to six-hour wait. As a result, the pharmacist's role has become one of providing vital triage health care, as you will see by the examples I will provide shortly.

Boggio Pharmacy is known as a pharmacy offering great patient services with the community interest at heart. I reiterate the key words "patient services" and not "customer services." Every individual who enters the pharmacy is just that: our patient. Our motto is, "Be patient with the patient." Therefore, community members have come to depend upon Boggio Pharmacy, firstly for trusted information and advice on all health-related topics, and secondly for safe dispensing of medications.

This trend is strongly revealed in the following research statistics. In a Leger Marketing survey completed earlier this month, 98% of the 1,000 Ontarians interviewed said they trust their pharmacist to give them helpful and accurate information—98% trust their pharmacist. In addition, 88% said they trust their pharmacist to have an open discussion about their health-related questions, whether or not they are medication-related. Therefore, to emphasize how important our currently unpaid cognitive services are and how these depend upon professional allowances, I would like to prove to you the importance of 10 minutes to my patients.

Presenting today in 10 minutes on Bill 102 may not seem long enough for some. However, 10 minutes to a patient seeking advice from their pharmacist on their medication and chronic disease or illness could mean improved quality of life or could even save their lives.

The current government mandate is to increase access and decrease wait times for all Ontarians to health services. Bill 102 will jeopardize both of these if the financial viability of pharmacy is not maintained. To illustrate, with physician shortages, the pharmacists' role as triage personnel has increased dramatically. Brett, a 39-year-old male, woke up with tightness in his chest, nausea and a drained feeling. His physician's office said he could have an appointment in six weeks. In despair, he presented at the pharmacy for advice. After asking a few questions, I recognized his need to be assessed immediately, as he had many signs and symptoms of a possible myocardial infarction. I had known Brett for many years and I realized when he came in that he just didn't look right. Something was wrong, so I called 911. A week later, Brett and his spouse came in to get a number of prescriptions filled and to thank me for recognizing the signs of a heart attack that could have saved his life.

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Likewise, numerous times distraught parents have entered the pharmacy with pills in hand found in their teenage child's dresser, asking if I could identify them. Frequently, these are innocent occurrences and I calm the parents down. However, some incidents have revealed drug addictions that require links to be made to the appropriate resources and caregivers. I am able to respond to these issues in a much more timely manner than many other health care providers.

Similarly, a physician called from the emergency room asking for a patient's medical profile. It seemed this individual lived alone and was found unconscious. Without my immediate medication profiling, this individual's life would be in jeopardy.

An adult male visiting his parent from British Columbia realized his father's memory and cognitive capabilities are declining and asked for my help organizing his medications. I arranged for dosette packaging of medications that go along with a weekly visit from a pharmacy employee to check on the health and welfare of this individual. This individual can therefore live independently for a longer period of time at a lower cost to government resources.

An elderly woman collapses in the pharmacy waiting area. By the time the ambulance arrives, one of my pharmacists has already printed a medication list and has informed the attendant that the woman had been fasting for a religious holiday and was experiencing hypoglycemia, a drop in blood sugar levels.

A local ophthalmologist called me at home late at night one weekend with an emergency. A young boy was hit in the eye with a dart and he required specialized eye drops for the surgical removal of the dart. Despite the late hour, I went to the hospital to use the sterile fume hood and prepared eye drops to help save the child's eye.

Each of these scenarios has a commonality. The pharmacist gave a minimum of 10 minutes of his or her time, without remuneration, providing a positive outcome to each patient. This time could not have been given without professional allowances, as staffing in pharmacies would be drastically cut and consequently patient consultation times would equally suffer. As I'm sure you are aware, these are patient situations which happen in every community pharmacy in every city and town in Ontario. Why? Because pharmacists are accessible and trusted. If changes in Bill 102 are made that impact on the long-term sustainability of pharmacy, these principles could be compromised.

In my profession, allowances from generic companies are invested in many different ways to enhance patient care. An elimination of these allowances would limit my ability to enhance patient services. Some of the services I offer to my community include clinic days focusing on medical conditions such as diabetes, osteoporosis, cardiovascular care and asthma, and flu shot clinics. Concordantly, at a recent cardiovascular risk-assessment day held in the pharmacy, patients booked 45-minute appointments where a nurse would conduct a blood screening of lipid levels, cholesterol, triglycerides and sugars as well as blood pressure and weight. Next, they were able to visit with a dietitian for 15 minutes to talk about their diet. Then they spoke to a pharmacist regarding their medication profile and how to manage their risks. Our pharmacist wrote a synopsis to each person's family physician and called the patient, reemphasizing the key outcomes.

Due to physician shortages, this time allotment is not possible through a physician; however, professional allowances provide an opportunity for these events to occur in a community pharmacy. Consequently, these allowances also permit pharmacists to speak on various health topics in their own communities, whether to church groups, the United Way, city council, physicians or schools. I received a call from a school principal who had a student with a ketamine overdose, called "special K" on the streets. I was asked if I could speak to staff and students on the dangers of drug abuse. After researching the topic, I realized that a presentation to students from grades 7 to 12 would be a great education component in which pharmacists, being drug experts, could speak at schools in their communities. I partnered with a pharmaceutical company and the Ontario Pharmacists' Association to develop a high-impact presentation which I have personally delivered to thousands of students at many schools. Without professional allowances, these student talks could not occur. I could not afford to do them.

Therefore, in the best interests of Ontario patients, it is important not to impose a limit on investment of professional allowances. What would be acceptable is the creation of a transparent and enforceable code of conduct between the generic manufacturers and the Ontario Pharmacists' Association. OPA is recommending this in their approach.

On another note, as the DSS has heard and as is common knowledge in the pharmacy world, the cost of dispensing a prescription is much greater than the $7 being offered.

In my other life, I am the chair of the Ontario Pharmacists' Association, the recognized voice of pharmacists in Ontario. OPA presents an amendment that recognizes its role in policy and implementation of policies for the profession. Augmentation to our dispensing fee will be part of that.

As a most accessible, trusted health care provider, most of my day is spent listening to patients' health concerns and questions, and in turn, providing them with precise and accurate information, ensuring their safety and positive health outcomes. I do this because they are my patients.

Pharmacists are generally compassionate and empathetic individuals. Whether it is answering calls late at night or providing information out in the community, practising pharmacy in a small town where family and friends live is a 24-hour job. Pharmacists are a vital part of every community.

As a passionate pharmacist committed to my profession and my patients, I encourage the government to listen carefully to all concerned parties to ensure a health care system that is not just sustainable but innovative and caring. Thank you very much.

The Chair: Thank you, Mr. Edwards, and I congratulate you on your precision timing.

CLARK'S PHARMASAVE

The Chair: On behalf of the committee, I would now invite our next presenters, Greg Smith and Steve Flexman, owners of Clark's Health Centre Pharmasave. Please come forward. As you've seen the protocol, you have 10 minutes in which to make your presentation. I would just once again inform members of the audience

and all interested parties that there is overflow seating, closed-circuit television, ringside big viewing available in the room next door. Your 10 minutes begin now, gentlemen.

Mr. Steve Flexman: Good morning. My name is Steve Flexman, and with me is Greg Smith. We are both pharmacists and co-owners of Clark's Pharmasave in Simcoe. I'd like to thank the committee for giving us the opportunity to speak with you today with respect to the proposed changes offered in Bill 102.

We own and operate two independent pharmacies under the banner Pharmasave that service Simcoe and the surrounding rural areas of Haldimand–Norfolk. We also provide home infusion services through our contracts with CCACs—community care access centres—for Haldimand–Norfolk and Oxford counties.

We employ close to 70 full-time and part-time people between our two stores. This includes six pharmacists, five nurses and 12 pharmacy technicians. Our locations are both open seven days a week and holidays, and we have a pharmacist and nurse on call 24 hours a day to service our clients. Our customers find us very accessible and always willing to help in any way we can.

Greg and I met at pharmacy school at the University of Toronto just over 10 years ago. We became close friends and dreamed of one day becoming business partners and owning our own pharmacy. In February of this year, four months ago, the dream became a reality and we purchased our two stores from the previous owner, Harley Clark. At the time of the purchase there was much back-and-forth between lawyers and accountants until we all agreed on a reasonable purchase agreement. This price was based on current market practises.

Being new owners for just the past four months, we've been faced with a number of challenges, but none as great as the one posed by the impact of Bill 102 on the financial aspect of our business. In order to purchase the pharmacies, Greg and I have had to take out a substantial loan from the bank, and have commitments to pay back that loan, as well as payments to the previous owner over the next several years. With the proposed changes, the economic environment for pharmacy going forward will be substantially different from the circumstances under which we made the deal to purchase the stores.

That being said, our analysis of the proposed legislation will make it very difficult to meet our financial commitments to the bank unless we make some changes to our operations that unfortunately will affect the level of service we can provide to our patients. We estimate that between our two stores, if the bill is implemented as it currently reads, we will incur a loss of close to half a million dollars in gross revenue annually. This revenue allows us to staff our pharmacies at a level that provides the best possible patient care. This revenue allows us to reinvest in technology and training to provide the highest quality of care to our clients.

Yesterday's announcement to rescind the $25 cap on prescription drug markups is welcomed. This should cut our losses by $100,000, but still taking away $400,000 in revenue on an annual basis will require some drastic adjustments in how we operate our business.

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At Clark's Pharmasave we have made a firm commitment to provide above-and-beyond customer service, and our customers have come to expect this type of service level. We've previously won a commitment to patient care award, a Pharmasave outstanding service award, and we're the second pharmacy in Canada to become ISO 9001:2000 registered. To date, there are only five pharmacies like that in the world. I provide these as examples of our dedication to customer service excellence, not to mention the many local charities and organizations we support.

Some of the services we provide include one-on-one consultations, clinic days, community seminars, blister packaging, free delivery, consultation on home infusion medications and specialty compounding. These services and more are made possible through our arrangements with our generic drug manufacturing partners that allow us to have pharmacist staff available to provide these services. On most days, we have two pharmacists available to provide one-on-one consultation, diabetic meter training, or to simply sit down with a patient and ensure they know how to take their medications properly or solve their drug-related problems.

It's not uncommon for the overburdened physicians in our area to send newly diagnosed diabetic patients to us for instruction on how to inject insulin, lifestyle changes, diet recommendations or meter training. Oftentimes, hospital-discharged patients who, for example, recently had a heart attack will talk to one of our pharmacists about the five to six new medications they've just been prescribed. We'll sit down with them for up to an hour.

We enjoy providing these services and helping our patients. It's what makes being a pharmacist great, but providing them takes time and costs money. We expect that if the bill goes through, we'll have to eliminate this overlap in pharmacist time, which will reduce our ability to provide these services and increase the waiting times for patients to have their prescriptions filled.

We commend the government for recognizing pharmacists as health care professionals and being willing to pay us for cognitive services. However, we need more clarity on what will be paid for, the process for reimbursement and the professional fees that will be allowed. At present, this uncertainty, and the fact that the dollar amount available for cognitive services will not come close to offsetting revenue lost through promotional allowances, has hindered our ability to make investments in the business that will continue to enhance patient care. We ask that you take a hard look at the costs involved in running a pharmacy to ensure that the changes you make allow independent pharmacies to remain sustainable.

I applaud the government for yesterday's announcement to remove the $25 cap on the prescription drug markup. This would have been a crucial blow to the provision of home care pharmacy and catastrophic to our

patients who are afflicted with such conditions as Alzheimer's, arthritis, cancer and multiple sclerosis, just to name a few.

In closing, I'd like to thank you again for the opportunity to speak here today. I hope we provided some input that will be considered as this legislation moves forward. The sustainability of community pharmacy is at risk, the service to patients is at risk and the jobs of a number of our employees may be at risk if these concerns raised are not addressed. Thank you.

The Chair: Thank you very much. We'll begin with the Liberal side, Mr. Fonseca.

Mr. Peter Fonseca (Mississauga East): Greg, Steve, thank you very much. It's wonderful that you got that ISO designation. You were saying that only five pharmacies around the world have received that. I'm sure that will bring a lot more quality service to the patients you serve and your customers.

You brought forward many of the things that you do in the community. As you know, in section 8 of this bill we are looking at paying for those cognitive services that have not been addressed in the past and making sure that we take into account the value that the pharmacist provides to the community, outside of just dispensing the pills, in terms of all the things you do around disease management etc. On that, what would be some of the top priority cognitive services that you would like to see reimbursed? You can use your community as an example.

Mr. Flexman: A basic one that all pharmacists can relate to, and how we're trained at the University of Toronto and all schools across Canada, is addressing medication reviews, medication consultations, where we'll sit down with a client and discuss their medicines one on one, looking for drug interactions, ways to cut down maybe on the number of meds they're taking. Sometimes they're missing a crucial medicine that they should be on. That's very key. That requires extensive pharmacist time, though, and the amount of money that's been pledged forward, $50 million—

The Chair: Thank you very much, Mr. Flexman. We'll go to the PC side, Mr. O'Toole.

Mr. O'Toole: Congratulations. As a couple of young entrepreneurs, that's good. Good for you. But the assumptions you made, just picking up on what Mr. Fonseca was saying—one of the previous presenters recognized that there are two main things in here that are in conflict. One is this idea of the consult fee, recognizing your professional contribution to health care, primary care, and the $50 million. The other one is the $500 million they're going to pull out of it.

Interjection: At least.

Mr. O'Toole: That's the whole issue here. Your basic business plan has been premised on some sort of—this bill is about saving money. That's what it's about. I think it was Novopharm that said it's going to devastate pharmacy, and most of the coalition people are saying that. The OPA doesn't, though. They seem to think it's going to work out somehow; they'll make a deal with George. What's your sense on this? Isn't this the committee that's supposed to listen to the input of you, the professionals, and make amendments or recommendations? What recommendation would you like us to put forward on your behalf, in the hopes that the government will not just extensively be trying to yank $500 million out of the system, so that you can stay in business and provide the service you suggest?

Mr. Flexman: I think it needs to be written in the bill that there is room for promotional allowances still to exist for pharmacies so that we can continue on with looking for innovative ways to fund the business. I also think it's important that we do have the pharmacy council that's being talked about more clearly defined, what they're going to be able to do.

Mr. O'Toole: Then Novopharm won't be able to—

The Chair: Thank you, Mr. O'Toole. I have to offer it now to the NDP side.

Ms. Martel: Thank you, both of you, for being here today. I go to section 8, where it says the government is going to pay you something. All it says is that the executive officer will set payment amounts and disburse payments for professional services that pharmacy operators provide. It doesn't even include $50 million. It certainly doesn't say how that's going to be done, and it certainly doesn't make up for the loss in promotional rebates that you've already talked about.

Can you tell me, is the $400,000 loss that you talked about based on an 8% markup that's on the wholesale price or a different price, because that will change your bottom line as well. Of course, that's not defined properly in the legislation either and there's lots of confusion around what that 8% markup actually refers to. Can you enlighten the committee?

Mr. Flexman: That was one of the key questions we had, about the 8%. We pay a 6% wholesaler up-charge to get the drug in the first place, so 8% after wholesale is a big difference. Also, we expect about a $400,000 loss in revenue coming from a $600,000—initially, from rebates in the first place. So that's a humungous change in the revenue side of how we operate our business. It's devastating.

Ms. Martel: Thank you.

The Chair: Thanks to you, Mr. Smith and Mr. Flexman, for your deputation on behalf of Clark's Pharmasave.

ABBOTT

The Chair: I would now invite our presenters from Abbott pharmaceuticals: David Link, national manager of market access and government affairs, as well as Scott Oke, manager of provincial affairs. Gentlemen, if you've seen the protocol, your 10 minutes begins now.

Mr. Scott Oke: Thank you very much. My name is Scott Oke. I'm the Ontario manager of provincial affairs for Abbott Canada. Joining me today is David Link, who is our national manager of market access and government affairs. Let me start by thanking the committee for providing us with this opportunity to share our thoughts on Bill 102.

Abbott is a developer and manufacturer of brand name pharmaceutical products. In addition, we are a leader in the field of nutritionals and medical products, including devices and diagnostics. Abbott employs over 1,200 people in the province of Ontario in five different divisions, with operations in Brockville, Kanata and Mississauga.

Abbott's point-of-care division in Kanata currently employs 800 highly trained staff who develop and manufacture medical diagnostic products for bedside blood analysis. The Abbott facility in Kanata is currently looking to increase their manufacturing capacity, which would require moving 100 production jobs from New Jersey into Ontario. This potential $30-million capital investment would occur over an 18-month period.

On the brand name pharmaceutical side, we currently have over 700 patients in clinical trials in Ontario and have invested close to $10 million in clinical research in the past three years.

I would like to begin by stating that there are parts of this bill that we believe are long overdue and we recognize the minister's work in bringing those changes forward. Specifically, I am talking about changes that would provide for more patient involvement, result in the potential for faster listing by eliminating the need for cabinet approval for drugs that receive a positive recommendation from the CED, and reduce paperwork for physicians and pharmacists through the elimination of section 8 and the return to its original intent for exceptional cases.

Unfortunately, there are also parts of Bill 102 that cause us great concern as researchers, as employers, and as individuals committed to improving the health outcomes of patients around the world.

I want to focus the committee's attention on the words Minister Smitherman spoke as he introduced Bill 102, because I think they are important to the work you are being asked to perform here today. According to the press release put out by the Ministry of Health that day, Minister Smitherman said, "All patients will continue to receive the drugs they currently receive."

I have no doubt that when people heard the minister's words, they breathed a sigh of relief and went back to their busy lives.

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The problem is that Bill 102 establishes no such guarantee; quite the opposite, in fact. Consider the following. The government is planning to cut almost $300 million out of the seniors' drug budget this year and $600 million from patented medicine reimbursement over the next two and half years. Then look at the principles of Bill 102. When you do so, you will notice that three of the five principles speak only to money, while none of them speak to improving patient outcomes.

Viewed in this context, we have grave concerns over how brand pricing agreements and the new interchangeability clauses will be implemented. We've heard what the minister has said about therapeutic substitution; we just want the bill to say the same thing.

Without major amendments, we believe that the fears of forced switching and therapeutic substitutions at some time in the future are absolutely justifiable. That is why we are asking you to amend Bill 102 now.

Specifically, and at a minimum, we would like Bill 102 amended so that current ODB recipients are grandfathered. By grandfathering we mean that patients who are currently well controlled on their existing branded medication would not be forced to switch and fail on a less expensive, non-interchangeable medicine before being returned to their original medication. These treatment failures add significant costs to the health care system, effectively eliminating any perceived savings. Just as the minister promised, a grandfathering amendment would ensure that under no circumstances would a senior be forced to switch to a non-interchangeable medicine.

Let me quickly explain why we believe Ontarians should be concerned about the forced switching of non-interchangeable medication based on price alone. By definition, unless they are truly bio-equivalent generic products as established by proper evidence-based comparative analysis, no two drugs are the same. Different drugs behave differently in the body. Moreover, the same drugs can behave differently in different bodies. To optimize safety and effectiveness, physicians need access to a full complement of therapies in order to choose the right ones that will work best for their patients.

Proof of this is easy to find. When a similar cost-cutting measure which forced patients to switch medicines happened recently in British Columbia, the BC government's own numbers showed that 25% of those patients experienced a treatment failure. That is, those individuals, mostly seniors, had to return to their doctors' offices and emergency rooms because the cheaper medication the government forced them to switch to simply did not work for them. Instead of saving the government money, theses changes simply shifted costs from the drug benefit plan to hospitals, physician reimbursement and out-of-pocket fees paid by the patients themselves.

I would now like to spend my last few minutes talking about the value of medicines and concerns we have about the view that many in government seem to have about rising drug costs. Again, allow me to give you some context.

Mr. Smitherman has worked hard and is to be congratulated for his efforts to transform the Ministry of Health from an organization with several hundred silos to an integrated system. Unfortunately, the same is not true of the drug budget. Instead of looking at the system-wide financial benefits of investing in innovative medicines, the ministry instead looks only at the cost curve of the ODB and the total amount spent purchasing medicines. In this new age of integration, why doesn't the Ministry of Health acknowledge that money invested in medicine dramatically reduces hospital stays, surgeries performed, doctor visits and the costs of nursing care in our long-term-care centres?

Make no mistake: Investments in new medicines actually save money—lots of money. According to a 2002 study by Professor Frank Lichtenberg of Columbia University, new medicines reduce other costs in the health care system by a factor of seven to one. That is, for every dollar spent on drugs, seven dollars are saved elsewhere in the health care system.

Innovative medicines help avoid more invasive procedures. They reduce or prevent hospital stays, reduce wait times and keep people with chronic illnesses healthier.

As one of the world's leading manufacturers and researchers of AIDS medication, Abbott is proud that its work has helped result in a 70% drop in the mortality rates and a corresponding 71% reduction in the hospital stays from this disease alone.

The same is true of research and innovation, two pillars upon which the Premier wishes to build Ontario's future economy—so much so that he took on personal responsibility for the portfolio as Ontario's first minister in this role.

The numbers are clear. Everyone in Ontario gains from brand name pharmaceuticals' ongoing commitment to develop new medicines and vaccines.

The research-based pharmaceutical community employs about 9,000 men and women in Ontario, creates an additional 24,000 spinoff jobs and injects $2 billion annually into the province's economy. Last year alone, we invested over $350 million in research and development, of which more than $40 million went directly to universities and hospitals here in Ontario.

Rx&D has made it clear to the ministers of health, research and innovation, and economic development and trade that we believe Bill 102 undermines our future ability to invest in research and development in Ontario, from plant and equipment to clinical trials which serve 40,000 Ontario patients. Investment activity is a global endeavour, and Ontario will be substantially less attractive for these activities. Over time, these funds will move away from Ontario to other provinces and other countries that support innovative industries.

With that, I would like to once again thank the committee for this opportunity to express Abbott's thoughts and concerns. I hope this presentation helped to convince you that Bill 102 should not pass without major amendment. We would strongly urge you to adopt amendments which prevent therapeutic substitution, eliminate brand pricing agreements and grandfather those patients already stabilized on their current medicines.

We would be happy to answer your questions now.

The Chair: Thank you, Mr. Oke. There are about 30 seconds per side. Ms. Witmer.

Mrs. Witmer: Do you not think that Ontario should get discounts because it's a large purchaser?

Mr. David Link: Can I answer that question? Thank you. That's a good question. As you know, Ontario already is getting best pricing. The brand name pharmaceutical companies have a number of hurdles to get through before a final price point is delivered. First of all, we go through the Patented Medicines Prices Review Board, which makes sure that our prices are consistent and fair from an international perspective. Most of the people in this room will know that our current prices are 9% lower than international median prices and significantly lower than what's happening in the United States, so much so, as you know, that cross-border trade—

The Chair: With apologies, I will have to intervene. Ms. Martel.

Ms. Martel: Have you had any indication from the government about the framework for the negotiation of drug products and pricing?

Mr. Link: No. We've been given some sense that this is modelled after the Department of Veterans Affairs. All we know is that the context of those negotiations will be based on price and that if you're not able to effectively negotiate a price with the government, you will likely be delisted, which would force patients off that therapy.

The Chair: Thank you, Ms. Martel. To the government side: Mr. Peterson.

Mr. Peterson: Thank you very much for your presentation. Under our legislation, if a doctor puts on the prescription "no substitution," there will be no substitution, so the efficacy of the medicine will be maintained.

Thank you for also tabling information about studies done concerning keeping patients out of hospitals by using drugs. When our committee consulted extensively with the industry, we found mainly anecdotal evidence; we didn't find hard enough evidence. Part of going forward is that we'd be able to solidify that medicine, because we are the government that has gone to patient focus, away from hospital focus. We appreciate and we'll look forward to working with you to establish better information on that level. Thank you very much for tabling your information on that. I look forward to reading it and working with you in the future.

Mr. Link: You're welcome.

The Chair: Thank you, Mr. Peterson, and thanks as well to you gentlemen, Mr. Oke and Mr. Link of Abbott pharmaceuticals, for your deputation and written submission.

TARO PHARMACEUTICALS INC.

The Chair: I invite our next presenter, Mr. Doug Robins, vice-president at Taro Pharmaceuticals. As you've seen, Mr. Robins, you have 10 minutes in which to make your presentation.

Mr. Cameron Jackson (Burlington): On a point of order, Mr. Chair: I would like to request information. Several deputants have referenced this American-based, United States Veterans Affairs model. There are three models that have been discussed. Could we ask research to prepare some background information for the committee?

The Chair: Mr. Jackson has raised a request for further written materials regarding the American-based models, as you've heard. I direct legislative research to comply with that.

Mr. O'Toole: It was mentioned yesterday in one of the presentations.

The Chair: Thank you. Mr. Robins, please begin.

Mr. Doug Robins: Good morning. My name is Doug Robins and I'm the vice-president of sales and marketing for Taro Pharmaceuticals, located on East Drive in Brampton, Ontario.

Taro Pharmaceuticals is a wholly owned subsidiary of Taro Pharmaceutical Industries, with corporate head offices located in the United States. Taro Canada is part of a bigger generic pharmaceutical industry of great value to Ontario, consisting of 13 companies located largely in the greater Toronto area. The Ontario generic drug industry employs over 7,500 Ontarians in well-paid, high-skilled jobs which include research, development and manufacturing.

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Since 1984, Taro Canada has been manufacturing, exporting and locally marketing generic pharmaceuticals sold by prescription and over the counter. These products are made in Canada, and sold in Canada, the United States and throughout the world. They are, for the most part, low-cost versions of the higher-priced brand name drugs and are sold after the brands' patents have expired.

We currently occupy in excess of 350,000 square feet in four buildings at our Brampton campus on East Drive. These buildings house manufacturing, our research and development laboratories, administration and warehousing. We employee 378 people in high-value, full-time positions, as well as an average of 32 contract and temporary personnel in a given week.

While we represent less than 2% of the total generic pharmaceutical sales in Ontario, we have a significant pharmaceutical export business from our Brampton plant. In 2005, we manufactured over 73 million tubes of semisolid pharmaceutical product, 93% of which was exported. For this manufacturing, we purchased over $50 million in raw materials locally and our payroll was in excess of $24 million.

Our products provide the same quality, purity, effectiveness and safety as the high-priced brand name drugs. They have been approved by Health Canada and meet the same strict regulations established by the Food and Drugs Act for generic and brand name drugs.

It is important to remember that the products we manufacture and export from Brampton are low-cost versions of branded pharmaceuticals, and this manufacturing takes place only after the patents on the brands have expired.

As well, our ingredients meet the same scientific norms and standards set by Health Canada for brand name products, with the same proven safety and efficacy. We also have a proven track record that our products' active ingredients are as pure, dissolve at the same rate and are absorbed in the same manner as the originator's product.

I thank you for allowing me the next few minutes to show support for Bill 102 and share with you the following observations.

Let me begin by saying that there is a place for both branded and generic pharmaceuticals in the Ontario, Canadian and international marketplaces. As governments try to cope with soaring drug costs, generics provide a logical solution. The branded industry seeks access for their new products, while governments have been reluctant to underwrite these due to high costs.

The lines of demarcation between brand and generic are indeed blurring. The branded industry now has a significant presence in the generic business. Novartis, the number four worldwide branded company, owns Sandoz, the number two worldwide generic company. As well, generic companies continue to invest heavily in basic research and biotechnology.

As a generic manufacturer, we see this bill as an opportunity to increase availability of low-cost generic drugs, thereby saving money not just for the government but also for private employers and consumers. The savings realized from generics could be used to purchase new branded products. We applaud these initiatives. We also applaud the Ontario government's efforts to bring greater transparency along with these cost savings to the operation of its drug benefit programs.

These cost savings will also be available for Ontarians not covered by the Ontario government's drug plan, i.e., those with private drug insurance through their employer and those unfortunate few who have no insurance at all. One calculation of an initiative in Bill 102—off-formulary interchangeability, or OFI—suggested savings for Ontario businesses and families of more than $30 million in the first year alone. These savings are based on the difference in prices currently charged by brand name and generic companies for drugs affected by OFI.

Unlike virtually every other jurisdiction in North America, Ontario's current interchangeability rules deny access for employers and consumers to low-cost generic drugs—clearly not the original intention of legislation that governs the interchangeability of generic drugs. These rules also penalize Ontario seniors and social assistance recipients who need medication not covered by the government's drug plan.

The need and support for OFI has been expressed by every major employer that provided comment during consultations on the government's proposed changes. These stakeholders include the Employer Committee on Health Care in Ontario, or ECHCO, and Green Shield, a large private insurer which operates the drug benefit plans for the Big Three automakers as well as many other employers in Ontario.

It should be noted again that the products affected by OFI have already enjoyed the benefit of up to 20 years' exclusivity through patents. Those patents have now expired and it is time for Ontario—private employers and consumers—to benefit from lower prices generated by generic competition.

Taro Pharmaceuticals pledges to work with the government and our pharmacy and wholesaler partners to develop rules for generic reimbursement. We, like other manufacturers and stakeholders, would like to be included in discussions relating, but not limited to, a new

code of marketing conduct; the arbitrary pricing of generic products at 50% of brand; a mechanism for a phasing-in period of Bill 102 perhaps for new products on a go-forward basis; help the government achieve the goal of full transparency; and help all stakeholders ensure long-term viability and sustainability.

In conclusion, I want to reiterate our support for Bill 102. With continued consultation and dialogue such as this, followed by a balanced approach to implementation of the regulatory and policy aspects of the government's overall proposals, Bill 102 will be a success. Let me also add that, because of the profound impact Bill 102 will have on the rest of Canada, this dialogue and consultation should also include participants in the national pharmaceuticals strategy initiative.

I ask all members of the committee and all members of the Ontario Legislature to support the taxpayers of Ontario by supporting this important piece of legislation.

Thank you, and I'll be happy to answer any questions.

The Chair: Thank you, Mr. Robins. About 30 seconds or so per side, beginning with Ms. Martel of the NDP.

Ms. Martel: You focused on a concern, the arbitrary pricing of generic products at 50%, and you want to work with the government. In an earlier presentation from Novopharm, another generic company, they said, "We encourage the minister to leave the current system of first generics at an initial price of 70% of brand to ensure future investments in innovation." Would that be the position of your company as well?

Mr. Robins: Somewhere in that neighbourhood, yes.

Ms. Martel: So you have a similar concern and essentially want the two-step pricing model to remain in effect?

Mr. Robins: I would like to see the two-step pricing model remain in effect because it does encourage innovation.

Ms. Martel: Are the numbers similar then or do you have a different sense of—

Mr. Robins: Keep in mind that Taro's a very small manufacturer. We're also a niche player, so—

The Chair: With apologies, we go to the government side, Ms. Wynne.

Ms. Kathleen O. Wynne (Don Valley West): Mr. Robins, thank you very much for being here and for your support before, during and after.

Can you just talk to us a little bit about the relative investments in research and development of generic and brand? Can you give us some statistics around the percentage investments? Do you have those?

Mr. Robins: I can only speak for Taro, and that's proprietary information. I think probably the best people to ask would be the association, which I understand is going to present on Monday afternoon, if I'm not mistaken.

I spent 25 years in the branded pharmaceutical industry before I moved to the generic side and I can assure you now that as the lines blur, the investments in research in Canada by generics and branded are approaching each other.

The Chair: Mr. Jackson of the PCs.

Mr. Jackson: Mr. Robins, could you explain to me what the market forces are that cause you to provide rebates to pharmacists if they acquire your generic drugs?

Mr. Robins: When you're in a commodity market and you are one manufacturer along with five or six others that have the exact same product, the only way you can differentiate yourself is by price, and since that price is legislated by the government, then you have to find ways of compensating for that in the form of education allowances.

Mr. Jackson: If those are eliminated, how will that affect your ability to promote your generic drugs?

Mr. Robins: My understanding is that this bill will not completely eliminate them, that they will still allow educational grants, along with, in its current form, up to a 29% reduction in price. So our bottom line isn't going to be affected one way or the other. We'll have to differentiate ourselves by coming up with unique and novel educational pieces that the pharmacists can use in conjunction with dispensing our products.

The Chair: Thank you, Mr. Jackson, and thank you as well, Mr. Robins, for your deputation on behalf of Taro Pharmaceuticals.

COBALT PHARMACEUTICALS

The Chair: I would invite our next presenter, Mr. Terry Fretz, president of Cobalt Pharmaceuticals, and colleague, to introduce yourselves for the purposes of recording. Your 10 minutes begins now.

Mr. Terry Fretz: Thank you, Chair. I was advised yesterday that you folks were cloistered away on the hottest day of the year in a room, but somehow everyone's looking relatively robust this morning and I trust that the weather will be kind to you throughout the day.

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Mr. Peterson: It's because of good drugs.

Mr. Fretz: Absolutely, because of great generic pharmaceuticals.

My name is Terry Fretz and I am the president of Cobalt Pharmaceuticals. Cobalt is a full-service global developer and manufacturer of generic pharmaceutical products located in Mississauga, Ontario.

Cobalt is a member of the Arrow Group of companies, operating globally and focused primarily on generics, but with interests in branded prescription products and over-the-counter products.

Cobalt is pleased to have this opportunity this morning to provide its perspectives on Bill 102, the Transparent Drug System for Patients Act, as well as the accompanying range of pharmaceutical policy reforms that were announced on April 13, 2006.

At the outset, let me say that Cobalt Pharmaceuticals supports the aims of the bill and the key principles underlying those aims. We agree that there are opportunities in the Ontario drug system for the government to achieve better outcomes for the $3.5 billion that it spends on pharmaceuticals and, at the same time, achieve better access to drugs for patients, promote the appropriate use

of drugs, and reward innovation. As well, Cobalt supports the government's plan to improve the governance, accountability and operations of the public drug system. In summary, Cobalt can do business under Bill 102, provided the government commits to a dialogue with the generic industry as regulations are developed.

At the same time, Cobalt recognizes and acknowledges the challenges that confront our retail pharmacy partners from several provisions of the bill. We will not speak in detail to the concerns that have been expressed from some elements of the Ontario retail pharmacy community. Certainly that's been ongoing for the past several weeks and yesterday and today and for the duration of these hearings. Many of those expressions are well known by all parties. What we can say is that it is vital that the government deals with the concerns of pharmacy in an appropriately fair and transparent manner, as our retail pharmacy partners come to grips with the new policies and compensation models that will eventually be established.

In particular, Cobalt would like to stress the importance of the government acting as expeditiously as possible to assist the retail pharmacy sector in transitioning from an outmoded compensation system to one in which pharmacists are compensated fairly, appropriately and transparently for the services they provide, whether they be core dispensing services, enhanced professional services or specialty services, some of which you've already heard articulated this morning from other presenters.

The government has already stated that it recognizes the value of pharmacists as front-line health care providers, a position which we wholeheartedly support. To do less than make that compensation truly reflective of their skills, expertise and time would be a disservice to the profession and to the interests of the patients the bill purports to serve.

At the same time, we acknowledge that the promotional investments made by the generic industry to pharmacists should be governed by a code of conduct that is developed in consultation with government and pharmacists. This code must provide fair and reasonable guidance to pharmacists and suppliers, and it must be transparent and enforceable on all parties. This code must be applicable to manufacturers, agents and brokers alike.

Cobalt would also like to offer some perspectives on the issues of innovation and research and development from our position as a Mississauga-based generic pharmaceutical organization.

Comments have been made recently by some observers that the effects of this bill will greatly harm the interests of the brand name drug sector, a number of whose members are located in Mississauga. As a generic manufacturer, Cobalt respects innovation in drug therapy. We, like our generic competitors, depend upon expired patents in order to research, develop and manufacture safe, high-quality, lower-cost bioequivalent pharmaceuticals for Canadians. What we simply ask is that government recognize us as an equally important component of the pharmaceutical industry and acknowledge the significant contribution that we make by helping to lower health care costs and drive the economic development of the province of Ontario.

In Mississauga, we operate a state-of-the-art global manufacturing facility employing more than 250 people, 100 of whom are engaged in research and development. We have recently invested $35 million in our plant and equipment, and in 2006, Cobalt will reinvest one third of its $90 million in revenues into research and development. More than 50% of the product that we manufacture in Mississauga will be exported to other countries. That speaks to the nature of the employment and the kind of people we employ. These are high-paying, quality jobs. We're investing into the local economy, into the Ontario economy and into the Canadian economy.

It is therefore critical that the government take a fair and equitable approach in policies affecting the pharmaceutical sector, both brand and generic. If generic utilization approached US levels of, say, 50%, we submit that the estimated $400 million to $500 million that Canadians would save on drug expenditures could surely be more effectively utilized in improving access to new drugs and enabling public coverage of the often catastrophic costs associated with expensive drugs for rare diseases. Off-formulary interchangeability, or OFI, will save Ontario businesses and families more than $30 million in the first year alone.

Cobalt believes that, on balance, Bill 102 achieves the objective of improving access to high-quality, cost-effective drug therapy for Ontario's 12 million citizens while respecting the government's mandate to make responsible decisions that ensure its public drug program will sustain Ontarians well into the future.

In conclusion, Cobalt Pharmaceuticals would like to again reiterate its support for the principles and aims of Bill 102, as they generally support a viable public drug system and a dynamic pharmaceutical market in Ontario.

I thank the committee for your time and attention.

The Chair: Thank you, Mr. Fretz. We have a minute per side, beginning with the government.

Mr. Peterson: Thank you for your presentation and thank you for your positive support of innovation and technology and the development of industry in Canada.

One of the issues that's been confronting the government is, first, to get a handle on the size of the rebates and try to find a better way to use those to further the drug industry and further patient care. We're talking about a code of conduct. Do you have any suggestions for us in this area?

Mr. Fretz: The dialogue needs to engage all parties—obviously the payer, the government, the manufacturers who ultimately provide those professional fees back to our pharmacy partners or the community, as well as the pharmacists. One of the things I'd like to stress is that the dollars are frequently referred to as simply a rebate, and that just implies money on the table. What you heard this morning from one of the presenters were the kind of services that community pharmacy provides back to its community, back to it stakeholders, and I think it's very important to be cognizant of that.

What we grapple with is to find a balance where all parties can continue to commit to their stakeholders and—

The Chair: With apologies, Mr. Fretz, we'll move now to the PC side.

Mr. Jackson: I'd just continue on in that vein, then. I'm interested in knowing about this distinction between the current 70% of brand to the 50%. I suspect the government is going to dig in its heels at the 50% level. Would you like to see that in regulation or would you like to see—

Mr. Fretz: I'd like to see it not at all, quite frankly. I was aghast that that was part of the bill.

Mr. Jackson: How is it that your association and any drug manufacturer, whether you're generic or not, will be protected in terms of pricing under the new mechanism of having an unelected body develop that pricing with no appeal mechanism?

Mr. Fretz: It's a serious challenge, Cam. It's an issue—I think the brand presenter earlier referenced PMPRB, which is in place, which affects brand pricing. You also know that the provinces are in dialogue and are part of NPS, which also looks to pricing. Mr. Oberman from Novopharm referenced earlier some of the more recent studies that have been done that qualify the pricing of generics in Canada and substantiate the prices at which we're already selling in the market—

The Chair: Thank you, Mr. Jackson. Ms. Martel.

Ms. Martel: Thank you for being here. You said you wouldn't like to see that reference change to 50% at all, so I'm going to ask you the same question now. In the presentation by Novopharm, it was very clear that they were advocating for a two-step pricing model and that essentially "the minister leave the current system of first generics at an initial price of 70% of brand to ensure future investment and innovation." Would that be your position as well?

Mr. Fretz: Absolutely.

Ms. Martel: Should I gather, although we're going to hear from the association next week, that among the generics that would be the position?

Mr. Fretz: I would let the association speak on behalf of all companies. It's not my purview to speak on behalf of or for other companies.

Ms. Martel: Have you directed that concern to the ministry yourself—never mind the industry, but yourself as a company?

Mr. Fretz: Previous dialogue has expressed concern about the arbitrary reduction in price.

The Chair: Thank you, Mr. Fretz, for your deputation on behalf of Cobalt Pharmaceuticals.

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INSTITUTE FOR OPTIMIZING HEALTH OUTCOMES

The Chair: We welcome our next presenter, Ms. Durhane Wong-Rieger, president of the Institute for Optimizing Health Outcomes.

Dr. Durhane Wong-Rieger: My name is Durhane Wong-Rieger. I am the president and CEO of the Institute for Optimizing Health Outcomes. We are a not-for-profit organization that is dedicated to improving health outcomes of Canadians living with or at risk for health conditions. We work in partnership with health care institutions, we work with health care providers, we work with other patients' organizations, patients' families, and we work with the governments to develop and implement a variety of innovative programs for research. We provide education, and we're conducting large-scale programs on self-management.

I also am personally the president of the Canadian Organization for Rare Disorders, and I sit as the secretary of the Canadian Hepatitis C Network and also as the secretary for Canadian Fabry Association.

I'll start by saying that there certainly is support from our institution of the need for reform of the Ontario Drug Benefit Act. We recognize that drug plan costs are rising, but we also recognize that Ontario patients are not getting access to new medicines. There's much in the policies and in the bill that we can see as benefits to patients, but in the interests of time, I'd like to focus on a number of concerns that we do have.

First of all, we have some underlying concerns with regard to the principles and the process of Bill 102. The government unfortunately has not made available the evidence, the research, the statistical analyses and the background documents that would normally justify the recommendations and changes proposed in such a sweeping bill as 102. We in the public actually have no way of knowing whether the government's calculations and conclusions are valid. We have no way of confirming that the recommendations are based on solid analyses and will generate the benefits concerned. I ask, if the process thus far has lacked transparency, how can the public trust that there will be greater transparency in the future?

I also want to point out that there has been insufficient time for genuine stakeholder consideration of the proposed policy changes in, again, such a sweeping bill as Bill 102. There has been inadequate time allocated for hearings here, and I point out that there have been a very limited number of patients and patient groups among those presenting at the hearings. There are only three today that I recognize.

If we do not have sufficient consultation leading to this legislation that will determine the regulations and policy, what confidence can we have in the promise that has been made to us for adequate patient participation and consultation in the development and implementation of the regulations and policies?

I'll move to some very specific concerns. I do have a major concern around the stage for therapeutic substitution that has been set by the language in Bill 102. It does allow the executive officer to declare as interchangeable drugs with "similar active ingredients." There is no such thing as a scientific process for determining what is a drug with a similar active ingredient.

We have a process for declaring a generic substitution. It is a process that the manufacturers have to go through

in front of Health Canada, demonstrating that there is pharmacodynamic and pharmacokinetic equivalence. There is no such thing for declaring interchangeable drugs with similar active ingredients or similar activity.

We are concerned that Bill 102 also encourages competitive pricing—not that that, in and of itself, is bad—but coupled with this, it will certainly set the stage for the government to allow a category of so-called similar drugs to be designated, ask the companies to compete on those drugs and then force physicians to prescribe to the lowest-cost drug in that category of so-called similar drugs, again without any scientific basis that these drugs are indeed similar.

The bill technically might not say "reference-based pricing"; it might technically say it does not interfere with the physician-patient relationship. However, I would say that pressure will be applied at the physician level to prescribe only the lowest-priced drug that is listed, without consideration for the specific patient.

We would also like to raise concerns regarding the rapid review. The revisions to allow for rapid review are certainly welcome. However, we would like to point out that this can only be of benefit for breakthrough drugs if in fact the government will recognize that these kinds of breakthrough drugs—especially for targeted patient populations, and especially for rare disorders, which I represent—are going to be more costly than the old chemical entities. They're going to be more costly than new versions of existing drugs, than the me-toos. To ensure that a rapid review does not lead just to a rapid "No," we have to recognize that the usual criteria for cost-effectiveness or cost savings cannot be applied here.

I point out that the Ontario government has yet to follow through on its 2004-05 commitment to rapid access to breakthrough drugs for two rare disorders: Fabry and MPS1. If we can't have faith that the government will follow through on these positive rapid reviews, how can we have assurance that this bill will provide for more?

Just quickly, then, we also have concerns with regard to accountability for the executive officer, and support those who have asked that there be a second review process in place so that all negative decisions, in fact all key decisions, around interchangeability, rapid review, drug listing, delisting, conditional listing and exceptional status have to be open to some process of review.

My final statement here is that we do have concerns regarding the viability of pharmacies. We personally have no way of knowing whether or not the impact that is being claimed in terms of Bill 102 on pharmacies is legitimate. What we are concerned about is that there is wide discrepancy between what the government is claiming is the impact and what the pharmacies are saying is the impact. Unfortunately, again, without access to the government's background documents, their research and cost analyses, we have no way of knowing who is actually correct.

We do believe that there has to be a sufficient number of viable pharmacies in our communities. They're vital to the safety of patients. We do support that pharmacies should be compensated appropriately for the losses sustained through the changes in Bill 102, and we urge the government again to make those available to us.

In summary, I would like to say there is much that we do support. We certainly recognize the need for change, but we recognize that there are some real key elements of Bill 102 that need to be addressed, and we are very concerned that the period of time for comment and the period of time for even this committee to make its recommendations is far too short for such major changes.

The Chair: Thank you, Ms. Wong-Rieger. We'll begin with the PC side, about a minute each.

Mrs. Witmer: Thank you very much for an excellent presentation. It certainly comes to us with a bit of a different perspective, which I appreciate.

You mentioned access to the new drugs and that some changes are going to have to be made, because if it remains the same, we're still not going to see improved access. What, primarily, will the government have to do in order to ensure that these new breakthrough drugs are made available if they're deemed to be appropriate?

Dr. Wong-Rieger: There is nothing, number one, in the bill or even in the government's background documents that acknowledges, first of all, that we don't have access to new medicines. I think there has to be specific recognition that these are not going to be drugs that cost the same as the me-too drugs. As we have seen in the Common Drug Review, none of the breakthrough drugs that have been submitted for adoption by the Ontario drug benefit plan has actually been listed.

So we have to have some new rules. We have to have new criteria. We have to recognize right up front that these are more costly drugs. Unless we build that in, I don't think we're going to have anything but a more rapid "No."

The Chair: Ms. Martel of the NDP.

Ms. Martel: Thank you for your presence here this morning. I want to focus on two things, first, some of the important proposed policy changes that don't appear in the bill. You talked about the committee to evaluate drugs—not in here; the formation of the citizens' council—not in the bill; the creation of the pharmacy council—not in the bill; the process for faster drug funding decisions—not in the bill; a new process for unlisted drugs, special cases, the old section 8 process—not in the bill; the rapid review process for breakthrough drugs—not in the bill; even a definition for "breakthrough drugs"—not in the bill, and the list goes on and on. So we're kind of buying a pig in a poke, because we don't have any idea of what's going to come out here at the end of the day.

My second point: Here's the fact sheet the government put out on the projected savings. It says $289 million. There's been no other information released on how they're going to get there. One of the interesting ones is $67 million, having the federal government become the first payer for its employees, an agreement that's not even in place. So there's no guarantee they're going to

get that $67 million. How do you feel about trying to deal with a bill where so many things that the government promised didn't actually make their way into the bill?

Dr. Wong-Rieger: Two things: One, as you say, we are very concerned that we have been given none of the background documents. Normally we would expect to see at least a white paper, at least see the analyses, and this is a promise—

The Chair: With apologies, Ms. Wong-Rieger, I will have to intervene. To the government side.

Ms. Wynne: Thank you very much for being here, and thanks for your comments. I just wanted to go back to the very beginning of your presentation around the consultation issue. I wanted to make sure you were aware of what did lead up to this bill and why I personally have faith in its integrity.

Are you aware that in June 2005, the Drug System Secretariat was established, and a system-wide review began at that point? There were 250 experts from around the world who were consulted. The folks from the secretariat visited two jurisdictions; They went to the UK and they went to the US. They received 100 submissions, and held 105 meetings with 350 stakeholders. There was a public forum for patient groups and they did public focus group research. That was before we went into this process, which is the discussion of the legislation. So that seems to me a year-long, pretty substantial consultation.

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Dr. Wong-Rieger: We participated in a lot of that. We appreciated everything that was done then. However, we are still saying, where are those background documents, what was the research and the evidence that was collected. Let us see what it is.

Secondly, this part of the process, with the bill coming out, which is the keystone of what this is supposed to be: There has been very little time for consultations, very little time for review on this part of it, and this is what everything is going to be based on.

The Chair: Thank you, Ms. Wong-Rieger, for your deputation on behalf of the Institute for Optimizing Health Outcomes.

CARPENTERS AND ALLIED WORKERS, LOCAL 27

The Chair: I now invite our next presenter, Mr. Mike Yorke, vice-president of the carpenters. union, Local 27, and colleagues. Please be seated, gentlemen. As you've seen the protocol, you have 10 minutes in which to make your deputation. Please do also introduce yourselves for the purposes of the permanent record, Hansard recording. Please begin.

Mr. Ucal Powell: Thanks, Mr. Chairman. Good morning to the committee. Unfortunately, Mike Yorke isn't here today. My name is Ucal Powell. I'm the president of the Carpenters' District Council of Ontario. At my right is Mr. Brian Foote, director of labour relations for the general contractors' section of the Toronto Construction Association. On my left, Mr. Mike Neheli from the firm of Manion, Wilkins & Associates. We're going to be tag-teaming a little bit with respect to our presentation. Mr. Mike Neheli will be doing the technical side of things and Mr. Foote will be addressing some issues after with respect to some concerns we have that are presently not in the bill.

Mr. Foote represents the management side of the construction industry, and myself from the union side. We're both trustees on the carpenters' health and welfare plan, which provides health and welfare benefits for our members, and we're really concerned about the issue with the cost of drugs. At this time, I'd like to turn it over to Mr. Neheli, who will be dealing with the technical side of our presentation.

Mr. Michael Neheli: Thank you, Ucal, and good morning. As Ucal indicated, Manion Wilkins is a firm that provides third-party administration services to our multi-employer benefit clients. We're responsible for the administration of their health and welfare programs. In the past year, we've seen in excess of $16 million coming through the trust fund book of business in relation to prescription drug costs. Over the last four or five years, these prescription drug costs have almost doubled. This has forced the plan sponsors to look at various cost containment initiatives in terms of still providing a meaningful health care program to their members without limiting or reducing the quality of health care. In doing so, they've adopted a tiered formulary that recognizes the ODB as the primary provider. Under the ODB formulary, reimbursement is at a prescribed co-insurance level. Any drugs falling outside of that formulary are then reimbursed at a different co-insurance level.

We fully support and endorse the recommendations in the bill with respect to generic drugs being added to the ODB formulary because we believe that, through the generic drug program, additional savings have, in fact, been realized. On our book of business in 2005, approximately 83% of the prescription drug claims that went through were done so based on the ODB formulary, 17% of which were non-ODB. I believe that the more important statistic we've identified is that the percentage of generic multi-source or single-brand drugs was clearly indicating that single-source drugs were the largest, as a percentage, of the net cost incurred by these benefit programs. But as a percentage of the number of prescriptions put through the programs, generic drugs were roughly 37% to 40% of the prescription drugs coming through—single-source, multi-source or generic. So we strongly see that there will be advanced opportunities for the members through these programs to realize additional savings through the enhancement of availability of generic drugs through the ODB platform.

Mr. Brian Foote: One concern we wish to raise—and again, it's a joint union-management committee that is appearing before you, Mr. Chair—is something that does not appear to be in the bill but was in the recommendations of the aforementioned secretariat, namely, the move to second payer for ODB of over-65 retirees. In the construction industry currently, with the health of the

industry in the industrial-commercial and residential sides, we have a huge number of retirees currently back working, essentially, with the aging of the force and the shortage of skilled workers. Those persons are covered by our plans; however, we are not first payer in respect of the over-65s. In introducing the bill, the minister indicated that there would be no change in eligibility of those payments, and we believe that to be the case. However, we would raise the caution that we would oppose any such move in the future, and it is contained within the document, along with the reference to the federal public service plan. Thank you.

The Chair: Thank you, gentlemen, for your deputation. You've left a very generous amount of time for questions. We'll begin with the PC side, about two minutes each. Ms. Witmer.

Mrs. Witmer: I'd just like to ask you: What do you think about the rebates that currently flow to the pharmacists? How do they impact the lives of the people that you represent?

Mr. Neheli: We attempt, as best possible, to make sure the benefit programs are clearly communicated and understood not only by the plan sponsors—in this case, the boards of trustees—but also the members. In doing so, we believe it's important for the members to understand that their prescription drug costs are made up of two components: the professional dispensing fee as well as the ingredient cost.

The communications also identify the opportunities for the individual pharmacists to mark up their pricing. What we've done is incorporated a cost control mechanism into our program to limit the markup to 10%. With respect to the rebates, I think it brings an added cost to the benefit program, but based on the structure that we have in place, I think we've capped the ability for that rebate to go back.

Mrs. Witmer: I guess this is a very big concern to the pharmacists as far as their sustainability. Without the rebates or some form of professional allowance—

Mr. Neheli: No question.

Mrs. Witmer: —a lot of them are not going to be available to dispense the drugs to the people you serve.

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

Ms. Martel: Thank you for your presentation. I want to go back to your last comments about first payer. Can you just clarify that for me? Right now, for your retirees, the plans are not the first payers because they would be covered under ODB.

Mr. Foote: Correct.

Ms. Martel: Okay. And now people are coming back, after age 65—

Mr. Foote: Yes.

Ms. Martel: —to continue to work, and there would obviously be a change, because now they would be back on your plan.

Mr. Foote: We have no mandatory retirement in the construction industry. People can work as long as they want, but we have many people who do retire at 60, 62, 65 who are now back at work. Our oldest working carpenter is 73, I believe.

Ms. Martel: So when the minister said on second reading that he wanted to reassure people that there wouldn't be any change with respect to the copayments that they pay etc., that's what your reference is to right now, because yes, there will be a change for those folks.

Mr. Foote: We can't find the reference in the bill. I admit I just reviewed it twice yesterday, but if it were to be there, yes, there would be a change. There'd be an increased cost to us. Furthermore, in the construction industry and many industries, we bargain on a total wage package basis, so to the extent that the health benefit cost goes up—it's an hourly premium—that comes out of the wages allocated to the worker. So it would be a cost directly to the worker if that was to be implemented.

Ms. Martel: Right. Your reference to the fact sheet—because you've seen this?

Mr. Foote: No. I saw the report of the secretariat. That's where I drew that information from.

Ms. Martel: Could you share that with the committee? You don't have to do it now, but if we could get photocopies of it, that would be really useful.

Mr. Foote: It's on your website, I think.

Ms. Martel: Is that the stakeholder copy? Because there was an MPP copy, there was a media copy, and then there was a stakeholder copy—

Mr. Foote: The briefing to stakeholders.

Ms. Martel: —and each one was a little bit different. Thank you very much.

The Chair: Any written materials, whether it's on the web or not, feel free to duplicate. It's not a problem.

We'll move to the government side. Mr. Peterson.

Mr. Peterson: Thank you very much for your presentation. The two driving forces of us proceeding with this bill were that the industry wanted a reformation of the way business was done, and they've been asking for it for over 20 years. We're the first of three governments that have looked at it, and we're the only one to tackle it, because we thought that the government was not getting good value for its large purchasing power because of the high volume of these rebates, and that we should be able to reflect the lower price. You've mentioned that the generic goods will help us save money.

But the other one is the sustainability of the medical care system. We all know that the medical care system, if it hadn't been reined in and cost control hadn't been put in place, would have been occupying over 50% of the total budget of the province of Ontario. We're now at about $32 billion to $33 billion of a $78-billion expenditure, and that was anticipated, if the growth levels hadn't been curtailed, going up to 50%. Frankly, we would not have been able to maintain our health care system.

The drug benefit program at about $3 billion is a little less than 10% or that program, and it was spiralling. We've heard lots of suggestions as to how good drugs and use of drugs can actually curtail costs in our health care system by keeping patients at home and having patient-focused things, and not in hospitals, not in clinics.

Right now, all your payments for all of your senior people are covered by the age exemption under the ODB. What percentage of your people are covered by private plans or are we the main insurer for them in the drug benefit plan?

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The Chair: Mr. Peterson, that's another question that will have to remain rhetorical. I will thank, on behalf of the committee, Mr. Foote, Mr Powell, Mr. Neheli, and Mr. Yorke in absentia, for your deputation on behalf on of the carpenter's union, Local 27.

I understand we have a point of clarification, Ms. Martel.

Ms. Martel: I'm looking at page 7 of the stakeholder briefing. The second point says "Secondary payer," and the government says, "We intend to become the second-in-line payer for the federal public service health care plan and for working seniors with private insurance plans." It says, under "Further consultation," "Discussion with federal government."

There's no discussion going on here with employers. I would like some clarification from the ministry—it doesn't have to happen now—because I don't think this is in the bill either. So I'd like to know for sure whether or not this is in the bill, and I'd like to know what kind of discussions the ministry has been having with the employer community around that particular provision, which would clearly have an impact on these folks.

Mr. Powell: In this case, it's not only employer, it's joint labour-management—

Ms. Martel: Absolutely, Brother, you're right. Sorry about that.

Mr. Foote: We never fight.

Ms. Martel: Well, okay.

The Chair: Thank you, Ms. Martel. Your questions and comments have been duly noted by the parliamentary assistant. I leave it to them to respond, either now or at a later time.

HAWTHORNE PHARMACY

The Chair: I'd now invite, on behalf of the committee, our next presenter, Mr. Faisal Khawaja, the owner of Hawthorne Pharmacy. Mr. Khawaja, as you have seen, the protocol is 10 minutes, which begin now.

Mr. Faisal Khawaja: My name is Faisal Khawaja. I'm a pharmacist. I'm also a husband, father of four children and sole income earner in my household. My practice is a mom-and-pop operation located in the town of Milton, Ontario. My patients are mostly young families, moms and dads with infants or small children. I provide service in this already underserviced area of the province.

When Bill 102 was announced, some colleagues and I immediately undertook a full analysis of the bill with an MBA facilitator to determine what the impact would be on the various stakeholders. It didn't take long to determine that the impact was going to be devastating to many pharmacies, like a tsunami that nobody had expected was coming. We developed a document called the Pharmacy Sustainability Report and e-mailed it to every MPP at Queen's Park, along with an executive summary entitled "The Real Impact of Bill 102." I know some of you have read it because it has been quoted on several occasions in the Legislature in the past few weeks.

Pharmacies and patients will suffer negative impacts as a result of this bill, while all other stakeholder impacts are neutral or positive. The primary problems, as we have identified them, with the bill are:

—The elimination of free market competition between generic manufacturers, in the form of promotional allowances, a step which is antitrust in every sense of the word. Competition is the cornerstone of our economy and the government seeks to stifle that with this bill.

—The proposition that the bill applies to private prescription business as well as that paid for by government is simply unfair.

—Furthermore, the government is already free to set prices for the drug benefit formulary as it sees fit. Why not just control prices from the manufacturers, which achieves the desired savings, and leave the competitive process intact?

—The bill focuses mostly on generic manufacturer allowances, but 85% of the drug dollars spent are on brand name products. Bill 102 is penny-wise and pound foolish.

—It proposes to reduce markup on drugs from 10% down to 8%. The problem with this is that wholesalers take approximately 5.6% of that, which means we're going from effectively from 4% down to 2%. Our effective markup is reduced by half. This will be on reduced drug prices to boot. Furthermore, about 800 drugs are actually at 0% markup because manufacturers have increased prices to pharmacies and ODB has not matched those increases in their payments to us over the years.

Pharmacists are front-line, primary health care providers. We provide tremendous value for the taxpayer's dollar already. In my community, as in every other community in this province, patients typically come to their pharmacist, to me, first, when they have a health care complaint. They do this because I have earned their trust and because I am accessible to them. We see patients without an appointment, and most pharmacies are open extended hours. They come to us first because we have their confidence and their support. This was evidenced last year when almost 700,000 Ontarians put pen to paper to petition the government to give pharmacists a greater say in how health care policy is developed in the province. I regret to advise those Ontarians that their behests may be falling on deaf ears.

In addition to helping patients self-diagnose ailments and recommending treatments, pharmacists play a critical role in triaging patients. Just last week, a young lady came in wanting me to recommend something for her husband's persistent night-time cough. After I took a brief history of his symptoms from her, I decided to call him on the phone. It became clear to me that he needed more than just a cough syrup. I advised that he should see

a doctor without delay. He did, and as it turns out he had walking pneumonia and would likely have ended up in the hospital emergency room or worse had I not sent him to the doctor.

Furthermore, pharmacists prevent unnecessary trips to the doctor and hospital as well. I screen patients who have symptoms, for example, of a viral cold, for which there is no curative drug treatment, and offer them a plan of care, including symptom control, and under what circumstances they might need to see a doctor later on. Very often an assessment leads to no product sales at all, but rather non-drug management and health promotion advice. I work hand in hand with the physicians in my community to make sure patients are getting the best health care possible. Pharmacists do this every day.

My pharmacy is a focal point in the community. It is a central point of access not only to medications, but to current health care information and objective, unbiased advice—a commodity that is very much threatened in today's health care system. Patients tell me how wonderful it is to have a pharmacy within their community, how thankful they are they don't have to drive 20 minutes to get a medication for their crying infant, and how happy they are to have a real partner in the management of their family's health care.

At my pharmacy, I also provide a state-of-the-art blood pressure screening station, individualized care plans and one-on-one health teaching on diabetes, asthma and high blood pressure. I offer medicine cabinet clean-ups, compliance interventions, anti-embolism stocking fittings, and the list goes on and on. All of these services will be eliminated if Bill 102 passes without amendment.

If my pharmacy is forced to close, larger stores may be happy to pick up the pieces, but the 45-minute wait times that are not uncommon in busy stores for prescriptions will just get longer and longer the more prescriptions they have to fill. I can't imagine why they would even want to. When you are losing money on every prescription, you can't make it up on volume. Higher volumes just mean bigger losses. I believe those companies are starting to figure this out.

At this time, my practice is approximately 20% public, which is ODB, and 80% private, which is non-ODB claims. This is a much lower proportion of ODB prescriptions than the typical 50-50 split that might be seen in most pharmacies. You might think, then, that I have little cause for alarm. This is one of the most insidious parts of Bill 102: It doesn't just propose to eliminate profits from ODB claims; it applies to all prescription claims, public and private. I am left with no way to offset the bleeding losses from my ODB claims.

I had the opportunity to speak directly with Minister Smitherman at some length shortly after the bill was announced. I did not get the sense at that time that he had it in for pharmacists. In fact, I was, and I still am, completely convinced of his sincerity in that:

—He hopes for a sustainable drug budget. So do we; our livelihoods depend upon it.

—He hopes pharmacists will continue to provide excellence in patient care and outcomes from medication therapy. So do we; it is the very reason our profession exists.

—He recognizes that pharmacists play the central role in achieving these outcomes, and has announced long-overdue cognitive service funding in the bill. However, this was funding we had requested to cover the cost of cognitive services that we have been providing for free for many years. This was supposed to be new money.

This committee must find that Bill 102 is seriously flawed. It is flawed in its commitment to protect the health care of Ontario's patients, it is flawed in its failure to ensure the sustainability of that critical health care resource which is the local pharmacist, and it is fundamentally flawed in not recognizing that one depends directly upon the other.

I, my family, my patients and my community implore this committee to see to it that the amendments to Bill 102 proposed by the Ontario Pharmacists' Association are implemented in their entirety prior to the bill's third reading and vote. This will at least provide us with some hope for a balanced outcome that does not leave patients without the pharmacist of their choice, and leave pharmacists and their former employees looking for work.

We respectfully request that the assurances that have been made by the government in the past few weeks actually be written into the bill.

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Finally, we ask that the government acknowledge and respect the wishes of the almost 700,000 Ontarians who instructed this government to give pharmacists a greater say in how drug policy is implemented in this province. We are accountable to these petitioners. If you ensure pharmacists a meaningful leading role on the pharmacy council, the people of this province will thank you, which is much better than us going back to them to tell them that their demands were ignored by this government.

In our handout you can see what I've proposed to fix Bill 102. Essentially, it's to accept OPA's requested amendments to the bill. I would also like to mention that my pharmacy—I am a member of the Coalition of Ontario Pharmacies, whose message and mandate is right in line with OPA, so we have a very consistent message and represent more than 85% of Ontario pharmacies. I thank you very much for your time.

The Chair: Thank you, Mr. Khawaja. We have 30 seconds each, beginning with Ms. Martel of the NDP.

Ms. Martel: I'm glad to put the quote in from the minister to replace that revenue stream, because everything we've heard to date is that the revenue stream is not being replaced; far from it: People are going to suffer some tremendous loss. You will know the pharmacy council is not even written into the bill in terms of a detail.

Mr. Khawaja: That's correct—very disappointing.

Ms. Martel: You should know that the reference to the services you provide is pretty vague. It says, "To pay operators of pharmacies for professional services, and to determine the amount of such payments subject to the prescribed conditions, if any."

The Chair: With apologies, Ms. Martel, I have to intervene and offer the floor to Dr. Kular, of the government side.

Mr. Kuldip Kular (Bramalea–Gore–Malton–Springdale): First of all, thank you very much for your presentation. The government intends to make pharmacists front-line health workers.

Mr. Khawaja: We already are front-line health workers, yes.

Mr. Kular: I am a family physician, still practising family medicine, so I know what pharmacists do. The government is providing $50 million, educational allowances, making the markup 8%, removing the $25 cap. I would ask you, what are two more things you would like us to do besides these—

The Chair: With apologies, Dr. Kular; to the PC side.

Mr. Khawaja: A fair system would be good.

Mrs. Witmer: I'd just like to pick up on the fact that despite all the promises we've heard, very little in the way of what's actually going to be involved in providing recognition for the cognitive services you provide is contained anywhere in the bill. The only thing we know is that you're going to lose the rebates and, as a result, there's certainly a threat to the sustainability of pharmacists and pharmacies. I hope the government will put something in the legislation in order that pharmacists can be reassured they can continue to provide front-line services.

The Chair: Thank you, Mr. Khawaja, for your presence and deputation and written materials on behalf of Hawthorne Pharmacy.

COMMUNITY HEALTHCARE PROVIDERS' NETWORK INC.

The Chair: I would now invite our next presenters, Terry McCully, CEO of Community Healthcare Providers' Network, and colleagues. As you've seen, Mr. McCully, the protocol is 10 minutes in which to make your presentation, which begin now.

Mr. Peter Yurek: Good morning. Mr. McCully is unable to attend. I'm presenting on his behalf. My name is Peter Yurek, of Yurek Pharmacy in St. Thomas. With me is Steve Flexman, of Clark's Pharmasave in Simcoe, Ontario. We're presenting today on behalf of the Community Healthcare Providers' Network, which is comprised of 22 community pharmacies and one hospital-operated pharmacy. We provide home infusion services to approximately half of the CCACs in Ontario. Most of our members serve rural and northern CCACs, where often no alternative suppliers are available.

My presentation will focus on the impact of the proposed bill on the pharmacies that provide home infusion services, the resulting effect on CCAC clients and, ultimately, the hospitals in our community.

If the bill is passed as proposed, it is unlikely that our member pharmacies could continue to provide services, resulting in more patients having to stay in hospital to receive treatment. Home infusion pharmacies compound sterile IV prescriptions that the nurses contracted by CCACs administer in homes across the province. We play a vital but largely unseen role in providing health care services in the home rather than in the expensive hospital environment. We estimate that at any given time, Community Healthcare Providers' Network members are helping to keep 1,000 patients out of hospital and emergency departments in Ontario.

Home infusion pharmacies have large start-up costs and must be dedicated to ongoing quality improvement. Page 7 of the handout that accompanies this presentation details the start-up costs for one of our new members. It was in excess of $200,000. There are less than 30 pharmacy operations across the province that can provide this service, and the barriers for new companies to enter this business are huge.

I welcome the fact that Minister Smitherman has withdrawn the $25 cap on the markup; however, other concerns do remain. The loss of the promotional allowances or rebates by the generic manufacturers to pharmacies will also have a severe impact on the viability of our pharmacies. On page 9 of the handout, a financial analysis shows a profit margin of 30% for prescriptions dispensed under the current system, with the rebates being taken into account. This positive profit margin is turned into a profit margin of -3 % for prescriptions dispensed under Bill 102. The rebates that our members receive account entirely for the profit that is generated.

The May 2005 Caplan report, Realizing the Potential of Home Care, addressed home infusion pharmacy and the need for quality standards to be developed. It is unlikely that the very home infusion pharmacists who have developed the skills and systems for CCAC services over the last six years would be able to provide the time to the OACCAC committee developing the guidelines. Bill 102 will effectively stop any quality initiatives recommended by Caplan for home infusion dead in their tracks.

Bill 102 is not the only consideration for home infusion pharmacies; however, it compounds the problems that already exist in the reimbursement model, where the time and amount allowed by the Ministry of Health to prepare IV medications is not representative of the actual costs to prepare the drugs.

Delivering home infusion services requires advanced skill levels for pharmacy staff, and with an estimated operating loss of 3% after Bill 102, a number of our members could cease to provide services. If our members chose to no longer provide these services, considering the limited number of providers available in Ontario, the high skill levels required, the large start-up cost and the poor return on investment, it is likely that the patients who currently receive home infusion would have to go to their local hospital to receive their IV therapy. The communities that would be hardest hit would be the smaller rural ones that our community pharmacies predominantly serve.

In closing, I respectfully urge this committee to consider the consequences that this bill will have on home

infusion pharmacies and, ultimately, on CCAC clients. I would ask this committee to recommend that the pharmacy council be entrenched in Bill 102 and that the OPA be recognized as the chief negotiator for pharmacy. This would ensure that we have a vehicle to address issues such as not being properly reimbursed for time taken in preparing infusion medications. I would also recommend that the limit on investment through the code of conduct be removed and allow the market to determine what limit the investment should be. It is disappointing that there has been so little consultation on this bill and that there are still so many unanswered questions on a bill that will have such a large impact on the people of Ontario.

I strongly urge the government to clarify the issues brought forward by the OPA. Whether you are an infusion pharmacy or a retail community pharmacy, rebates have served to fill the gap created through inadequate government funding. Bill 102 takes a lot of money from pharmacies, with little given back. The result would be devastating for pharmacies that provide valuable home infusion services.

The Chair: Thank you, Mr. Yurek. We have about 90 seconds per side, beginning with Dr. Ramal.

Mr. Khalil Ramal (London–Fanshawe): Thank you for your presentation and for doing your service on behalf of all the rural areas and small communities. I know how important for small communities, especially in rural areas, the pharmacists are, playing the role of doctors and hospitals on many different occasions.

I just want to ask you some questions. I want to tell you that, on behalf of our government, we do government differently. We ask questions and we listen to the answers. You noticed the announcement yesterday by the Minister of Health about the $25 cap being eliminated. That's why we have this format today, to listen to many pharmacists and stakeholders. We hope that when we come to clause-by-clause, we have some kind of amendment to help the pharmacists and pharmacies across Ontario to survive and continue servicing the people of Ontario.

Another thing you talked about was the reimbursement from generic companies and many different drug companies. How much of a percentage does that rebate represent for your company?

Mr. Yurek: Overall, it's probably in the 8% to 10% range of gross revenue.

Mr. Ramal: Is that in the form of cash or drugs? Which format?

Mr. Yurek: It's cash back, a cheque.

The Chair: Thank you, Dr. Ramal. We'll move to the PC side. Ms. Witmer.

Mrs. Witmer: Thank you very much for sharing with us your role. As you've indicated, it is a relatively new role that you have assumed, and it's really very valuable work. As a result, you're obviously having a tremendous impact. What in particular is the government going to have to do in order to ensure that the business you're providing is going to be sustainable? It's great for the government to say, "Here we are listening to you," but the reality is that a lot of the listening could have been done before the bill was introduced, and we wouldn't be here. What is going to have to happen in order for your very specialized business to be able to continue to show a profit and deliver services to patients?

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Mr. Yurek: The big issue would be to fairly replace revenue taken off from the loss of the rebates. The second issue, which isn't addressed and which I highlighted in here, is that the time issue to prepare the medication is large. I believe the government in the past tried painting everybody with the same brush—

Mrs. Witmer: Exactly.

Mr. Yurek: —but home infusion has huge time issues, especially when you're preparing a TPN, and expense and equipment and building to create the environment to provide safe medication for the people we serve.

Mrs. Witmer: Have you had an opportunity to meet with the ministry staff at all on this particular Bill 102?

Mr. Yurek: No.

Mrs. Witmer: So that would be useful to you, to meet one-on-one with the staff and review with them how they could support you in providing this service.

Mr. Yurek: Yes. We've met with some staff with the OACCAC last summer when we talked about some of these issues.

The Chair: Ms. Martel of the NDP.

Ms. Martel: Thank you for being here today. I want to go to the mixing time fee on page 10. It says that you're paid 50 cents per minute to mix or compound the drugs, but this is much more timely, given what's being dealt with in this regard. The second item that was interesting is, it's capped at 99 minutes by the ODB because of the limitations of their software systems. Do you want to tell me what that is?

Mr. Yurek: Apparently, the Ministry of Health computer will only accommodate two digits in billing for time. It's not uncommon, especially if you're just starting a TPN medication, to spend a couple of hours just doing the calculations before you even get to the point of mixing it.

Ms. Martel: So you'd be far beyond.

Mr. Yurek: Yes.

Ms. Martel: In the markup allowed by ODB—because you clearly say that "the bill does not stipulate that this 8% markup is before or after wholesale charges." Which did you use, then, for your column on Bill 102? This is on page 10.

Mr. Yurek: I think we went with a clear 8% markup on that calculation.

Ms. Martel: Eight per cent on wholesale.

Mr. Yurek: Wholesale, yes.

Ms. Martel: Because what would be the change if it—

Mr. Steve Flexman: It would be more like 4% that we'd really get.

Ms. Martel: So can you give us an estimate of the loss of income? Right now, you've gone with the best-

case scenario, essentially—in terms of the markup, at least—on your figure on page 9, right?

Mr. Flexman: I guess effectively you could add another 4% loss to the 3% lost revenue already—

Ms. Martel: At the bottom.

Mr. Flexman: Not revenue, but profit; sorry.

The Chair: Thank you, Ms. Martel. Thanks to you as well, Mr. Yurek and Mr. Flexman, for your deputation on behalf of the Community Healthcare Providers' Network.

LEON PHARMACY

The Chair: I would now like to, on behalf of the committee, call our next presenter forward: Mr. Ramez Tawfik, the owner of Leon Pharmacy. As you've seen, Mr. Tawfik, the protocol is that you have approximately 10 minutes in which to make your presentation, which begins now.

Mr. Ramez Tawfik: Thank you very much for allowing me this opportunity. My name is Ramez Tawfik. I have been a licensed pharmacist in Ontario for approximately 11 years. I have owned Leon Pharmacy in Oakville for approximately nine years. I am a third-generation pharmacist. My dad, who is 72 years old, still owns and operates full-time his own independent store. I was raised in that store with my father. My wife Maggie is a pharmacist and my brother-in-law is a pharmacist too. My dad and his ownership of his independent store were the main reasons for me going into pharmacy.

I love my profession and was raised on the firm belief in community pharmacy and what it represents as a value to the public. I serve a large community of seniors located in a limited-income neighbourhood on Kerr Street, south of Speers. My seniors are low-income seniors. Low-income seniors are the ones who make less than $16,000 a year or a maximum of $1,300 per month. A low-income senior couple makes approximately $600 each per month. This is to cover costs for housing, which eats up a major portion of their income, clothing, food and transportation. That sum usually runs out before the end of the month. They rely primarily on their children to help them with their living costs if their children can afford to do so. I run a tab at my store for these patients so they can pay it down whenever money becomes available, like at Christmas time when their children are visiting them. They are not given any leniency at chain or grocery stores. It is the humanitarian touch that I am able to give to them.

My seniors consider me as their friend and talk to me about their medications and health concerns before going to their doctor. If I close, their doctors will be bombarded by hundreds of calls and questions daily.

Senior patients have daily living expenses that are not covered by OHIP: expenses for incontinence supplies, personal hygiene, diabetic supplies and many more. These patients have very limited income and are barely surviving with government grants. I will not be able to offer them the break that I currently do on their day-to-day expenses if Bill 102 passes the way it reads today. I will not be around if Bill 102 passes.

I also serve a group of brain-injured patients, PHABIS. These patients have acquired brain injuries after tragic incidents or car accidents. These patients need exceptional care. I am on call 24 hours a day, seven days a week, for these patients to answer their challenging questions: missed or refused medications, emergency changes in their blood sugar levels.

I serve one home in Oakville, three in Mississauga and one in Brampton. I know each patient like the palm of my hand. I know every single medication they are on. I offer them services, visit them and consult with their medication policy reviewers to establish individualized protocols for over-the-counter and prescription drug treatments for their chronic conditions.

Personally, I visit them at their home to offer them personal advice, talk to their parents, bring them gifts and arrange special events for them like Halloween and Christmas parties, not because I have to do so or it's my duty, but because of the love I have for these patients and their caregivers, and ultimately because I love being a pharmacist.

When I started my business, I had to contend with goodwill loans, inventory loans, escalating hydro bills and business improvement taxation, in addition to professional service fees like the College of Pharmacists and OPA memberships. Hiring competent staff to run my store, ancillary jobs, are a huge part of my business. I employ three part-time pharmacists, three full-time technicians and two part-time technicians, and retain three delivery personnel. It is very costly running a small, independent store.

I have learned to communicate with my patients in Italian, Portuguese, Punjabi and French, even though none of them is from my background, because of the firm belief of the message for my patients and the primary concern, which is their health.

Removing the marketing allowances, the 8% markup, or 2.4% after sharing it with wholesale, is not a possible model for my store. It has been my heart and soul for nine years, and Bill 102 will close down Leon Pharmacy.

I'm going to have to start by laying off personnel like technicians, followed by pharmacists who assist me to free me up to better help my patients. I'll reduce my business hours to control costs, and finally close my doors to the people, patients and seniors who have known me for all these years.

Leon Pharmacy has been open in Oakville for over 30 years and prides itself on being the oldest independent store standing. Leon is a true independent community pharmacy. I am in a residential neighbourhood. There is no doctor or medical building in walking distance, and my seniors cannot drive a car.

Seniors come to my pharmacy because of the level of service they have come to expect from me, their friend, the only health care professional they can call 10 times a day and who will answer every single question when they call.

I have also with me here a petition signed by our seniors, 304 of them, in one week. If Bill 102 is passed the way it reads and closes me down, it will anger a whole lot of seniors.

I have with me the current financials, enclosed in the package, after running my business for nine long, hard-fought years in a tough industry and business that is a unique blend of health care and retail. As you can see, my revenues have increased 7% from the previous year, bringing my sales to a total of $3.7 million in 2006. My gross profit, which has the marketing allowances declared, is 24%, which is considered very well below any normal business. Businesses in the food industry like restaurants and Tim Horton's gross 40% and 50%. Is 24% too much that Bill 102 wants to trim some more off? My business's net income after income tax is paid, which will be lost revenue to the government if my business closes because of Bill 102, is $72,000, or 1.8% return on my investment for sales close to $4 million. I challenge any investor to put forward $4 million in sales to get $72,000 at the end of the year.

Bill 102 forecasts a loss of about $100,000 to $150,000 from my business. That puts me at a deficit of over $75,000 annually. That will force me to close within 12 months of the bill. I will lay off staff worth salaries in excess of $475,000, or half a million dollars. This staff will end up on unemployment or social assistance, costing the government money.

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I am enclosing in my package actual real financials for six different pharmacies located in different cities in Ontario. None of them can take Bill 102 proposals and stay viable. In fact, I guarantee you, with the new model, they will close—if not in a year, in two.

These pharmacies will affect the care of people in ridings of this very committee: Mr. Qaadri in Etobicoke; Mr. Ramal, we met within London; Mr. Fonseca, Mississauga, in my riding; and Dr. Kular in Gore and Springdale. Even in Rosedale, Hon. Mr. George Smitherman's riding, the very people who voted for him will see a community pharmacy being shut down.

Bill 102 makes sense in recognizing the pharmacist's role as a front-line health care professional. That has been overseen for many years. Hon. Mr. George Smitherman, our Minister of Health, does not want to see us as pill-shovellers. I wish to say to Mr. Smitherman, we are very far from being pill-shovellers.

Bill 102, if passed with the current terms, will force us to reduce staffing, take us away from our customers and become pill-shovellers. Today's community pharmacy is a complete, total package of medical, pharmaceutical, health and business knowledge.

Do not remove the community pharmacist from his role; otherwise, you will see a health system collapsing, and ultimately Ontarians, the very people who voted for you to represent them—your parents, family, kids for generations to come—being the ones to suffer from the consequences of Bill 102.

I am still young. Bill 102 might drive me to seek career opportunities in the States or other provinces. Ontarians and seniors are the ones who will lose the care they have been getting for free, with no obligation; the love, advice and what is good will be lost. The public will have no one to go to.

Your attention, listening, and the opportunity for me to come today means so much to me and my family—Maggie, my wife; Anthony, my six-year-old son; and Natalie, my four-year-old daughter.

You will be touching the lives of people in your ridings, people who trust you to do everything in your power to make sure they are delivered the very best health care possible from their pharmacist. Thank you very much.

The Chair: Thank you, Mr. Tawfik. We have very limited time, about 20 or 30 seconds. Ms. Witmer.

Mrs. Witmer: I want to thank you for coming today and letting us know first-hand how much it means to you to serve the people in your community. I just want to express my appreciation. What you're doing is absolutely phenomenal. I applaud you and I congratulate you. I hope the government will listen to you.

The Chair: Ms. Martel of the NDP.

Ms. Martel: Thank you very much for your presentation. Can I ask, in terms of the background, would the pharmacy A example be your store?

Mr. Tawfik: That is actually my very store.

Ms. Martel: I want to be clear. Does this include everything in the store?

Mr. Tawfik: Everything in the store; that's my total sales, yes.

Ms. Martel: Okay, so whatever you—

Mr. Tawfik: That's everything.

Ms. Martel: The whole nine yards.

Mr. Tawfik: Even rebates. I declare everything that I get. Whether it be in free goods or marketing allowances, they are declared in my statements. Everything that's on here too, my employees: Those are actual employees I have in my store to serve the people.

The Chair: Thank you, Ms. Martel. To Mr. Fonseca.

Mr. Fonseca: Thank you, Mr. Tawfik, for your care, your presentation, your openness and transparency, and for sharing all this information with us, which will help in terms of moving forward and making this the best piece of legislation possible, and making sure that the sustainability of pharmacists like yourself will be something that we will have today and long into the future in Ontario. That's what we want to make sure happens.

The Chair: Once again, on behalf of the committee, thank you to you, Mr. Tawfik, for your deputation and written submission on behalf of Leon Pharmacy.

HARLEY CLARK
GREG SMITH

The Chair: I invite now our next presenter, Mr. Harley Clark and colleagues. You've seen, Mr. Clark, the protocol for the 10 minutes. I invite you to begin now.

Mr. Harley Clark: Joining me at the table today is Greg Smith. My name, as you have just said, is Harley Clark. I'm a pharmacist. I was first licensed to practise in 1963, so I've been in the business and the profession for quite some time. I was a store owner until February of this year. I owned two stores in Simcoe, Ontario, which were and still are affiliated with the Pharmasave banner. The two gentlemen who purchased the business are with me today. Steve Flexman has been up here earlier, and Greg Smith is the other partner who has purchased the business. I still practise as a staff pharmacist to keep my finger in the business a little bit.

I've also been involved with Pharmasave at board level for the past four years; two years as national director, four years as regional director in Ontario and two as board chair. The experience at the board level of Pharmasave has given me a greater insight into the profession and the business of pharmacy, and to see the need for professionalism in the practice of pharmacy.

In order for optimum health care to occur, there need to be relationships and co-operation between pharmacies, manufacturers, physicians and the balance of the health care team to be able to provide the best health care possible.

During the time of my retirement as a business owner, I was amazed by the number of kind wishes and thank-you notes for my efforts over many years. Many events were long forgotten, and the messages related to how much I had touched their lives at some point in time over the years. This kind of relationship is the norm in independent pharmacy. My knowledge level is not to the degree of the newer graduates, but I do see, when I work on a daily basis, the current generation of extremely knowledgeable pharmacists practise very professionally. The pharmacists' ongoing daily contact with clients demonstrates their real caring about their clients.

Pharmacists are, according to many surveys, the most trusted professionals in day-to-day contacts in our population. The main role of the pharmacist is to provide medication information and advice to their clientele. This is accepted and accomplished by the majority of our profession. However, in order to provide the many and varied services, they must also be businessmen and businesswomen. This is where Bill 102 is going to affect the health care of many Ontarians. If there is not sufficient reimbursement for services, there must be reductions in service levels, staff levels and quite likely some store closures. There must be financial viability for small, independent stores to stay in business.

Bill 102 is a major concern to the viability of pharmacy, particularly the community-based independent pharmacy. Small rural locations where there is only one pharmacy are in jeopardy of closing. The ability to have a pharmacy in a convenient location with a staff that you know and trust and who know you may be gone for many Ontarians. It may be off to the big-box store, who will not get involved with you as a person or really understand your personal health care needs.

The government of Ontario is the major third-party provider for most of Ontario pharmacies and has not had a fee structure even close to the actual cost of dispensing a prescription for many, many years. In following along with that, many other third-party brokers who sell benefit packages to business have failed to see the advantage of asking pharmacy for assistance in reducing costs in drug management. The solution offered is to cut back the dispensing fee or some other cost, which digs right into the bottom line of the pharmacist.

The Ministry of Health has suggested that there is money available for cognitive pharmacy services. This is a welcomed recognition. The criteria under which it will be distributed have yet to be defined, and it's an unknown benefit. If you divide the number of dollars on the table by 3,000 stores, it doesn't come out to a whole lot of dollars per store. I think that the placing of the cognitive money on the table is a way to say that you're recognizing our services, but it's not going to be a great financial benefit.

Pharmacy can offer many services to assist in medication compliance and proper medication utilization, such as one-on-one consultations, seminars and clinics, in addition to daily counselling on new and ongoing medications. Our clients repeatedly tell us that the pharmacist is the primary source of medication information; the physician just doesn't have time to do that anymore.

Proper medication management leads to better overall health care and major reductions in health care costs to hospitals, physicians, home care and many other integrated health services also paid by the Ontario taxpayer through the Ministry of Health.

It has been stated many times that a significant number of emergency room clients are there because of drug management problems. This is where pharmacy, if they cut back their services, will not be able to carry on in that area to the same degree that they do now.

As I mentioned earlier, it is encouraging to know that there may be some monies available for cognitive services. The money is nice, but the recognition that the pharmacist is really part of the health care team is more significant.

Medications today are as complex as they are expensive. Therefore, the need for better understanding of medication is ever-growing. The pharmacist needs to be reimbursed according to the value of the service rendered. If Bill 102 is approved as written, the level of service most desirable may not be affordable and thus not available.

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Our business in Simcoe was able to thrive because we saw the ongoing pressure on the profitability of just filling prescriptions. We identified market niches in which we could grow the business, such as home care contracts with CCACs, specialty compounding and adding natural health consultants to our staff.

However, there are many small dispensary-only independent pharmacies that do not have the luxury of niche market business to supplement prescription profit. These are the stores that may not survive. I do not fault the ministry for trying to contain medication costs, but I do

not condone the primary thrust of trying to control costs by drastically reducing the income of pharmacists.

I've heard comments over the past few days that the changes will be revenue neutral for pharmacy, but this is rather hard to believe when the significant changes, such as allowance eliminations and markup percentage decrease, reduce income, and minor changes—a very small fee increase and cognitive services payment with no criteria—increase revenue. I applaud the increase in fee structure, but I maintain that the recommended figure is too little, too late, and still far below the average dispensing fee in Ontario.

The reduction of the markup from 10% to 8% is a bottom line profit reduction, and again, no criteria have been specified. The only area I might concede is a reduction of rebate dollars to be negotiated through the OPA, provided that there are other new areas of revenue as part of the package. However, the pharmaceutical industry must be allowed to invest in pharmacy to some degree to allow some of our services to continue.

One essential point I would like to make is to specify ongoing mandatory procedures for the Ministry and OPA to work together to provide excellent health care at reasonable cost and reasonable return to the pharmacy. This aspect must be written into Bill 102. The wording should also contain the exact powers of this committee.

That's all I have. I would like to thank you for your attention today, and I look forward to a resolution that will be beneficial, firstly, to Ontario health care recipients and taxpayers, and also to the Ministry of Health and to pharmacy as other partners in this whole process of negotiation.

The Chair: Thank you, Mr. Clark. Thirty seconds per side, beginning with Ms. Martel of the NDP.

Ms. Martel: Thank you very much for pointing out that the changes will not be revenue neutral. You pointed out that the $50 million might be to 3,000 stores, but there are going to be two or three pharmacists in some of the stores, so the pie is even smaller, isn't it? Can you give us an idea of what we're looking at in terms of how many pharmacists and what the maximum might be that they receive?

Mr. Greg Smith: We calculated about $17,000 per store, which is what would come back in cognitive services if you divide the $50 million by 3,000 stores. That's just a rough number; it could be even less.

Ms. Martel: And you have three pharmacists in there.

Mr. Smith: Yes.

The Chair: Thank you, Ms. Martel. To the government side: Ms. Wynne.

Ms. Wynne: Thanks for being here. So you are happy about the symbolic recognition of pharmacists with the cognitive fees, but you're arguing that they're not high enough. Can I ask a question about the OPA recommendations? Have you seen them? Do you support the code of conduct—some of those issues?

Mr. Clark: I think the OPA recommendations certainly recognize the role that pharmacy plays in the health care system, and I think that's the most important part of what is coming out of the OPA recommendations and the part—

Ms. Wynne: And what are the services you provide as—

The Chair: With apologies, I have to intervene, Ms. Wynne. Ms. Witmer of the PC Party.

Mrs. Witmer: In 30 seconds, I think all I can say is, thank you very much for a very comprehensive presentation. I hope that the government will respond to the concerns and recommendations you've made.

The Chair: Thank you, Ms. Witmer, and thanks to you as well, gentlemen, particularly to Mr. Clark for your presence and deputation.

MAIN DRUG MART

The Chair: On behalf of the committee, I now invite our next presenter, Mr. Maher Hanna, vice-president of Main Drug Mart, and colleagues. As you've seen, Mr. Hanna, the protocol is that you have 10 minutes to make your deputation. Time remaining will be rigorously distributed among the parties for questions or comments. Please begin.

Mr. Maher Hanna: Thank you. I have with me Mr. Amal Gendi, our executive director.

Mr. Chair and honourable committee members, my name is Maher Hanna, and I'm here to represent Main Drug Mart pharmacies.

By now, and after hearing presentations from other Ontario pharmacists, I'm sure that the committee has formulated a clear idea about the risk involved if Bill 102 is passed through legislation without any amendments. Although I am a pharmacist and a pharmacy owner, I'm speaking today in front of this committee as a concerned citizen who cares about my fellow citizens who are forming the community of Ontarians. I understand that democracy brought me here to express my concern, and I also understand that the same democracy—and I mean true democracy—is able to amend any given bill or proposal, even if it is dictated by the party in power.

We all understand that the honourable Minister of Health is facing a shortfall in his budget. We also understand that in order to resolve this problem, he might have one of the following options to choose from:

—to come up with enough funds either from his government or from the federal government;

—to face the people of Ontario with cuts in health services at a time when more services are needed as our population ages;

—to switch his problem to other honourable ministers, such as the Minister of Finance in the form of lost revenues via taxes; the Minister of Labour and human resources in the form of layoffs and collection of EI benefits; the Minister of Community and Social Services by forcing workers who lose their jobs to collect social assistance payments; and a few others.

The honourable minister has chosen the third option. This option appears easy to be sold to some people who

do not know anything about the economy of a drugstore and its economic effect on the whole community.

Bill 102 will not only affect Ontarians at the pharmacy level with regard to less services provided and less accessibility, particularly in rural communities, as you have heard from my colleagues in previous presentations; it will also affect the whole pharmaceutical industry. In addition, it will have a negative spillover effect on the Ministry of Finance and will definitely place more strain on our social programs. As I explained earlier, Bill 102 will result in lost revenues for the Ministry of Finance with less corporate, business, property and personal taxes collected. Bill 102 will result in layoff of pharmacy staff, who will collect EI and might end up forced to collect social assistance payments.

Mr. Smitherman is looking at saving $250 million for the Ministry of Health. Has he consulted with the finance minister how much of a burden he's just shifting from one ministry to the other? Has he calculated the lost revenue in taxes from all these people losing their jobs? Has he also factored in that these people will not only stop paying taxes, but will also start collecting employment insurance and social assistance if they do not end up finding jobs?

Pharmacists are the most accessible health care providers in Ontario. We provide front-line health care to thousands of citizens every day, with no direct remuneration from the Ministry of Health. Bill 102 will result in closing pharmacies and placing more strain on our hospital emergency rooms and increasing patient waiting times in these facilities. Has the Minister of Heath calculated how much this will cost his own ministry?

Accordingly, I'm resting my case and ask for reconsideration of the following: the honourable government to redo the math, if their real intention is providing transparency to their proposed bill—transparency means fairness also; to recognize the generic rebates as part of the economical pillars to our business in order to keep its sustainability.

Yesterday's announcement to fix the capping of $25 is strong evidence that the government has started to recognize that the whole bill should be totally revised and fixed. I really appreciate that the government has the courage to reconsider, not only the capping but also the generic allowances.

Thank you for giving me such an opportunity to speak in front of you. I'm open to any questions.

The Chair: Thank you, Mr. Hanna. We'll begin with the government side.

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Mr. Ramal: Thank you very much, Mr. Hanna, for your presentation. You started correctly at the beginning, this format about listening to pharmacists and stakeholders in order to make changes and amendments to basically suit the whole atmosphere of the bill.

You mentioned a lot of things. I want to assure you, Mr. Hanna, that this bill was introduced in order to correct and transform the drug situation in Ontario. It was not about raising money or collecting money for the Minister of Finance. That's one. Plus, the money from this transformation of the drug situation in Ontario would be reinvested in listing more drugs and enhancing other drugs to suit the many clients across the province. That's the intent of the bill. And that's also why we're here today, to listen to you and to others in order to see your concerns, and as a great example of what's happened—

Mr. Hanna: But it will not save money for the government, because the government will lose money in other revenues, and hospital wait times will be longer. When you come to your pharmacist and ask for advice on a simple ailment, the pharmacist helps. If you have to go to a hospital or a doctor's office for a simple cold or a simple diagnosis, then—

The Chair: Thank you, Dr. Ramal, and thank you, with apologies, Mr. Hanna.

Mr. Hanna: No problem.

The Chair: Now to the PC side. Ms. Witmer, about 90 seconds.

Mrs. Witmer: Thank you very much for your presentation. I think you've demonstrated that it's simply not possible to cut hundreds of millions of dollars from the budget without some very severe consequences on patients, and obviously on pharmacists as well. You're simply not going to be able to maintain or increase the level of service that you provide.

You've indicated that the government has made a good first step: They've removed the cap of $25. But I guess the other big issue really is the generic allowance. Would you be amenable to that being reinstated in some form and, as opposed to calling it a rebate—and up until now, it's not been all that transparent—having something that would be called a professional allowance or educational or whatever, and having some sort of code of conduct where the government could clearly track the rebates coming from the companies, as well as the amount of any rebate that would be flowing to the pharmacists? Would you be agreeable to something like that happening?

Mr. Hanna: Definitely. We understand that the transparency has to be fair for both sides. We would like to keep all of these allowances open to everyone, as long as they are not capped at a certain percentage or level, because each store has different requirements and a different level of allowance that they require for sustainability and continuing to serve the community.

The Chair: I offer the floor now to the NDP.

Ms. Martel: Thank you for your presentation. Let me just follow up on something Mr. Ramal said, which was to say to you that the government, with its savings, is going to reinvest in more drugs for more people—I'm just paraphrasing. I have a couple of points in that regard. I agree with you that a lot of community pharmacists are going to go down, so we're not going to have any savings. Even if we did—let's just say we might—the government has said they project $289 million worth of savings for reinvestment. It's interesting that the government hasn't provided any background papers as to how they arrive at these savings. In fact, one of the points

they raised, that the feds are going to start paying for their own employees and we're going to save $67 million, is not even in place yet. So it would be really interesting to see the background.

Finally, there's nothing in the bill—not a provision; not one anywhere—that says any savings that are found are going to be invested in the drug benefit program. Nothing; no provision in the bill guarantees that. So if there are savings, you can bet they're going into the consolidated revenue fund, not back into the drug program.

Do you have an idea of how this bill is going to impact on your store particularly? Have you run the calculations?

Mr. Hanna: I'll let Amal do that.

Mr. Amal Gendi: Actually, a high school graduate can do the simple math, but our economy—

Ms. Martel: My math was never good, so go through it with me.

Mr. Gendi: Okay. If you calculate the gross revenue minus the actual cost, you will definitely get to the negative bottom line without any allowances, and that allowance is the only thing that has kept our stores sustainable in the last more than 17 years.

The Chair: Thank you, Mr. Hanna and your colleague, for your deputation and presence on behalf of Main Drug Mart.

AXIS VILLAGE COURT PHARMACY

The Chair: On behalf of the committee, I would now invite our next presenters, Mr. Amin Shivji, owner of Axis Village Court Pharmacy. Welcome. Please be seated. As you've seen the protocol, you'll have 10 minutes in which to make your presentation. I would invite any colleagues of yours to please identify themselves for record-keeping purposes, for the permanent record here at Hansard.

Dr. Amin Shivji: I'd like to introduce my colleagues and independent pharmacists Munir Dharamshi, Karim Mamdani and Shahinur Visram. My name is Dr. Amin Shivji. I am the pharmacist owner of Axis Village Court Pharmacy in Haliburton. Haliburton is a beautiful area that has among the highest number of senior retirees per capita in Ontario. It will therefore come as no surprise to you when I say that well over 50% of my clientele is made up of seniors. Bill 102, as proposed, has very little that I can claim to be positive to my pharmacy.

Every one of us in this room today is aware that anyone can walk in off the street, into a pharmacy, speak to the pharmacist, receive advice, and leave without any obligation to make a purchase, let alone pay for the service. Not many other professions in the world, if any, provide this level of service of care to their clients, and no one is prepared to provide any service without appropriate reimbursement. I provide this high level of service, but it is about to change with Bill 102.

Ladies and gentlemen, I grew up in Kenya, the first son of a Third World farmer with limited income. When anyone in my family had health concerns, my parents sought the advice of a local pharmacist. In many cases, the problem was solved without the expense of moving up the health care chain.

Like my pharmacist from many years back, today I am available to patients without appointments, patients who are seeking advice, who may be having trouble with their medications, issues that can often be resolved quickly before they escalate or cost the health care system unnecessarily. This is about to change.

Bill 102 is telling me that my government no longer wants me to provide my patients with this service. If I cannot provide this basic service, how does the government expect me to provide high-level, time-consuming cognitive services to save my diabetic patients?

Community pharmacy is unique insofar as it provides professional health care in a retail setting. We are all aware that promotional allowances and rebates are normal business practice in the retail sector. Community pharmacy has come to incorporate promotional allowances and rebates into their business model, largely because of the unfair treatment it has suffered at the hands of third-party payers.

The dispensing fee is perhaps the most abused portion of the reimbursement model by government. Every time a government has sought to contain drug costs, it has treated community pharmacy indiscriminately. Independent pharmacy owners like myself have been the most adversely affected.

Twenty years ago, the cost of dispensing a single prescription was calculated at $6.71. The ODB fee was $6.22. Today the cost of dispensing one prescription with a 25% profit is calculated as $11.28. The ODB fee is $6.54.

Neither the current fee nor the anticipated increase is anywhere near the raw cost of dispensing, let alone allowing for generation of profit. As the cost of living goes up, so too must the wages I pay my staff. Occupancy costs go up, and of course the costs of drugs have gone up. Successive governments have failed to deal with the manufacturers' price increases. Once again, I have been penalized, this time due to the erosion of the existing 10% markup as a result of the price increases.

Bill 102 proposes to allow a markup of 8%. If pharmacies are expected to pay the wholesaler up-charge from this 8% markup, the true markup will end up being in the neighbourhood of 2%. What other retailer is forced by government to operate under these conditions?

If the government aims to reduce rebates, I will require that the loss in income be made up through appropriate, fair and honest markup provisions and a dispensing fee that reflects the true cost of doing business in 2006. My government must also guarantee that these will be adjusted in a timely manner to reflect cost increases. With the continued demographic shift, escalation in the total drug bill is inevitable. Unlike in the past, I as a pharmacist-owner must be assured that any attempt to reduce the cost will not once again be done at my expense.

1200

Much is being made of the fact that the government is putting aside $50 million to pay for additional services. One is given the impression that this additional funding will offset some of the loss in revenue through promotional allowances or rebates. While this additional funding is welcome, it must be put into context. This funding is for new responsibilities and new services. Finally, a government has come to understand that pharmacists in the community can play a pivotal role in helping provide Ontarians with exceptional health care services. Pharmacists find nothing new in this. To provide these services, however, I will incur new costs. Not only does this bill fail to recognize that, but it also does not provide for a legislated mechanism of reimbursement for these new services. It has chosen instead to remain ambiguous about the mechanism. Furthermore, it fails to recognize that the daily dispensing function I provide today must be viable before I am able to put into practice the processes that will be required to attain any portion of this new funding.

It is important to understand that loss of revenue from one function, that of daily dispensing as we know it today, cannot be made up in whole or in part by another, namely cognitive services, which in itself will incur new costs. If I am driven out of business because I cannot afford to dispense prescriptions, I will not be able to provide cognitive services, no matter how much the government is prepared to pay for such services.

Over the last five years, I have worked hard to put into place the pieces I will require to provide these services to my patients. I have gradually remodelled my pharmacy to provide the physical requirements, and employed additional pharmacists and dispensary technicians to allow appointment-based services. I have done so even though my current volume does not warrant it. I have done so because I believe that I as a pharmacist can do more, much more, than dispense prescriptions. Bill 102 will force me to undo most of this simply to stay in business. I will have to reduce my staff numbers. I will have to reduce expenses by reducing my service levels. I will be in no position to add the new patient care responsibilities, the only positive thing talked about in this bill.

The government talks about transparency. I have no problem with that, but I do expect my government to be similarly transparent in its actions. The ambiguity and lack of clarity within the bill show anything but transparency.

The Chair: Thank you, Dr. Shivji. We have 30 seconds or so per side, beginning with the PC, Ms. Witmer.

Mrs. Witmer: Thank you very much for an excellent presentation. Do you have a copy of your presentation?

Dr. Shivji: I can leave mine behind.

Mrs. Witmer: Okay, that's great.

You have really hit upon some of the failings of this bill: the fact there isn't transparency; the fact there isn't any clarity; the fact that this recognition of these new services is great, but there are going to be additional costs incurred. Obviously, there's no mechanism to ensure that you are properly reimbursed.

How greatly do you—

The Chair: With apologies, Ms. Witmer, I will have to intervene and give the floor now to Ms. Martel, the NDP.

Ms. Martel: Thank you for your presentation. Thank you for your comments about transparency, because it is so clear that so much of what the government actually promised doesn't even make its way into the bill in any way, shape or form. I don't want to go by a promise or a government announcement. I'd like to see the details in the bill, and they should be in the bill for the benefit of those who are going to be affected.

Can you tell me about the cost to you for new services with respect to offering cognitive services?

Dr. Shivji: Right off the bat, it's pharmacists' time. That is my single priority. I have to have somebody available to provide that service. So you take that time and you multiply it by the time it—

The Chair: Thank you, Ms. Martel. Mr. Peterson.

Mr. Peterson: Are you a medical doctor?

Dr. Shivji: No, I am a PhD in pharmaceutical sciences.

Mr. Peterson: Thank you for your presentation. We are listening. It is the intention of this government to work with the OPA and yourselves to make you frontline care providers in Ontario. That's why we're looking at making the 8% markup a guaranteed markup, not eroded by prices as it has been in the past.

Dr. Shivji: I'm glad to hear that.

Mr. Peterson: That's why we're increasing the dispensing fee. That's why we're also looking at a cognitive fee, and we'll work with you to define that and we look forward to you giving us suggestions on what that cognitive fee should cover. We're also looking at the education amounts—

The Chair: Thank you, Mr. Peterson. On behalf of the committee, thank you to Ms. Visram, Dr. Shivji, Mr. Dharamshi and Mr. Mamdani, for your presentation. As was asked, please feel free to leave any written materials to our committee clerk, Mr. Day. Thank you for your presence.

TINA PERLMAN

JIM SEMCHISM

The Chair: I'd now like to invite, on behalf of the committee, Ms. Tina Perlman and Jim Semchism. As you've seen the protocol, you have 10 minutes in which to make your presentation. Please begin.

Ms. Tina Perlman: Good morning. My name is Tina Perlman. With me is my colleague and friend Jim Semchism. We're both from London, Ontario. I'm currently a member on the board of the Ontario Pharmacists' Association, and I am an independent pharmacist, practising in a variety of community settings, independent and chain pharmacies, as well as an outpatient hospital

pharmacy. Jim is the pharmacist-owner of Ealing Pharmacy, a neighbourhood community pharmacy in London.

Jim and I have served for many years on the executive of the London and District Pharmacists' Association, and we feel that the issues and concerns regarding Bill 102 that we bring forward today are representative of those of our colleagues in the London area. We thank you for this opportunity to present to you today. Both Jim and I have been members of the OPA since we graduated from university—Jim a little bit before me. We are full supporters of the association as our exclusive and official voice.

The board of OPA is comprised equally of independent and chain pharmacists, with representation from the Ontario Chain Drug Store Association and the Canadian Society of Hospital Pharmacists. By virtue of this composition and its over 7,000 members, OPA is truly representative of all pharmacists and pharmacies in Ontario.

In several provinces in the country, the professional pharmacy associations are recognized in legislation or in regulations as the official negotiating body.

We urge the committee to recommend an amendment to Bill 102 that recognizes OPA as the exclusive negotiating body for pharmacists in Ontario.

All components of pharmacists' reimbursement for traditional services, such as dispensing fees, markups and costs, should be determined through negotiation with OPA. We need to ensure that OPA is involved in the development of a fair and viable reimbursement model for all pharmacies in Ontario for the short and long term.

We commend the minister for acknowledging the value of pharmacists as front-line health care providers and for his intention to reimburse pharmacists for medication management services.

We strongly encourage the establishment of a pharmacy council in Bill 102 that will assist the ministry in defining these professional services, developing a fee code and determining the policy, process and implementation of these services.

We support OPA's proposal that the pharmacy council be co-chaired by OPA and the ministry. The inclusion of a pharmacy council in the legislation to provide expert advice to the ministry will send a very positive message to all pharmacists that the government is serious about the involvement of pharmacy in the development of drug and health policy in Ontario for years to come.

Earlier this morning, you heard from OPA and their proposed amendments to the bill. We believe that the approach OPA has taken permits the sustainability of pharmacy, allowing patients continued access to the valuable services pharmacists provide each and every day in every community in Ontario, services that result in dollar savings in other areas of the health care system, partly by keeping them out of emergency departments, urgent care departments and doctors' offices.

At the same time, OPA's proposed amendments also ensure that the goals of the ministry are achieved. In the end, pharmacists, like the ministry, are committed to improving patient care, and if we can work together, we are more likely to be successful. We urge you to consider and accept OPA's amendments and make Bill 102 workable for all.

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Mr. Jim Semchism: I've been a community pharmacist-owner in London, Ontario, for the past 24 years. My practice was opened in 1952 by my father. Nine members of my immediate family are practising pharmacists. Our practices include independent pharmacies, corporate stores and a hospital outpatient pharmacy. Currently, I am the chair of a 29-store, independent buying group in the London area.

I'd like to thank Minister Smitherman for announcing the removal the $25 markup proposed in the initial draft of the legislation. Pharmacists have pointed out the negative economic consequences of this proposal and the minister has listened and acted wisely on the profession's advice.

Within 24 hours of Minister Smitherman's announcement of Bill 102 in the House, an aura of doom seemed to overcome most pharmacist-owners within this province. We feared for our survival. Many of the buying group members felt that their retirement nest egg, their business, had been greatly depreciated.

Yesterday and today, you heard from pharmacists about the economic impact of the bill. My practice and those of my family and business colleagues are no different. Removing industry generic allowances puts us all in the red. Without them, none of us can launch the innovative cognitive services that the minister proposes to fund. None of us can make a profit today if you remove that generic funding from our current businesses, when one takes into mind the low remuneration we receive from the Ontario drug benefit plan for prescriptions on the ODB. The removal of the generic funding, compounded with the reduction in markup, will result in my business losing several hundred thousand dollars annually.

I believe that the Drug System Secretariat has significantly underestimated the value of these rebates. Within our group, the average generic rebate amounts to about $180,000 per store per year. This funding supports the wages of professional staff, the education of this staff and the provision of special services to our patients.

My own business has funded the education of a pharmacist as a diabetes educator, a pharmacist as an asthma educator and the training of a pharmacist to monitor and train patients in using blood coagulation devices. We've funded pharmacy students for the past five summers, and this summer we have taken on a pharmacy intern for four months.

Our pharmacists have attended continuing education programs put on by provincial and national pharmacy conferences over the last 25 years. On Friday, two of our staff will be flying to Edmonton to attend the national conference.

Rebates also cover renovations to our dispensaries. Two years ago, my practice doubled the size of the

dispensary, enhancing our efficiencies, allowing us to provide more physical space for the services that the minister expects us to provide.

Generic funding also allows us to provide prescription delivery service, which allows seniors and those patients who are non-ambulatory to receive their medication without coming directly to the store.

My own business serves a multicultural population. I have tried to hire staff who speak a variety of languages. Currently, we have staff members who speak Portuguese, Greek and Italian fluently, and this helps us in our communication with members of these ethnic groups.

In regard to the markup reduction from 10% to 8%, today, 95% of purchases are from wholesale. When the 10% markup was put into place in the mid-1980s, 70% of dispensary purchases were direct from the manufacturer. This has changed dramatically. I believe that the effective markup that pharmacy is receiving today is approximately 4%. This is because the ministry has left prices at 1997 levels, totally eliminating the 10% on over 700 drugs that we commonly dispense. Also, the brand name industry has forced us to depend on wholesale distribution in their practices in recent years.

A 2% markup cut will not be helpful to pharmacy. Even if the legislation eliminates the cost to operator claims, our dependence on wholesale up-charges at the 5% level probably nets us down to 3%, which is less than the 4% we are currently at today.

The markup reduction, from my perspective, is negative. I've tried to calculate it out within my own business as being approximately $25,000 annually. If my pharmacy loses $280,000 a year in generic rebates, plus a $25,000 reduction because of the 2% clawback on the reduction of the markup, I estimate that my losses off my gross profit will approximate $300,000.

If we look at the dispensing fee increase that is proposed, the 46 cents, I currently fill 27,000 prescriptions, and you can see that it does not come near to accommodating the loss caused by the impact of the other two issues. My estimate is a loss in my own business of approximately $290,000. If the minister was serious about allowing the 20% education allowance funding, the loss still remains significant at over $200,000.

Many of my colleagues are very concerned about the potential of a ministry rollback in generic prices. This, again, would have a significant impact on pharmacies' viability.

One last point worth considering is that if one calculates the amount of generic prescriptions that are filled in the marketplace today, one comes up with a number of 45% of the prescriptions. But if you look at the actual dollars that are spent on prescriptions, the generic dollars amount to only 17%.

In conclusion, the 29 pharmacist-owners in the buying group that I chair feel that Bill 102, as proposed, will wipe out the inherent value of our businesses. I have worked for 30 years at my practice providing health care services in southeast London. Today, like my colleagues, I feel that my business has potentially lost much of its value if the legislation moves forward as proposed.

The Chair: I will have to intervene there. I would like to thank you, Ms. Perlman and Mr. Semchism, on behalf of the committee for your deputation and presentation today.

I would also like to advise all my colleagues that we will be recessed, but we will be resuming immediately following question period, not after orders of the day petitions.

This committee stands recessed. Thank you.

The committee recessed from 1216 to 1532.

CANADIAN ORGANIZATION FOR RARE DISORDERS

The Chair: Ladies and gentlemen, on behalf of all members of the committee, I will welcome you and call this committee back into session. As you know, we're here to deliberate on Bill 102, An Act to amend the Drug Interchangeability and Dispensing Fee Act and the Ontario Drug Benefit Act.

I will now call, on behalf of the committee, our first presenter, Mr. John Adams, treasurer of the Canadian Organization for Rare Disorders. I remind all interested parties that we have a very strict 10-minute rule and that we have more than 100 presenters coming before the committee. I would invite you, Mr. Adams, to being now.

Mr. John Adams: My organization, CORD, is a national charity focused on providing information, support and advocacy for Canadians who live with a rare disorder.

What is a rare disorder? We don't have a definition of a rare disorder in Ontario, in this bill or anywhere in Canada, unlike Europe, Japan, Australia or the United States. The European Union's definition of a rare disorder is a health condition affecting one person in 2,000 or fewer, and the European definition of an ultra-rare disorder affects one person in 100,000 or fewer.

There are more than 8,000 conditions which meet that European definition, so collectively the known rare disorders affect many, many people here in Ontario and across Canada. For most rare disorders, unfortunately, there are no treatments yet, so a driving commitment to research and to quick access to clinical trials and breakthrough treatments are key issues for us. Overall, CORD supports the need for improvements in Ontario's public drug program.

I was in this very same hearing room last September on behalf of CORD to help inform and educate MPPs about the case for expanded screening for newborns for rare disorders. That hearing was a lowly private member's bill, and each presenter was given 20 minutes. In my view, it is a crying shame that citizens petitioning their elected representatives today for changes in this powerful government are restricted to a mere 10 minutes. While this committee will hear something like 100 presenters, it is a shame that more than 200 individuals and organizations who asked to speak are denied access to

this process by the use of time allocation or closure. This is not a sterling example of local democracy working well.

Last summer the Ontario Ombudsman described newborn screening in Ontario as being like "Third World conditions." That's a quote. Mr. Marin was 100% accurate, and his report helped the Ontario government understand that dramatic changes were needed.

The lesson of newborn screening in 2005 is that it took a strong commitment from the Minister of Health to overcome inertia and silo-minded advice. It took the government three tries before it got mostly right the case of expanded newborn screening. Last July, for example, the plan was to expand from three to eight disorders. Once the Ombudsman levelled his criticisms, the plan was to include 22.

There are MPPs here today who were present last September and they remember the outrage from citizens when the announced plans to expand newborn screening did not included sickle cell diseases. Thankfully, the government came to its senses on that issue—

Mr. Ramal: We did.

Mr. Adams: Yes, you did—no, you haven't done it yet. July 1, right? George Smitherman did revise the plan, and we will begin screening all babies in Ontario for sickle cell on the first of July, and also have the public intent to screen all babies for 28 disorders by the end of this year. But we are waiting for cystic fibrosis to be included, as it is in Australia, Mississippi, New York state, North Dakota and the Calgary health region, to name a few jurisdictions.

Skepticism about the new rhetoric of citizen participation accompanying this Bill 102 is understandable when we see no citizen participation in the new advisory committee on newborn screening. I submit to you that the Ombudsman's description of "Third World conditions" applies equally to other aspects of dealing with rare disorders. Unlike the Americans and the Europeans, we have no focus on rare disorders in terms of government funding for research or market incentives to discover and develop what are called the orphan drugs for rare disorders. CORD asks all governments in Canada to work on a national strategy for these orphan drugs.

The Americans and the Europeans have public policies and programs which recognize that it's difficult and expensive to discover and prove the safety and efficacy of new treatments for previously untreatable rare disorders. There is a lack of a coherent federal and provincial strategy for rare disorders that has a profound burden on Canadians with rare disorders. We are, unfortunately, increasingly the last people in the developed world to get access to new breakthrough therapies for untreatable conditions. This is one of the wait lists that we should be measuring and reporting.

I believe that Tommy Douglas, the political father of medicare, or public health insurance, is rolling over in his grave over the distortion of his ideas. Public health insurance at its core is not about covering every expense. It was created to protect families from catastrophic expenses if you had the bad luck to need major help. It is foremost about pooling the risks of catastrophic health costs so no one is denied necessary medical services because of their personal finances, or is forced to rely upon the vagaries of private charity, as happened to Mr. Douglas as a boy.

When I was nine years old, my mother was going to die because of a serious heart condition. She was the fourth person in Canada to have open heart surgery and is the only person I know to have open heart surgery three times. Each operation and convalescence would have bankrupted our family.

When Mr. Douglas launched medicare in Canada, its scope was limited to doctor and hospital services. It did not and does not cover prescription drugs, which were few and far between in the 1950s and 1960s compared to today. Thank heavens that medical treatments have improved dramatically.

CORD supports and wants to reinforce the need for rapid review for new drugs for life-threatening or serious disease for which no other treatment or effective drug therapy exists, or which represents a significant improvement in terms of efficacy or reducing side effects. We ask for a definition of breakthrough drugs and a definition of decision-making criteria for rapid review of breakthrough drugs to be added to this legislation.

These breakthrough drugs will be expensive, and the impact on saving lives and the quality of life of patients for those without any other treatments must be evaluated on humanitarian grounds and not just on cost. And I am aware that there are some informal discussions and there seems to be light at the end of that particular tunnel, although it may appear in the form of draft regulations rather than the statute. But I would hope that the committee might exercise its political oversight and encourage the decision-making criteria for rapid access, rapid review, to be included in the legislation. That would give it the highest profile and the highest legal certainty.

1540

We are waiting for Ontario to fulfill its promise made last year to provide rapid access to breakthrough therapies for two life-threatening rare disorders: Fabry and MPS I. There is also the additional case of a 5-year-old boy with MPS VI which is on the minister's desk.

CORD joins with other patient organizations to ask for more time and more consultation on this legislation and the draft regulations to come. While we did participate in the previous useful consultations with ministry staff as the drug secretariat was considering policy, there has been far too little time to digest the full significance of the actual legislation.

CORD, like others, is concerned about the language in Bill 102 setting the stage for therapeutic substitution. We ask for a review process for decisions by the executive officer with proper accountability.

Thank you very much.

The Chair: Thank you, Mr. Adams. We have about 30 seconds per side, beginning with Ms. Martel of the NDP.

Ms. Martel: Given the time, I think I'll just make a comment. I'm concerned about citizen participation, be-

cause I see that the citizens' committee is not anywhere in the legislation. I'm concerned about the promise for a rapid review, because there's nothing in the bill about that, nor is there anything in the bill about what new process will replace the section 8 process. There isn't anything about breakthrough drugs. Finally, I'm worried about treatment being considered with respect to economic evidence, because it clearly says on page 6 of the bill, "Funding decisions for drugs are to be made on the best clinical and economic evidence available," and many people think that's why so many of the cancer drugs haven't been funded.

Mr. Adams: Please change that section.

The Chair: Thank you, Ms. Martel. We'll offer it to the government side.

Mr. Peterson: Our consultations have been undertaken over a year, and we've done extensive consultation with all kinds of different interest groups. If you don't feel you've been properly consulted, I look forward to receiving any other information you have on what areas you think we're missing in this. If you could briefly tell us what you think those areas are at this point in time, I'm here to listen.

Mr. Adams: The most important thing for the rare disorder community is that the criteria for decision-making around rapid review to access to breakthrough drugs include quality-of-life considerations.

The Chair: Thank you, Mr. Peterson. Mr. Jackson of the PC Party.

Mr. Jackson: Thank you very much. Welcome, John. I appreciate your brief. Are you concerned that the government has acted—if we just take the microscope up, the government says they're going to do all this and they're going to save $300 million, maybe half a billion dollars. I'm struggling with the notion—just a general question: How do we expect to get so many more new leading-edge drugs when all the evidence is clear that we are so far behind other jurisdictions across Canada? I'm not just talking about cancer. That's the one I'm completely familiar with. You bring to the table a whole series of other drugs. Would you like to comment on that?

Mr. Adams: We need to be spending more on effective drug therapies, not less—that's it in a nutshell—because there are so many breakthroughs now and Ontario residents with rare disorders are usually behind Bulgarians in terms of getting access to those new therapies.

The Chair: Thank you, Mr. Jackson, and thank you, Mr. Adams, for your deputation on behalf of the Canadian Organization for Rare Disorders.

WALSH'S PHARMACY

The Chair: I will now call on behalf of the committee Mr. Joseph Walsh, owner of Walsh's Pharmacy. Mr. Walsh, you've seen the protocol. You'll have 10 minutes in which to make your complete address. Any time remaining will be distributed evenly among the parties for questions and comments. Your time begins now.

Mr. Joseph Walsh: Honourable members of the committee, I come before you not as a corporation or association but as the sole owner of an independent pharmacy. Bill 102 will put me out of business. Let me repeat this: Bill 102 will put me out of business, the way it is written.

My father started my pharmacy over 50 years ago in a small town of 2,500 people. He worked hard to create a business that was community-oriented and successful. I know this because I worked there and started from the bottom of the proverbial ladder as a garbage boy. My brothers and sisters all worked in the family business, which gave us a sense of community and pride in our work, which has helped us forge our own careers. Mine was to follow in my father's footsteps. I saw how he helped people and took great pride in his business and his community and this inspired me. I took over the business in 1992 and I've carried on the dream of providing our small community with all the services and products that the bigger centres take for granted, plus that little extra that we're known for that helps small communities.

We call our pharmacy Walsh's Pharmacy because we are proud of what we have accomplished and want to let people know that we own this business. We take pride in calling this a family practice pharmacy, a play on words. Our family—literally, my wife, son and daughter—all work there now, and we look after our patients' families, from being born right through to home care for seniors.

Our store of 3,500 square feet gives jobs to 14 people. If Bill 102 goes through, 14 people will be out of work because we will be out of business. Let me repeat: 14 people will be out of work. Multiply this by approximately 3,000 pharmacies and the numbers rise very quickly.

How is Bill 102 going to put me out of business? Increasing the fee to $7 is a joke and an insult for what we do for the government in health care. The fee, when the drug benefit was created, was not much lower than this, and what can you get now that you could get 30 years ago? The OPA fee guide states that we should be doing 12 prescriptions per hour, from greeting the customer to counselling at the end of the session. At $120 an hour, that is $10 per prescription, with a 2% increase yearly which is not negotiable. Ninety-day supplies should be only listed on low side-effect medicines. With all other medicines, it should be 30 days only.

Price erosion: Name another business that has a third party dictate the cost to get the product in, what you can sell it for, what your fee is to do this, have a minimum requirement of what you have to do to get paid, and then you have to put the cost and your profit, which are theoretical, on the price tag, which is the receipt we give to the patient, which is mandatory. I cannot think of any other business like this except for pharmacy under drug benefit. I've put an example on the sheet you have there of medicine with cost erosion. I'm not picking on Lipitor and Pfizer but it just came into my head. With this medicine you can see that at the end of it I'm losing over $10. I get $6.54 from drug benefit. How I'm losing money is not rocket science.

Why is there price erosion? Because the price has been fixed for as long as I've been a pharmacist: 15 years. Pharmaceutical companies are allowed to increase the price but we're not able to charge the patient the difference, so the pharmacy absorbs the difference in the cost. When I started, there were approximately 10 products. Now, 15 years later, I believe it's pushing 300 pharmaceutical items that fall into this category.

Bill 102 wants to cap the markup at $25. I just got a fax yesterday that this has been taken back, but just to add to this, the 10% that's marked up now is out of date as well. Most management studies show that it's 12% to keep a product in stock. If I have a $1,500 cancer medicine for a patient, it's going to cost me more than 10% to keep it in stock for that patient. Bill 102 wants it to be 8%, but do we know if that is after the price erosions have been corrected or before? As far as I know, OPA and no one else knows this yet.

Interchangeability: We have the best health care system in the world. Why are we messing with it? We need a non-partisan third party to decide, after thorough testing, if a medicine is the same or similar, depending on which word you want to use, because both have been used in the information I've gotten. Not a single person, just to speed up the process, should have this power. I put my reputation on the line in a small community when I tell a patient, "This medicine is the same medicine that you'd be getting but less expensive, and Health Canada has tested it." Under Bill 102, if down the road the product is found not to be, who is liable? If it was me, then you can see how this can put me out of business. Interchangeability is not to be used to save on the bottom line but to allow more affordable health care to the taxpayer with no risk to their health.

Reducing rebates: This one really gets my back up. Rebates play a significant role in all businesses. Grocery stores have them for end displays and video stores get rebates for putting a certain poster up in the window. Most of us get a rebate for sending in for electric bulbs that are better, or even on your car you get a rebate. Why does Mr. Smitherman believe that pharmacy, which in my community is a business bringing health care to my area, is not able to have a rebate?

1550

Our rebate was created by drug trading under PPEP, which is an acronym for professional pharmacy education program. It was to show to all third-party insurers and drug benefit and was unanimously okayed, with no mention of a cap or a percentage needed. Why now? I even pay GST on this rebate, so health care even gets some of this money back.

For the committee to break down where the rebates go—I'll tell you right now that there's no list of couches, trips or yachts that I have in my backyard. Twenty-five hundred dollars goes to each clinic that I have, approximately 10 in a year; $1,200 for my blood pressure machine; and just last week I caught five people who weren't aware that they had high blood pressure. How much is that saving the health care system?

Continuing education and seminars: Everybody around this table has probably had to go to a convention or seminar. How much does that cost?

Again, as I mentioned: no mention of trips, cars or yachts. I don't have any in my backyard. I don't even like the water.

Taking a rebate away will be the biggest nail in the coffin for my pharmacy, as you can see on my financial statement, which is at the very back. It shows my gross profit last year of $62,000 and my rebates of approximately $80,000. Take away my rebates and you don't need a calculator to see the difference.

Rebates are going to supplement areas in our community in which the health care system and the Minister of Health have fallen short. My father, who's working for me today and celebrates his 80th birthday tomorrow, Wednesday, May 31, always said that you shouldn't argue or complain in a situation unless you have some solutions. So here are my solutions to make Bill 102 better:

Pay pharmacists what they're worth. Seven dollars is a disgrace and shameful. In the front line of health care, we look at the fee as what the government thinks of us. Fifteen dollars is where it should be, and non-negotiable.

Make home care coverage supplemental, which means if a home care patient has other coverage, why is the taxpayer paying the majority of the cost? This would save $6,000 per month at my pharmacy, which is $72,000 a year. Multiply that by the pharmacies. We already have a program in this, as in the Trillium program.

Trial prescriptions, which were suggested by OPA, should be revamped. Thirty days is still too long. Seven to 14 days is what we need to find out if the medicine is working, and that would also save double the amount saved by drug benefits. Only lower-side-effect medicines, which are already listed in the drug benefit book, should be a 100-day supply. All other medicines should be 30 days so that we can keep track of compliance, which will decrease doctor visits and hospital visits.

Strict guidelines for prescribing for pharmacists: Before OMA and all the doctors get on my back, it's strict prescribing. Why does a patient have to go to the doctor to get a refill on test strips for diabetes when the doctor writes the prescription back, "Glucose test strips"? The doctor doesn't even know what machine they're using. This would save on money and doctor visits and take pressure off doctors.

Cognitive services, which means paying us for taking pharmaceutical care to the next level, such as diabetic educators, asthma educators and weight loss educators, to name a few. All these hats pharmacists can do, but they are cost-prohibitive to us because the cost to get to this level takes time and money, which has not been reimbursed by insurers. This must be a priority to the next-generation drug benefit. We as pharmacists are ready, but the drug benefit must find a way to reimburse that is not time consuming and a burden to a pharmacy. I plea with drug-benefit: Take the next step, cognitive reimbursement, and see how much it reduces doctor visits and hospital wait times.

In conclusion, in pharmacy, my community would like me to continue to provide the highest standard of health care. Bill 102 will not allow us to do this. We, at the front lines of health care, recognize that this system needs to be revamped, but Bill 102 goes about this by handicapping individuals who have been relied on to deliver care in the past. We have ideas to correct the problems. Just ask. So I challenge this committee to fax a simple survey to all the pharmacies, asking for one or two ways to fix the system. I know it can be done, because you should see all the faxes I got from Bill 102. I know you will be surprised with the replies.

In closing, I leave this committee with this: Being the best only means that the next day you go out and try to get better. Wouldn't it be great if we could apply this to pharmaceutical care? Bill 102 will not allow us to do this. Thank you for listening.

The Chair: Thank you, Mr. Walsh, on behalf of the committee, to both you and your family for your written deputation and your presence here.

WARDROP PHARMASAVE

The Chair: I now invite our next presenter, Mr. Trevor Wardrop, the owner of Wardrop Pharmasave. Mr. Wardrop, as you've seen, you have 10 minutes in which to make your presentation. Please begin.

Mr. Trevor Wardrop: First of all, I would like to thank you for this opportunity to speak. My name is Trevor Wardrop. I own a retail pharmacy in Port Elgin, a small town with a large senior population on the shore of Lake Huron. I have been a pharmacist for close to eight years and have owned a pharmacy for the better part of seven years.

My pharmacy education was completed outside Ontario, in Michigan, so I am licensed as a pharmacist in Michigan as well as in Ontario. When I graduated from pharmacy school, I wanted nothing more than to return to my hometown to serve the people who helped raise me to the level I am at now. Although I received numerous outstanding job offers in the state of Michigan, I still chose to return to my roots and come home to Port Elgin.

As you can see, I have a physical disability which limits my mobility. Finally, I have my pharmacy set up the way I want it for me to be a productive, helpful member of my community. Because of my past problems, I know what it's like to be on the other side of the pharmacy counter. I really enjoy helping people, because I know what I needed when I needed help.

The pharmacy I own is very physically accessible. When I purchased the store, we lowered the pharmacy counter, widened the aisles and made it more accessible and more patient-friendly. Basically, my mission was to make a difference as a health care provider and business person in the community that I love. I fear that Bill 102 may drastically change my practice in a negative way.

At my pharmacy, we offer many services that go above and beyond what is deemed required service. One service that we provide is a shuttle that travels from my pharmacy to a medical centre eight kilometres away. This is provided to our customers free of charge and is covered by the pharmacy. Should Bill 102 go through without any amendments, this is an important service that I feel would have to be removed in order for my business to remain viable.

I'm sure you are aware of the highly accessible nature of the pharmacy profession, and that a number of residents of Ontario are currently without a family physician. That is true in Port Elgin, my hometown. My pharmacy serves as a pseudo doctor's office—I'm sure other pharmacists will attest to this fact—and there are a number of health-related questions that I receive on a daily basis. Should Bill 102 be passed in its current form, rural communities stand to suffer the most, with the potential removal of their most accessible health care provider. The wait times at emergency departments stand to become even longer, because questions that are normally asked of the pharmacist will now be asked of the emergency room doctor, much to the frustration of the ER doctor. However, a higher cost will be incurred, which will become obvious if Bill 102 passes as it stands.

Most pharmacies, including mine, offer influenza vaccination in the hope of preventing a pandemic of influenza. Should certain funding be eliminated and pharmacies close as a result of the passing of Bill 102, this could have devastating results, especially on the senior population. My pharmacy, in particular, had over 100 people vaccinated in just over four hours. Multiply that number by 3,000 and the number of pharmacy-vaccinated individuals across Ontario becomes clear. Most pharmacies operate an influenza clinic at a loss as a service to their patients and customers. This is another service that would not be provided as a result of the passing of Bill 102.

Currently, I am pursuing a master's degree in nutrition to further my knowledge in order to provide a unique aspect of pharmaceutical care to my patients. I'm also a structured practical experience program teaching associate for the University of Toronto, with the goal of helping young pharmacists become proficient in pharmaceutical care. Should the current form of Bill 102 be passed and rebates are eliminated, I feel pharmaceutical care may take a step backwards and force pharmacists who have the goal of providing elite pharmaceutical care to abandon that goal in an attempt to increase volume prescription numbers.

1600

In 2003, as you can see in your handout, I was awarded a drugstore outstanding service award as an outstanding owner/manager of a retail pharmacy. My mother was an honourable mention at this year's DOSA award ceremony in the same category. Our store has received an outstanding business award from our town for above-and-beyond service to the community. Our customers clearly value our role in the community. Again, should our business become unviable, our community suffers.

I feel that Bill 102 is trying to separate the profession of pharmacy from the business of pharmacy. This is not

possible, since in essence it is a symbiotic relationship. It's like trying to run a three-legged race with only two legs. Ultimately, the partnership fails.

In conclusion, there are obviously too many grey areas in the legislation as it stands, but the clear thing is the obvious cuts to pharmacies. These include the removal of rebate dollars from generic manufacturers, the 8% upcharge on medications and certain other aspects.

What I would like to see is a fix to Bill 102 that is viable to both pharmacy and the government. I am sympathetic with the concerns of the government as far as cost savings, but I feel that too much is being done at once. As the bill stands now, the major financial contribution comes from pharmacies. However, the ultimate suffering will be incurred by the patient population, perhaps somebody you love.

The Chair: Thank you, Mr. Wardrop. There's a minute each. We'll move to the government side.

Mr. Fonseca: Trevor, thank you very much for your presentation, and for your commitment and passion to your community in coming back to Ontario. We thank you for that.

We want to make sure that we fix a drug system that is broken today, and many of us here as MPPs have heard from all stakeholders about how the system is broken. This piece of legislation looks to fix it. As we do that, we want to make sure the profession of pharmacy is viable and sustainable today and for years to come.

In talking about that, what we want to make sure of is that through this piece of legislation—in section 19, you'll see that even after price erosion, there is an 8% guarantee that we will be bringing forward to pharmacists. We've raised the dispensing fee, and we are looking at how we can address those cognitive services you provide free of charge to the community today. We feel that the knowledge you are imparting to people in the community should be fairly compensated.

The Chair: Thank you, Mr. Fonseca. Now to the PC side.

Mr. O'Toole: Thank you very much for your presentation and dedication to your profession, and for taking the time and effort to make it here today to make your voice heard. That's what is most important. It's what you say, not what Mr. Fonseca said.

They aren't destroying health care; they're wrecking it. Yes, it needs to be fixed, and we would all agree there are some improvements in this bill.

Interjection.

Mr. O'Toole: Mr. Fonseca has had his time. He was rude to you—he lectured you—and now he's being rude to me.

These hearings are a sham. They're not listening, do you understand? They're going to yank out $500 million and tokenistically give you back $50 million to give some expertise, comment and assistance. If they wanted to really resolve primary care reform and integrate pharmacists into that collaborative health team, then there would be something to listen to. This process here is about cutting money out of health care and creating a two-tier health care system.

I'm here to listen to you. Respectfully, the things you've said today are quite refreshing.

Mr. Wardrop: What I would like to ask is, how much did you pay for gas 15 years ago? How much do you pay today?

The Chair: Thank you, Mr. O'Toole. Ms. Martel, about 30 seconds or so.

Ms. Martel: Thank you for your participation.

You heard the government say what they're doing for pharmacists. I'd put it this way: On one side, you've got a 10% markup moving down to 8%—and depending on what that's on, it's even less than that—and the loss of the professional rebates, which is huge in every pharmacy. On the other side, you've got a 40-cent dispensing fee, which isn't anywhere near the actual cost, and $50-million professional services, which among many pharmacies will be about $17,000 per pharmacy, and then, divided again per pharmacist, doesn't even make up for the promotional rebates. What do you think? Is that a fair deal for you?

Mr. Wardrop: No, I don't feel it's a fair deal. I go back to my answer before. Everything has increased, but a 40-cent increase in a fee is ludicrous, really. When you think of what you paid for even gasoline 15 years ago, we still have the same fee now, basically, that we had 15 years ago.

The Chair: On behalf of the committee, Mr. Wardrop, we'd like to thank you for your presence and deputation today.

TORONTO BIOTECHNOLOGY INITIATIVE

The Chair: I would now like to, on behalf of the committee, invite our next speakers, Mr. Grant Tipler, president, and Mr. Jeffrey Graham, corporate secretary, of the Toronto Biotechnology Initiative. Gentlemen, please be seated. As you've seen the protocol, you have 10 minutes in which to make your combined presentation, beginning now.

Mr. Grant Tipler: Good afternoon, and thank you for the opportunity to appear before the committee. The Toronto Biotechnology Initiative represents all facets of the biotechnology community in the greater Toronto area, including biotech and biopharmaceutical companies, researchers, students, investment firms and consultants. TBI has a long history of contributing to the community in the form of education and networking activities, and has on occasion been an important contributor to the public policy exercises within Ontario where interests of the sector have been put at risk. It is in that latter capacity that we appear before the committee today.

Ontario benefits from a well-established drug manufacturing industry, both brand name and generic, as well as a biotech sector with the greatest promise of any in North America. Next to the United States, Canada has more biotech companies than any other country, and

Ontario is home to many of them. The promise of biotech is just beginning to be reflected in a growing number of biotech, medical diagnostic and therapeutic applications entering the market.

Aspects of Bill 102 raise serious questions about the commitment of the government of Ontario to encourage a biotech sector as a centerpiece of its innovation strategy. At the same time as the Premier, also the Minister of Research and Innovation, is singing the praises of Ontario as a great place to commercialize biotech, the Ontario Minister of Health and Long-Term Care is announcing changes to the rules and policies related to drugs that diminish the economic prospects of brand name drug manufacturers in Ontario and in other parts of Canada as well. This is not the stated objective of the changes announced, but it is one of the obvious consequences.

Why should those of us who are concerned with the future of biotech in Ontario and Canada be troubled by Bill 102? The greatest promise for biotech in Ontario is in the medical sector. It is where the greatest number of Ontario biotech companies are developing products. These will be Canadian products that improve the diagnosis and treatment of disease of our citizens and become important sources of exports to other parts of the world.

Aspects of Bill 102 will impose unprecedented restrictions on the sale of brand name products in Ontario that will make it more difficult for Ontario biotech to be successful. Biotech benefits from a strong and growing drug manufacturing sector. That is not only true of Ontario. In virtually every country where there is a thriving biotech sector, one can point to a significant brand name drug presence close at hand. Drug companies are a source of investment capital to biotech, and essential partners for research and development activities and product commercialization. To the extent that brand name drug companies will find Ontario a materially less attractive place in which to do business as a result of Bill 102, Ontario biotech will be disadvantaged. Ontario biotech will find it more difficult to do deals with brand name companies, and the pool of experienced managerial talent from which biotech recruits many of its business leaders will be diminished.

At the same time, it will be more difficult to attract new brand drug manufacturing and biotech activity to Ontario. Bill 102 is widely perceived in the international biotech community as anti-brand name drug manufacturers and, by extension, anti-biotech. The work of the leaders of the brand name companies in attracting world product mandates to Ontario is being seriously undermined. The ability of the government to promote Ontario as a place to do biotech will suffer the same fate.

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What should the government do now? The government should rethink its decision to press ahead with Bill 102 and the related policies on an artificial timetable designed to limit informed discussion. To this point, there has been no meaningful consultation on Bill 102 and the related policies. The government's claim that there were extensive consultations before the release of Bill 102 in mid-April is simply not correct. There was an earlier extensive fact-finding process that involved many stakeholders, but at no time prior to the release of Bill 102 were there any consultations on what has been proposed in the bill and in the related policies.

Contrast the Ontario process with the more respectful process of drug policy review in Quebec that began in 2004 with a government policy paper and public hearings, followed by legislation last year. The Quebec policy paper recognized the importance of balancing the health policy objectives of access to formularies, fair and reasonable prices, and optimal drug use with maintaining a dynamic pharmaceutical sector in Quebec. This final policy objective, a dynamic pharmaceutical sector, is inexplicably missing from the Ontario exercise. To quote from the Quebec paper, "The pharmaceutical sector is a major player in the Quebec economy. It is therefore important to link health and industrial policy in order to ensure that the government acts coherently in these fields." How could anyone disagree with that observation, and why is the same statement missing from the Ontario initiative?

Specifically, what are we recommending? The government should complete the policy-making process in a sensible and respectful manner.

First, the Ministry of Health should be required to work with the other ministries of government that have an interest in drug policies, including finance, economic development, and research and innovation, in completing the economic and related analysis that should underlie changes to drug policy. Our sense is that this was never properly undertaken and the consequences of Bill 102 and the related policies were never fully considered, either by health or, for that matter, by these other ministries. The full economic consequences of each of the various initiatives with Bill 102 and the related policies needs to be considered, not simply the hoped for financial saving for the budget of the Ministry of Health.

Once that process of internal consultation and analysis is completed, the government should release details of the various proposed policies that are related to Bill 102 and that have been announced in brief summary only. To do anything less at this point would be, with respect, not responsible government. We have the right to insist that government make policy in a manner that is open and transparent and in the best long-term interests of its citizens. We are prepared to work with the government to turn this process into something we can all be proud of.

We urge this committee to heed this advice and recommend that further consideration of the bill be postponed until the policy-making process has been properly completed.

Thank you. We are now happy to take questions.

The Chair: Thank you, Mr. Tipler. We'll begin with the PC side. A minute each.

Mr. O'Toole: Thank you very much. I don't know where to begin. We did hear a similar presentation yesterday from Mark Poznansky of the Robarts Research

Institute, saying the rudeness of looking at the loss of R and D and the growth to advantage the treatment of our citizens and complex diseases—we're being denied that.

I think it's true as well, as you've said—I tried to make the question to the minister today say pretty much what you've said here: "The government should rethink its decision to press ahead with Bill 102 and the related policies on an artificial timetable designed to limit informed discussion." It's absolutely true. You're seeing it here: 10 minutes to deal with such a complex, important component of health care, which is the number one issue to our constituents. You said, "The government's claim that there were extensive consultations before the release of Bill 102 in mid-April is simply not correct." I would use a stronger word than that.

That's why I'm surprised that the government members, some of whom are doctors—actually, the Chair is—are sitting here placidly, eating the pablum given to them by George Smitherman. It's insulting. You, as a researcher, understand that. I think—

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

Ms. Martel: Thank you for being here. I want to focus on your point that there has been no meaningful consultation on Bill 102, because the government's going to talk about all the consultations with Helen Stevenson. Do you want to tell me the difference between the meetings with Helen Stevenson, if you ever had any, what went on at that time, and then the bill that's before you?

Mr. Tipler: The consultations we're referring to were certainly early on in the process. They were meeting with patients' groups to try and understand facts. Really, the issue we have, and as part of a meeting with Biotech Canada—we did meet with Helen Stevenson and we did talk about some of the contents within the procedures and policies that they were going to develop. A lot of it was, "Please trust me. We're going to work through these over the next number of months, but we don't know what they are and truly where we're going to get to."

Ms. Martel: You never saw a copy of the bill, though, at any point?

Mr. Tipler: No.

The Chair: Thank you, Ms. Martel. To the government side. Mr. Peterson.

Mr. Peterson: Thank you very much for your presentation. You emphasized that you're concerned about the branded industry being compromised by Bill 102 and that it'll hurt the biotechnology sector, yet we've had representations from the generic sector saying that as a percentage of sales, they have a much higher R&D component, and biotechnology is not chemical technology. I understand that they're the study of the hormones and the natural chemicals in the body, which is quite different from the drug industry. Could you explain this a little better for me?

Mr. Tipler: Truly, biotechnology is involved with forms of life, things that are natural within the body, compared to chemical entities which are built up. Really, the issue we have with regard to a strong biopharmaceutical industry is that about 30% of the funding of biotechnology companies comes from big pharma. Big pharma are the companies that are taking the biotechnology products through to the clinic, and ultimately, hopefully, we get them through commercialization.

The Chair: Thank you, Mr. Peterson, and thanks to you, gentlemen, Mr. Tipler and Mr. Graham, for your deputation and presence on behalf of the Toronto Biotechnology Initiative.

APOTEX

The Chair: I would now like, on behalf of the committee, to invite our next presenter, Mr. Jack Kay, president and chief operating officer of Apotex, and colleagues. Mr. Kay, as you have seen, you have 10 minutes in which to make your presentation. Please begin.

Mr. Jack Kay: Thank you for allowing the Apotex Group to present to the standing committee on social policy reviewing Bill 102.

I am Jack Kay, president and chief operating officer, and sitting beside me to my left is Linda Prytula, manager, government and public relations, for Apotex and a past chair of the Ontario Pharmacists' Association.

First, let me talk about Apotex and its importance to the Ontario economy. We are the largest pharma-health care company in the province and have a huge impact on this economy. We are Canadian-owned, with headquarters in Ontario.

Apotex has close to 5,000 employees in 21 facilities dedicated to research and development, production and distribution of generic and innovative medicines. They are located across Ontario, from Windsor, London, Brantford, Mississauga, Etobicoke and North York to Richmond Hill. Our salaries and benefits total close to $300 million per year, mostly in Ontario. Over the last 10 years, we have invested over $1 billion in our infrastructure in this province. We intend to spend another $20 million in building a new research and development facility over the next 24 months.

Apotex is the only vertically integrated pharmaceutical company in Canada and includes the research and development of fine chemicals for generic pharmaceuticals, which is our strength. As well, our organization includes innovative drugs through ApoPharma and biotechnology products through one of the largest biotech companies in Canada, Cangene, which is a publicly traded, TSE-listed company in which Apotex controls 83% of the common shares.

I would like to now blow out of the water a myth that has persisted for years that generics don't do research and development. The Apotex Group is the number one company in Canada in R&D spending for all pharmaceutical companies and number 12 across all business sectors, including companies like Nortel. We have planned R&D expenditures of over $2 billion over the next 10 years, and most of it will be spent in Ontario. We are a partner in the MaRS building, with research going on for innovative drugs through ApoPharma.

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Out of our 5,000 employees, we have close to 2,000 scientific staff, including over 100 Ph.Ds working on 606

future generic, innovative and biotechnology medicines. Since our headquarters are in Ontario, our product mandate is worldwide. We impact the Ontario economy by exporting these medicines to 115 countries. This represents over 40% of what we manufacture in Canada.

Our production capacity in all of our facilities is 20 billion tablets and capsules per year, which is more than all of the brand industry in Canada combined. Most of their products are imported, increasing the trade deficit to over $6 billion on a $13-billion industry.

Here is our position on Bill 102: Apotex strongly supports the government in its attempts for greater utilization of generics through off-formulary interchangeability (OFI) and interchangeability of "same" and "similar."

Ontario was one of the few jurisdictions in North America which did not designate generic drugs as interchangeable with brand name drugs that were not listed as benefits on the Ontario drug formulary. This important proposal, which brings us in line with other jurisdictions, will save Ontario employers and consumers $35 million in the first year. Businesses with drug plans in the province are supportive of this change. Also, with OFI, if the market switches to domestically manufactured products, this will result in more investment in Ontario by not only manufacturers such as Apotex but by employers as well.

On "the same" and "similar," the proposed wording for "similar" is not—I repeat, is not—an opening for therapeutic substitution. The same molecule but with a different salt is functionally the same as our tablets and capsules of the same molecule.

The case of Apo Omeprazole, the generic of Astra Zeneca's Losec, is a prime example of where the Ontario government could have saved over $70 million, and another $70 million for employers, if the government had listed it as interchangeable from January 2004, when it first received its approval on the Canadian market. Most of the other provinces made it interchangeable, but not Ontario.

On the price reduction of generics, it should not be arbitrary and implemented without allowing flexibility by generic companies to price certain molecules to recoup costs and make an acceptable profit. A flat 50% price reduction cannot work. It will result in certain products not being brought to market and the government paying the higher cost. Does it make sense to say, "If we can't save 50% on generics, we will save nothing"?

The generic industry is not the problem with escalating drug expenditures; it is the solution. The generic industry represents only 17.3% of drug expenditures in Ontario, while the brand industry represents 82.7%. Yet 44.8% of all prescriptions in Ontario are filled generically.

In conclusion, the current reimbursement model for generics has evolved over the past 15 years since a price freeze was put into place in 1992 by the Ontario Drug Benefit Formulary. It has forced companies to increase prices, which has resulted in numerous cost-to-operator claims and a reduction in pharmacy revenue. The government has always been aware of allowances paid by generic companies to promote their products, and took that into consideration in not paying a fair and reasonable professional fee to pharmacists.

On September 1, 1998, a letter of understanding between the Ontario government and the generic industry was signed. Specifically, point (f) stated, "The Ministry of Health will initiate a process in October of 1998 with affected stakeholders for the purposes of ensuring that the ODB plan reimburses the lowest possible cost on generic products."

Ladies and gentlemen, this process never took place until the introduction of Bill 102 in 2006 by this government.

As a final point, it is necessary to state unequivocally that generic drugs in Canada are as safe and effective as the brand name products that we genericize. The anecdotal evidence has never been proven by any scientific evidence.

Having said that, we support the passage of Bill 102 and look forward to discussions on the regulations which will dictate how we do business not only in Ontario but in the rest of Canada.

Thank you, and we are prepared to take questions.

The Chair: Thank you, Mr. Kay. We have an efficient 30 seconds each, with Ms. Martel of the NDP.

Ms. Martel: Earlier, some other generic companies came and said they would prefer to see the two-price structure maintained in place; that is, the first one into the market with innovation is 70% and then a decline from there, a scale-down from there. What do you think about that proposal?

Mr. Kay: I support that, except that the 70% is arbitrary. My concern is that we are developing generic biologicals, and to come in at 70% might not be economically feasible, which is why we're saying that there has to be some flexibility, because to develop generic biologicals, we have to do clinical studies, which can cost between $5 million and $10 million.

The Chair: Thank you, Ms. Martel, with apologies, Mr. Kay. To the government side, Mr. Peterson.

Mr. Peterson: We understand your concerns about our decree on prices, but, as the government, we're concerned about the value we get when the prices are high and you give big rebates. We're looking at trying to maintain the viability of our drug benefit plan. Could you comment on your price concerns in relation to the massive markups you give?

Mr. Kay: They're promotional allowances. I think the generic industry has a right to promote its products, as the brand industry does. The brand industry spends 25% to 30% of their revenues promoting their products to physicians to generate a prescription. We promote our products to pharmacists, who make the buying decisions.

The Chair: To the PC side, Mr. Jackson.

Mr. Jackson: Mr. Kay, I'm familiar with your presentation. If not a form of a rebate or an educational allowance, what should happen to the pharmacist's dispensing fee in the province in order to compensate them fairly, in your opinion, as a generic manufacturer, if in fact the government is going to pinch on the rebates?

Mr. Kay: I think the fee should be increased much greater than the 46 cents that it has been increased. It should go up by at least a dollar and a half to $2.

The Chair: Thank you, Mr. Kay, on behalf of all members of this committee, for your presence, written presentation and deputation on behalf of Apotex.

CANCER CARE ONTARIO

The Chair: I will now call, on behalf of the committee, our next presenter, Mr. Terry Sullivan, the president and chief executive officer of Cancer Care Ontario. Mr. Sullivan, as you're aware, you have 10 minutes in which to make your presentation, which begins now.

Mr. Terrence Sullivan: Thank you very much, Mr. Chair. I would also like to introduce, to my right, the chair of our board, Mr. Peter Crossgrove, and to my left, Dr. Carol Sawka, who is our vice-president, clinical programs. Dr. Sawka is a medical oncologist who practises at Sunnybrook and is a member of the faculties of health policy, management and evaluation, medicine, and public health sciences, and I'm also a member of the faculties of health policy, management and evaluation, and public health sciences at the University of Toronto.

First of all, let me state for members of the committee that Cancer Care Ontario is an agency of the provincial government, with a board of directors chaired by Mr. Crossgrove. We act as an umbrella organization to promote the highest possible standards of cancer services and steward close to half a billion dollars of provincial funds on behalf of the provincial government to promote improvements in the quality of cancer services and ensure optimal care for patients in Ontario.

I would say at the outset that Cancer Care Ontario fully supports the government's proposed initiative to reform the provincial drug system. We believe this legislative initiative is only part of the larger reform package that was announced some weeks ago, and we want to ensure that the full package makes its way through to a complete reform. We are committed to working with our provincial government to ensure that this happens.

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Beginning in 1997, Cancer Care Ontario began to work in the evolution of a new drug funding program for Ontario that is now spending in excess of $112 million, in this past year, for new and expensive cancer drugs. Cancer drugs, as members of the committee will know, are among the fastest-growing classes of new drugs because of new biological agents entering the marketplace, with very expensive initial prices.

Recently, we've also aligned the approval mechanism for the new drug funding program with the Ontario drug benefit program, and through this bill we will adopt the processes and procedures applied to the ODB as well as the broader policy reform in our management of the new drug funding program.

Our recommendations are focused on addressing the principles set out in the bill. We fully support the notion of consumer and patient involvement in transparency, fiscal accountability and the use of evidence in decision-making, and the application of those principles throughout the drug system.

As a general point, we believe that principle one should be amended to strengthen the role of Ontarians as patients as well as consumers and taxpayers. With respect to transparency, we would like to ensure that we have much greater transparency in the drug approval process in Ontario. With respect to the bill, the clarity should be strengthened in the bill with respect to how this will be implemented.

In support of this principle of transparency, we recommend that the executive officer be required to keep, maintain and publish a summary of their decisions, including reference to the evidence base on which these decisions were made in designating a product as being interchangeable with another product; to designate a product as a listed product under the Ontario drug benefit program and under the exceptional access mechanisms in the new section 16 of the bill; and that regulations made under the Ontario drug benefit program and the interchangeability be subject to a public consultation process.

We support the principle involving consumers and patients in a meaningful way in public drug reform, and we support the creation of a citizens' council to provide input to add consumer and patient voices to the complex social and medical decisions that must be made with respect to new and expensive drugs.

We also support the inclusion of lay representation and patient representation on the Drug Quality and Therapeutics Committee. It's important that the mechanisms to ensure public and patient participation be established through a consultative process.

We also support the principle of ensuring that funding decisions for drugs are based on the best available clinical and academic evidence available. I'm proud to say, with respect to cancer drugs, that we have a long tradition of doing this with clarity.

We recommend that Bill 102 recognize the decisions of the executive officer to designate a product as being interchangeable with another when it's designated as a listed product under the Ontario Drug Benefit Act and when the exceptional circumstance mechanism is used.

With respect to timely decision-making, we believe principle five should be amended to recognize the importance of timely decision-making and timely communication of decision-making as fundamental to the effectiveness of the drug system. We recommend that the regulations to Bill 102 set out time periods and performance measures for making and communicating decisions by the executive officer.

With respect to exceptional access, we recommend that section 16 of the Ontario Drug Benefit Act be amended to provide that where the executive officer approves the funding of a drug under the exceptional access provision, for same or substantially similar indications in a designated fraction of cases, the drug in question should be referred to the DQTC for consideration as to whether it should be more broadly listed on the public formulary.

The Chair: Thank you very much, Mr. Sullivan. We have about two minutes per side, beginning with the government.

Mr. Peterson: Thank you very much for your terrific presentation. It's great that you brought with you such a distinguished colleague to help you in the fight of cancer. Mr. Crossgrove is very noted for all the wonderful philanthropic things he's done, and I hope he's doing as good a job for you as he did for everybody else.

I'd like to defer this question to my colleague Kathleen Wynne.

Ms. Wynne: Nice to see you. Thanks for being here. You've come up with some very specific recommendations. My question was, are you in conversation with the ministry about these? Have you been in conversation? Can you talk about that?

Mr. Sullivan: Yes. We have been in conversation with the ministry and with Helen Stevenson throughout this process.

Ms. Wynne: Right. So from your perspective, has it been a good process in terms of us coming to the point where we've written this legislation, we've brought these recommendations forward?

Mr. Sullivan: It's been a good process from the perspective of our engagement in the consultation. Until the legislation was unveiled, we had no clear understanding as to what was in. As I stated at the beginning, we want to ensure that both the statute and the broader policy and administrative reforms move forward as a complete package.

Ms. Wynne: I understand, and some of the things you've talked about have been brought to us by others. You've added some language as well that we hadn't heard from other groups. We've heard some concerns about the consultation process and, from our perspective, there has been not just fact finding but also a back-and-forth with stakeholders, with patients, with providers about what should be in the legislation.

The Chair: Mr. Jackson.

Mr. Jackson: Terry, it's good to see you again. I admire the work you're doing. I'm sensitive to the fact that you are going through a tremendous number of changes in terms of how the government allows you to manage the drug component, and this is tricky. You know my strong feelings on this. I want to go to page 4, where you talk about the unfortunate consequences of the alignment of the new drug funding program and those of the ODB. Are you not concerned that not only will cancer patients not have as much input in this procedure but that the accountability will evaporate from publicly elected individuals to one individual whose process—we have yet to see how it will be operationalized in terms of getting new drugs into a formulary or, more directly, in the hands of your oncologists.

Mr. Sullivan: I think, with respect to patient engagement and public involvement, the bill is striking exactly the right chord. There does need to be broader patient engagement in the decision-making. It happens that when we worked out a relationship with the ODB, patients were not involved, and we're all aware of the fact that this is not a transparent process. In that sense, we have conveyed, and the government has heard clearly from us and others the—

The Chair: Thank you, Mr. Jackson. I will have to offer the floor now to Ms. Martel of the NDP.

Ms. Martel: Thank you for being here. My concern has to do with consumer and patient representation. You know there's nothing in the bill to allow for that either on the drug quality and therapeutics committee or on the citizens' council. There are no provisions in the bill for that.

My real concern has to do with the new cancer funding mechanism that was set up in 2005, whereby representatives from CCO and the DQTC deal with funding for cancer drugs, and there's no mechanism in this bill for consumers—for patients—to sit on that committee. That is key, because it's that committee that's making decisions about cancer drugs, not the DQTC.

Mr. Sullivan: To be absolutely correct, it is the DQTC. This panel recommends to the DQTC. In most cases, the DQTC is concurring; in some cases it isn't concurring. None of that is currently transparent. So we would like to see patient involvement in both of those committees.

Ms. Martel: On the joint CCO-DQTC subcommittee as well?

Mr. Sullivan: Yes.

Ms. Martel: Thank you.

My final question, section 16: Is this supposed to apply to intravenous cancer drugs as well? There's no mention of oncologists being able to apply and there's no mention of intravenous cancer drugs.

Mr. Sullivan: I think the intention is that we will manage this as a parallel process with the new drug funding program, using this as the same template. Section16 is—

The Chair: Thank you, Ms. Martel. Thank you as well, Mr. Crossgrove, Mr. Sullivan and Dr. Sawka, for your deputation on behalf of Cancer Care Ontario.

ASTRAZENECA CANADA INC.

The Chair: I would now, on behalf of the committee, invite our next presenter, Mr. Michael Cloutier, president and chief executive officer of AstraZeneca Canada, and colleagues. Mr. Cloutier, and to your colleagues, you've seen the protocol. You have 10 minutes in which to make your combined presentation, beginning now. Please begin.

Mr. Michael Cloutier: Good afternoon, and thank you very much for the opportunity to address this committee. I am Mike Cloutier, president and CEO of AstraZeneca Canada.

Let me begin with telling you a little bit about who we are. In Canada, AstraZeneca is the second-largest pharmaceutical company in terms of revenues. We generate about $1.1 billion per year. We employ more than 1,400 Canadians from coast to coast to coast. And we have a state-of-the-art basic research centre in Montreal.

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In Ontario, we are one of the largest research-based pharmaceutical companies, employing more than 800 Ontarians at our Canadian head office, which is located in Mississauga.

AstraZeneca has invested more than $400 million in research and development in Canada over the past four years: That's more than $100 million per year. In 2005, AstraZeneca conducted more than 250 clinical studies throughout the country. Through those clinical studies we involved more than 1,300 medical practitioners and more than 11,000 patients.

Our research centre in Montreal is one of only three pharmaceutical basic research centres that remain in Canada. We employ 125 primary research scientists that focus on new cures for acute and chronic pain. I'm very proud to tell you that this research centre which is a significant victory for Canada and for our company, because we operate in a global environment where it is increasingly difficult to bring research and innovation dollars to this country. The reason for it is that our country represents less than 2% of the overall global market.

Our decision to locate that research centre in Montreal—as all good businesses are—was based on the right blend of scientific talent, economic market conditions and a government that publicly supports our company, our industry and the partnerships that we continue to bring to improve the health care of patients throughout all of Canada. However, Ontario is our home in Canada.

As many of you know, we have just completed the building of our new Canadian business centre, our head office in Mississauga, and our commitment to Ontario is clear. In 2005 we invested more than $46 million in qualifying research and development and more than $6.4 million in non-qualifying research and development here in the province. In addition to that investment, we have funded a number of research chairs amounting to more than $8 million.

We support the government of Ontario's priorities on creating a culture of innovation. In our view, to build a culture of innovation we need to do three important things: the first is we must invest in education; the second is that we invest and support research and development; and third, that we foster an environment of commercialization here at home in the province. We at AstraZeneca Canada are deeply committed to supporting these three pillars to create a culture of innovation in Ontario.

I'd like to give you some further examples of just how committed we are to those three areas. With regard to education, AstraZeneca partnered with the government of Ontario recently to create a $1-million endowment to the Northern Ontario School of Medicine bursary fund. In research, in addition to the previous investments that I mentioned, AstraZeneca has provided the Ontario Cancer Research Network with a $1-million grant in support of important oncology research here in the province. And finally, with regard to commercialization, we are a founding partner of MaRS. Our initial investment of $1 million most certainly helped MaRS to become a reality, and we are now contemplating an investment of an additional $1 million to ensure the successful future of commercialization of Ontario's discoveries that will come about as a result of MaRS.

But let's be perfectly clear: These are exactly the types of investments that Bill 102 in its present form is putting at significant risk.

Our business is about patients. Our business is about improving health outcomes and enhancing patients' lives. We are very proud to be a global leader in six therapeutic areas including cardiology, oncology, infectious disease, respirology, the neurosciences and gastroenterology. Patients rely on our products each and every day to help cure, manage and control their diseases.

So where does that leave us? Well, let me tell you what I can and what I can't support in Bill 102.

AstraZeneca Canada absolutely supports an increased role for patients, and increased transparency in the drug system. Patients need to have a say in the establishment of policies that governs the Ontario's drug system, as well as a direct role in deciding what medicines get reimbursed or not, and the rationale for such decisions.

We also support the increased role of pharmacists that we'll have under Bill 102. As we move to an integrated health care system, it is critical that all parties work together to improve patient outcomes. That means that physicians need to be able to make the right choices in prescribing for their patients, and pharmacists need to play a critical role in education and appropriate-use counselling and, as such, should be fairly compensated for their role. We support the provisions in the legislation that expedite the listing of new medicines. And we know that section 8 has been a long-standing issue within ODB, and the efforts to bring it back to its original mandate are most certainly welcome.

What, then, are the sections of Bill 102 that need to be amended? There are four.

The first is in the area of breakthrough medicines. While we are glad to see the recognition of breakthrough medicines and the acceleration of their approval, we must ensure that the definition of "breakthrough" also includes incremental innovation, including those small, measured improvements which are the very foundation of enhanced patient care and health outcomes. Therefore, Bill 102 needs to be amended to include in the legislation a broad enough definition of breakthrough medicines that recognizes incremental innovation as better patient outcomes and/or financial efficiencies for the province of Ontario.

The second area is with regard to therapeutic substitution. The government has on several occasions throughout this process stated that their intent and the intent of Bill 102 is not therapeutic substitution. We are encouraged by those statements; however, the current language of the legislation does not reflect that intent. In its present state, Bill 102 will force patients off their medications. This will interfere with the ability of physicians and patients to choose the right medicine for the right patient

at the right time. It is therefore critical that Bill 102 and its related regulations define "therapeutic substitution" and include language prohibiting this from occurring.

The third area is in regard to interchangeability. Currently, Bill 102 changes the requirements of interchangeability from "same" to "similar" dosage form and active ingredients. This broadening to "similar" allows for the interchangeability of different chemical molecules within a therapeutic area, not just brand-to-generic interchangeability but also brand-to-brand interchangeability. This provision unduly interferes with the role of doctors and their patients and places patients at risk. Again, the government has stated that this is not their intent. Therefore, the word "similar" should be stricken from the legislation and the word "same" should continue to be the standard by which interchangeability is deemed.

The fourth and final area is with regard to the executive officer's powers. The person will be responsible for negotiating partnership agreements, competitive agreements deciding which medicines are listed on the ODB and which ones are not, in addition to being responsible for enforcing the provisions of the act. As such, a fair and transparent appeal process of these decisions made by the executive officer must be included in the legislation.

Finally, there are other provisions in the legislation, such as OFI and the 12-year price freeze, that need to be discussed seriously and amended, as they do impact the industry's ability to remain competitive and to attract new investments for us here in Ontario.

In conclusion, we are extremely proud of AstraZeneca Canada's partnership with the Ontario government in the past. We want to continue to move forward in the spirit of partnership with the government of Ontario in the future. We believe that in order to achieve its objectives related to patient outcomes and ensure that Ontario also achieves its objectives in making it a jurisdiction that's a leader in innovation, Bill 102 must be amended as I have outlined. We recommend that a cross-ministry initiative composed of the Ministries of Health, Research and Innovation, and Economic Development and Trade be established to ensure that health and economic policies are aligned in Ontario and that the necessary amendments to Bill 102 are passed. We also look forward to continuing our work together on the development of a life sciences strategy, because together we can achieve better patient outcomes and a fostering environment for research and development investments, and ensure a prosperous Ontario for all of us. Thank you very much.

The Chair: Thank you, Mr. Cloutier, on behalf of the committee for your deputation and your presence today from AstraZeneca Canada.

1650

PRESCRIPTION SHOPPE

The Chair: I would now invite our next presenter to come forward: Ms. Heidi Hanna of the Prescription Shoppe. Ms. Hanna, as you've seen, you have 10 minutes in which to make your combined presentation. Please begin.

Ms. Heidi Hanna: My name is Heidi Hanna. My husband and I are both co-owners of the Prescription Shoppe, a small pharmacy in Galt, Cambridge.

Bill 102, as it currently stands, will result in the destruction of our family business. Banning the funding from generic companies will decrease our pharmacy income by more than 50%. Lowering the markup to 8% is again taking away desperately needed funds. The amount that can be retrieved from these cognitive fees that the minister keeps jumping up and down about is only $17,000 on average per pharmacy. That is insufficient when you're taking away over $100,000 in funding from generic rebates. The meagre 46-cent increase in fees does not even begin to cover the real cost of dispensing prescriptions in Ontario today. Ontario is the province with the lowest dispensing fee in Canada, and continues to remain so.

Bill 102 will affect our patients, our community and our family. Let me first explain to you the services that we provide to our patients and our community.

We offer free delivery. That's essential, because 85% of our patients are seniors. Many of them live in rural areas and are not able to drive. We have several seniors who are homebound and have no access to their medication other than our delivery service.

We continue to waive the $2 copayment for low-income patients, making their medication more accessible to them. By doing so, we are subsidizing Ontario's health care system.

We have our patients' best interests at heart. Where a prescription is provided for a medication—that is, an over-the-counter medication—we look at the cost to the patient, and if it's cheaper to waive our fee and give them the medication as an OTC product, we do so.

We have free clinic days that cost us from hundreds of dollars to $1,000, and we provide home counselling for our homebound patients. We are the essential link between the patient, the doctor and the specialist.

The pharmacist in our pharmacy is the problem-solver. He is the one who will communicate with the patient, take the time to talk to the patient and understand their needs and concerns. He will communicate those needs and concerns to their doctors to help them determine whether this medication is meeting their needs or not.

All of these are services that are necessary to good patient care, and they require a great deal of time. The cognitive fees of only $17,000 offered by the government don't even begin to cover the time investment that is required.

The community services that we offer: As a local business, we pay our share of taxes. We declare our generic rebates on our financial statements and pay our share of corporate taxes on those.

We provide a free drug disposal service that protects the environment. In the region of Waterloo, that's particularly important, where we are struggling to find other drinking water supplies.

We regularly contribute to local charities. We support charities such as the Alzheimer Society, the diabetes

society, Cambridge Memorial Hospital, the mental health unit and the Lions Club.

We give community awareness lectures. We go to seniors' homes and to high schools and we give them lectures about drug abuse and drug interaction.

The result of Bill 102 on our patient care is going to mean a cutback of staff. We are going to cut back our hours. That means that we are going to cut back on the interaction and time we spend with our patients. Without spending that time with our patients, we are not able to do the problem-solving, the counselling and the additional medical reviews that are needed to provide excellent care for these patients. If we can't provide this, the patients need to seek this information elsewhere, which is going to result in increased patient visits to their doctors, to their specialists and to emergency rooms. If we can't survive as a business because of funding taken away from us, who is going to serve our rural seniors?

Patients come to small pharmacies because they are not treated as numbers. They want to be treated as people. They want someone that they can talk to who will take the time to understand them and who will help to serve their needs. These patients will be lost if we are closed down because of Bill 102.

Our community will also suffer. It will lose a tax base from the taxes that we pay as a corporation and as individuals. Six families—we employ six other employees besides my husband, who is the pharmacist—will suffer because we have to have layoffs. The environment will suffer because we can no longer afford to keep up our drug disposal program. If we have to charge for that, people won't use it. The local charities we support will suffer.

Particularly in the region of Waterloo, where a great deal of money has been spent opening a second pharmacy school, you are limiting or decreasing the demand for pharmacists by forcing the closure of at least 300 independent pharmacies. You are taking away the jobs for these graduates. You are forcing them to go to other provinces. There is no logic in what is being done. If you open a second pharmacy school to meet a demand for pharmacists and you're closing pharmacies down, it seems to me that there's a great deal of money being wasted.

The third aspect I would like to discuss is the effects on my family. This is something this government has been very flippant about. The director of the DSS will come out and say, "Yes, pharmacies will be closed." But nobody cares about what that means to pharmacy owners. Any business owner in Ontario, where the government closes down their business because of changes in regulations, should at least be heard by their MPP. John Milloy didn't even give me the time of day.

This government has had a very callous attitude and has no understanding of what it means to be a small business owner with children to support. You are looking at them and you bought this business for their future, to be able to afford to put them through school. Now you say, "Pharmacies will close. Big deal." Those were the comments made by the director of the DSS. Perhaps this government should take some time and think about the pain and isolation of being financially destroyed and what that means to you as a parent.

My recommendations for this government are to take the time and think and consult with independent pharmacists; we all want an improved drug system. Talk to the independent pharmacists and see what they can offer you. That hasn't been done. Ensure that the generic companies continue to invest in Ontario pharmacies, because these rebate programs are key to the survival of our pharmacy—not just ours; there are hundreds of other pharmacies that are in the same position. The 8% markup should be applied to medications after the wholesaler cost markup. Cognitive fees need to be increased to accurately reflect the time that is spent and the cost of patient care. The fee increase of 46 cents is ridiculous. The fee increase should be over four dollars. It has been widely accepted that the cost of dispensing a prescription is over $10 in Ontario. The fee increase needs to accurately show that.

Thank you for your time.

The Chair: Thank you, Ms. Hanna. Regrettably, your time has expired. On behalf of the committee, I'd like to thank you for your presence and your presentation on behalf of the Prescription Shoppe.

1700

KEN BURNS

The Chair: I would now like to invite our next presenter, Mr. Ken Burns. Mr. Burns, as you've seen the protocol, you have 10 minutes in which to make your combined presentation, beginning now.

Mr. Ken Burns: Hello, and thank you, committee members, for your attention today. My name is Ken Burns, and I am a pharmacist practising in northern Ontario in the town of Chelmsford, about 40 kilometres past the city of Sudbury. I hope, over the next few minutes, to give you a sense of what I do in health care, what I should do more of in the future and how Bill 102 impacts upon my present and my future and, more importantly, the future of my patients.

I have been practising for over 20 years, 15 of those in Chelmsford. My community currently has a physician shortage, with over 2,000 people without a family doctor. Those who do have a family doctor often wait several weeks for appointments. Fortunately, I am available as a primary care provider within my community. My patients can walk in off the street and ask me questions about their health. When you combine prescriptions and consultations, I can interact with hundreds of patients each week. Some need a minute, some five minutes and some half an hour. I attempt to accommodate all of their needs.

I have learned a few things in my years of practice. One is that to be truly effective as a health professional, you must develop caring relationships with patients that are based on mutual trust. I believe I have developed that. To quote one of my patients, "When I want the real

answer, Ken, I come to ask you." As we develop a health care system that attempts to cultivate the responsibility of patients for their own health, they will need the support of people like me in their community.

Every day I work with physicians and other health providers to help my patients with their medications and their medical conditions. Often there are gaps in care where the patient and I are the only ones left to try to manage issues. Whether it is maintaining an existing treatment when physicians aren't available, sorting out different recommendations from different providers or trying to find or access other services, my patients often come to me.

I've also identified in my town a few significant health issues. There is a high incidence of asthma and diabetes in the area. Several years ago, I instituted programs to help patients manage these conditions. I became a certified diabetes educator and a certified asthma educator to better help them. I recognized that there were a lot of needs my patients had that weren't being met by anyone in the health care system, and that their health was the worse for it.

For example, patients with diabetes monitor their blood sugar levels to help them assess how well they are controlling their condition. The Ministry of Health spends millions of dollars to supply test strips to these patients, and very little to ensure that they know what the numbers mean or what to do with the information once they have it. In my practice, I download test results electronically and aggregate the information to analyze it in a graphic format. I use that to go over the information with the patient, helping them understand how their diet, exercise, weight and medications all interact to affect their blood sugar. I also supply the physicians with this information to help them with disease management. There is no current health structure in place providing this service in my town—just me.

In asthma, it is well recognized that patients experience far more symptoms and illness than necessary. This isn't necessarily an issue of access to medications. Unfortunately, this is more often due to misunderstandings or beliefs about how medications work, how they are to be used and what actually constitutes good control. I have selected patients from my practice for an intensive assessment that explores their knowledge, their beliefs and their attitudes about their condition. I will be running a program like this in my local physician's office next month. I do these programs because the science tells us that patients won't change their behaviours because we tell them to, but rather they need to be engaged to change on their own. This is more effective when working with someone they know and trust.

The increased time I spend interacting with patients is supported by the work of the pharmacy technicians and other staff in my pharmacy. They are extra pairs of hands to make sure the work in the pharmacy gets done. They are extra pairs of eyes to watch for errors to keep our patients safe. The pharmacy technicians in my practice have taken on more responsibility to allow me to do these innovative things, and they tell me they are ready to do more in the future. If we do not fix the professional fee and inventory markup, I may lose one or both of my technicians. We need to make sure that pharmacy is represented by the Ontario Pharmacists' Association to ensure that my pharmacy work environment is secure.

My certifications in diabetes and asthma and the programs I deliver are among the things that are supported in my practice by the revenues we can generate from manufacturers, both generic and brand name. The manufacturers have recognized the value to patients, and that I, as a pharmacist in my community, can best identify the needs of patients. These certifications and programs are the infrastructure I need to build to begin to provide disease management services for my patients.

What I need as a pharmacist from Bill 102 is the ability not only to continue what I am doing, but to do a better job. Bill 102 appears to recognize that pharmacists have much more to contribute to health care. We need to make sure that my association, the OPA, is entrenched in the process of figuring out how I can do that. OPA needs to be an equal member in any pharmacy council because, with all due respect, pharmacists know better than anyone all of the ways we can contribute to health care. As a pharmacist, I need to be appreciated, integrated and compensated.

I am concerned that the government is considering a maximum amount that I can acquire from manufacturers to invest in providing services to my patients. In effect, I may have to tell my asthma patients that I can no longer provide programs for them because there's only enough left for my diabetes patients. Of course, it is possible that there will not be enough left for even that. If you limit the amount I can reinvest in caring for my patients, you limit the energy, enthusiasm and innovation that our health care system needs if it is going to effectively help patients in a system that will have greater demands in the future.

If the government fails to recognize the net difference between what we receive now from all forms of compensation and what Bill 102 prescribes for the future, the numbers state that my pharmacy will no longer be in business, which of course eliminates all of the good work that I've been trying to do.

I trust that the government will do the right thing. The government must, in return, trust that pharmacists know better than anyone what skills and services they can bring to serve their patients and their communities. We need Bill 102 to develop and assert this trusting relationship between government and pharmacists by entrenching the Ontario Pharmacists' Association in the pharmacy council. We need to be able to access tools, services and investments from drug manufacturers to advance our profession and improve the quality and availability of health care. We need to fix the professional fee and inventory markup to support the everyday dispensing of medications and professional counselling provided by pharmacists and supported by pharmacy technicians and other staff. My patients matter, and we need to have Bill 102 recognize that. Thank you for your attention.

The Chair: Thank you, Mr. Burns. We have about a minute per side, beginning with the PCs. Mr. O'Toole.

Mr. O'Toole: Thank you very much for your presentation. You've mentioned here quite a few things that have been mentioned quite frequently, I would say. There are actually a couple of groups that are—I'm not sure what the relationship is. The Ontario Pharmacists' Association, Marc Kealey and that group, have presented. They kind of represent the pharmacists, or most of them, I gather. Then there's another group, the coalition group. Which group do you think has the more informed voice about the specifics and the need for the small pharmacist to be heard here? The large organizations seem to be being heard by George privately. Do you understand what I mean?

Mr. Burns: Yes.

Mr. O'Toole: That's what worries me.

Mr. Burns: The pharmacy I practise in, I guess you would call it a small-town, neighbourhood pharmacy. But I believe that OPA does have my best interests at heart. I believe they represents pharmacists first, no matter where they practise. As a profession, we have to get together to work with the government. We need to solve a lot of the problems in health care that I think pharmacists can help solve.

The Chair: Thank you, Mr. O'Toole. We'll move to Ms. Martel of the NDP.

Ms. Martel: Thanks, Ken, for coming from home today, because that was a long trip.

Mr. Burns: A six-hour drive.

Ms. Martel: Yes. I want to focus on your comment that, "If the government fails to recognize the net difference between what we receive now from all forms of compensation and what Bill 102 prescribes..." you "will no longer be in business." Do you feel confident about making that statement? Do you want to add anything to it?

Mr. Burns: Yes, I do. I've got the numbers today, and just to give you an idea, the things we're talking about, the allowances from manufacturers amount to $64,000 in my pharmacy and the net profit of the pharmacy last year was $32,000. So I think the math is pretty simple from that.

The Chair: Thank you, Ms. Martel. To the government side. Ms. Wynne.

Ms. Wynne: Thank you very much for making the trip here today. I guess what I want to do is, I just want to reinforce what we've said before in these hearings, that it is not the intention of the government to put you or any other small pharmacist out of business. That's not the intention. We're trying, with the 8% guarantee, the markup, the cognitive fees, the dispensing fee and then the education allowance within that mix, to make your business viable. That is certainly our intention. Can you just comment on that? Is there anything further you want to add? As I said, working with you and working with OPA, it is our intention to make your business viable. Have you looked at the OPA recommendations?

Mr. Burns: Yes, I have.

Ms. Wynne: Okay. And you're supportive of those, or is there any one is particular that you want to talk about—

The Chair: Mr. Wynne, I will have to intervene there. Mr. Burns, you're welcome to confer with any member privately afterward. We thank you, on behalf of the committee, for your deputation.

1710

ERINDALE MEDICAL CENTRE

The Chair: I would now invite our next presenter to come forward: Mr. Emad Nossier, owner of the Erindale Medical Centre. Mr. Nossier, as you've seen, 10 minutes in which to make your combined presentation. I invite you to begin now.

Mr. Emad Nossier: Thanks for giving me the chance to be present here to give you my point of view, being here as an Erindale pharmacy and supported by a group called the IPO, the Independent Pharmacists of Ontario.

With Bill 102, we see that we're going in the direction of dumping of small businesses, which I don't think any government would encourage. How is this going? Medium or small pharmacies are selling around $1 million, on average. What they are making now is equal to about $33,000. With Bill 102, it would go down to about $45,000 to $48,000 negative. This difference was supported by about $80,000 to $90,000 of rebates. The difference between the $33,000 and the $90,000 was going for operational expenses, leaving the pharmacy with $33,000 at the end of the year. With minus $48,000, I don't think there is a new year for this pharmacy.

Larger businesses will be affected as well, but not as much. They will have to control their expenses, but at the expense of patient care.

One of the flags that comes with this bill is, are we going in the direction of the States, to a monopoly of the market? Is it going to be controlled by big chains? And then, God knows how prices are going.

What this bill is introducing, as well, is increasing the dispensing fee by 46 cents. The dispensing fee has been flat for 13 years. During these same years, the inflation rate was 27%.

Markup: Markup is distributed between the wholesaler and the pharmacy because of non-accessibility of the pharmacy to the manufacturer. It ends up that the wholesaler is getting about 70% of the 8%. In which country of the world does the wholesaler get double the retailer? For me, it's strange.

The markup cap didn't make sense, this $25. I don't know where this bill came up with this figure, but I heard some good news that this might be solved. It solves the smallest problem, but it's a good start for understanding our situation.

I'll go further, to some suggestions and to these demands: the dispensing fee to go up to at least $10, as has been expressed by different colleagues here, and the markup to be 8% net to the pharmacy. I think that's a very fair request. Which business in Canada, the US or

anyplace in the world makes a return on its investment of less than 8%?

This might cost the government some extra funds. Where can we get these funds? They've already pointed that out. Generic rebates eliminated from the market would account for about $600 million. Some people might have different figures, but we can be very close. The government is saving $253 million and then we have $337 million flying around in the air. We don't know where they're going to be used, because the government has made use of half the rebate while the other is taken off the market from the pharmacies—we don't know where.

Here are some ideas. If I look to the report by the Ministry of Health for the year 2003-04—I don't have the most recent one—it says a lot. The top two therapeutic classes are cardiovascular, or heart products and blood pressure products. If we add to them the psychotropics or central nervous system products and gastroenterology, we would go up to about 50% of the consumption of the cost to the government.

If I go further to the fastest-growing classes, we'll see that the same groups are there. Special drug programs cost the government about $159 million, with an increase of 10% every year. If we look at these groups that I was talking about, these are what we call maintenance therapy, not acute therapy. Maintenance means that everybody is using them for the long term.

I also found an interesting report by NAPRA, which talks about the cost of medication waste. The original report might be outdated, but in projecting the figures of the waste, it's $155 million roughly, in the year 2006 in Ontario only. They explain that dosage and drug change, patient death, and improvement of blood pressure control all contribute in part to the waste of these drugs. They recommend that investment in waste reduction programs will be substantially less than the millions in potential drug savings.

There is some more money that the government can look for. The way to do that, I'll put it in this summary: to get a dispensing fee of $10 and a markup of 8% net to the pharmacy; the resources are $250 million or the $300 million of the rebate that we don't know where is going. Also, Mr. Smitherman has offered pharmacists a 20% allowance on the different labels, like educational or promotional. These could be reallocated properly. Then we can go back to the monthly supply to our patients, which is one of the measures that would save on the waste of products. Because of change in medication, doses and so on, patients end up throwing away lots of their medication. If we go back to this, we'll save a lot. It's not an extra dispensing fee expense because the average prescription is $45, and only $7 would go to the dispensing fee, so it costs you $7 but you save the rest for the government.

Finally, please rethink Bill 102. Save everybody. We don't have to save at the expense of just one party. Thank you.

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

Ms. Martel: Thank you for your presentation. Twice now I've heard the government members put the 8% markup in the category of one of the benefits that they're giving to pharmacists, and I'm kind of astonished by that because right now we're moving from a 10% markup to 8%, and we're not sure if the 8% is going to be applied after the wholesale price markup, so we could be down to 2.4% as the markup. Do you see that as a benefit for pharmacists under this? Do you want to make some comments?

Mr. Nossier: I think, for any business, nobody can survive at 2.4%. That was unfair, and it developed at a time when manufacturers stopped delivering direct to the pharmacies, so that was the wholesaler role. I don't think that the government can overlook that. The government should guarantee in this bill that the pharmacist has access to the drugs on the formulary list and the manufacturers' list.

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

Mr. Peterson: At the present time under the current system, your 10% markup is being eroded by price increases. Is that not the case?

Mr. Nossier: Could you repeat that again, please?

Mr. Peterson: Your total 10% markup is being taken away by price increases from manufacturers and wholesalers.

Mr. Nossier: I don't think so.

Mr. Peterson: You are paying the price increases over top of the formulary price. If they increase the price, it comes out of the pharmacists' hands, so we're going to be fixing that formulary price, guaranteeing it at 8%, so that is an improvement to you, is it not?

Mr. Nossier: The formulary list has to be updated.

Mr. Peterson: Yes, and it will be under our new legislation. Do you understand? When the manufacturer increases the price over the formulary price right now, do you not pay for that?

Mr. Nossier: We are paying.

Mr. Peterson: Exactly. So you're not even making 10%.

Mr. Nossier: No.

Mr. Peterson: So if we fix the pricing and give you 8%, it's an improvement in your situation.

The Chair: Thank you, Mr. Peterson. Mr. O'Toole.

1720

Mr. O'Toole: Thank you very much. You've brought a couple of different points, and I'm going to pose these as questions for the committee, actually, to the researcher. One is on medical waste. I remember some years ago I read a report from Dr. Coambs—I think he's from the pharmacy school here at the U of T—about the same issue of medical waste. I'm asking research to get us up to date on this $150-million potential. I think it is a huge issue and it ties into the use of cognitive fees etc., using the appropriate amount for drugs and how many

times you see them renewing prescriptions and doctors' fees. The other one is the admissions to hospitals. I've been told here—I'd like to see a report on that—some people have said here that there's a relationship between medical misuse or non-use and hospital admissions. Each hospital admission has a value attached to it, probably $300 or $400 or more. Maybe research can see if—

The Chair: Yes. Thank you, Mr. O'Toole. I would like to thank you, Mr. Nossier, for your presentation and submission on behalf of the committee.

Mr. O'Toole, you have a point of order: direction for research, please.

Mr. O'Toole: Yes. I think research needs clarification on that. The two points were the prescription medical waste—there's a report on that.

Ms. Lorraine Luski: Pharmaceutical waste?

Mr. O'Toole: Yes. It's the prescriptive medicine that's wasted.

Ms. Luski: Okay.

Mr. O'Toole: It's about a third of all drugs. Twenty per cent of all drugs are actually not used—my understanding. Also, hospital admissions—we've had two presentations that have told us that there are a lot of admissions because of too much, too little or not enough medication. That's a prescription kind of thing and it's an educational thing that could save money.

The Chair: Mr. O'Toole, I will ask you perhaps to confer with legislative research after these committee hearings just to straighten out precisely the issues you're after.

Mr. O'Toole: I think it would be helpful. Do you understand? It will save money, and that's what this is about.

ROB MODESTINO

The Chair: I would now, on behalf of the committee, invite our next presenter, Mr. Rob Modestino, to come forward. Mr. Modestino, as you've seen, you have 10 minutes in which to make your combined presentation, and your time begins now.

Mr. Rob Modestino: Thank you, Mr. Chair, committee members and guests, for allowing me the opportunity to present to you today. My name is Rob Modestino. I'm an independent pharmacist in LaSalle, which is a small town just outside of Windsor. I'm the pharmacist-manager at Health Smart Drug Store. We have two other locations in the Windsor area.

My pharmacy specializes in patient education in a collaborative practice with the physicians in our building. We actually knocked out the wall between the pharmacy and the physician offices so that we could more easily interact. In my practice, we have provided patients with specialized care in many instances. I have completed the asthma educator program, which allows me to provide special care to my asthma patients.

I am very encouraged by the opportunity to be able to provide and be compensated for professional services which Bill 102 is allowing. This will result in better care for my patients. I am, however, concerned that if my pharmacy is not financially viable, these professional services cannot be provided.

I have looked at the situation in my location, and Bill 102, if not amended, will lead to a loss of approximately $120,000 annually. This is taking into account the complete elimination of professional allowances, the decrease in markup, the increase in dispensing fee and the addition of fees for professional services, which have yet to be defined. This means the loss of one full-time pharmacist and one full-time technician. This will now leave me, the pharmacist, absolutely no time to spend with patients or consult with physicians. Patients will no longer receive the specialized and individualized care they have become accustomed to in my pharmacy.

Patient care will definitely be compromised. Also, this will provide me less of an opportunity to provide preventive care to patients. With fewer pharmacists available in my pharmacy, I will not be able to provide programs such as smoking cessation, asthma care, flu shot clinics or other programs. This is a concern for me, not from a personal standpoint but from a professional standpoint as someone who cares for the patients I treat each and every day. Many of these patients will suffer without these added services.

What is also concerning to me as a pharmacist is the lack of clarity of certain aspects of this bill. The bill indicates the elimination of paperwork for special-access drugs such as section 8 limited-use drugs, and quicker access to these drugs for the patient. However, there is no indication as to how this will be accomplished. This change would help me provide better care to my patients by freeing up time to do so. Although this could be a positive for the pharmacy, the lack of clarity surrounding this process leaves me with concerns. As a pharmacist looking out for the best interests of my patients, I need to be assured that the process will be clearly defined and the access to these medications for patients is indeed quicker than it is today.

Pharmacies also need a clear indication of price for these medications. This will be important not just for patients who are covered by the Ontario drug benefit plan, but for all citizens of this province who may need access to these medications.

Being a pharmacist from Windsor who lived through the implementation of the off-formulary interchangeability by the CAW Big Three auto companies, I do have some concerns with the bill as it is written. It is important that Bill 102 be amended to clearly define similar drugs in DIDFA. One of the biggest issues with the implementation of the CAW plan was that there was some variability in the available lists of interchangeable products, creating confusion for pharmacists, thus delaying patient care. For patient safety and enhanced patient care, there must be a clear listing in the formulary of which products are interchangeable, similar to what is currently done with formulary drugs. Listing them in the formulary will not mean that they are eligible benefits on ODB, but it provides all involved, whether they are a physician,

pharmacist or patient, the assurance that these drugs have been reviewed and found to be interchangeable. The bill indicates that OFI would begin upon royal assent of this bill. Unless such a list can be ready by the time the bill receives royal assent, I'm suggesting a delay in implementation of this portion until a proper listing can be developed.

As a pharmacist who has been a member of the Ontario Pharmacists' Association, the OPA, from the time I graduated in 1989, I feel it is extremely important that the committee and the government recognize OPA as the voice of pharmacy. OPA represents all pharmacists and pharmacies. The board comprises independent, industry, chain and hospital pharmacists. OPA needs to be given the mandate by this government to negotiate on behalf of pharmacy. This needs to appear in the bill so that all future governments will also recognize this.

OPA's proposed amendments to Bill 102 hit the nail on the head. The proposed amendments will ensure the future viability of pharmacy. The amendments take into account both the transparency which the government is seeking in this bill and the sustainability of pharmacy which all pharmacists are seeking. In the long term, this translates to a system that benefits the patient not only with better care but also with transparency. The amendments also recognize the importance of the pharmacy council and OPA's involvement in providing input on future policy.

Most importantly, the proposed amendments recognize that pharmacy reimbursement is important. Some system for professional investment from manufacturers in the form of allowances is necessary. The amendments allow for this investment, but also allow for a mechanism to keep the investments transparent through a code of conduct. They also clearly define and differentiate between rebates and professional allowances.

Since the regulations will be an important part of defining the bill, I want to stress the importance of the government working with OPA when developing these regulations. The regulations will be important in providing clarity for all involved. These need to be developed in consultation with OPA in order for the process to achieve the government's objectives. These regulations will cover a major portion of pharmacists' reimbursement, including fees and markup. Therefore, the involvement of OPA is extremely important. All pharmacists, through OPA, need to know what the plans are for draft regulations, timelines and consultation. OPA is willing to partner with the government to provide solutions in development of the regulations. Let them help.

As a pharmacist, I'm willing to make Bill 102 work, with proper amendments. I put my full support behind the amendments being proposed by the OPA. This committee is tasked with making Bill 102 workable, and I feel that with the amendments proposed by the OPA this is possible. At the end of the day, only an accessible, sustainable drug system everywhere in this province will be accessible to the citizens of this province. Pharmacists want to work with the government to improve health care in this province. We are committed to doing that, both as individuals and as an association, but that can only happen if pharmacies such as mine remain sustainable businesses. Patient care will only improve if we work together to achieve that.

The Chair: Thank you, Mr. Modestino. A minute per side. First to the government.

Mr. Peterson: Thank you very much, Mr. Modestino. It was nice to see you at the OPA's annual conference and hear your contribution to the drug industry and the OPA.

We appreciate your support for the fact we are recognizing pharmacists as front-line health care givers and making it patient-focused. As we go forward with you, your main concern is that we have not delineated these cognitive fees to you. What cognitive fees, professional fees, would you like included that would assure you that you will not be put out of business, that you will be held in good financial esteem?

1730

Mr. Modestino: With the level of cognitive fees being suggested right now, it's not compensating for the suggested complete removal of the allowances. There's a wide range—

The Chair: With apologies, Mr. Modestino, we'll have to offer the floor to the PC side.

Mr. Jackson: Rob, good to see you again. As a past president of OPA, your input is appreciated.

Earlier today, OPA suggested a dispensing fee more in the neighbourhood of $11. I've asked a couple of the drug manufacturers whose rebates are being eliminated what a fairer fee would be, and they certainly figure that $9.50 or $10 is well in order. Would you like to comment on that? I'm concerned that the cash-paying customer continues to subsidize the ODB in this province, and you get caught in the middle with these fees.

Mr. Modestino: The current studies that we have at OPA show that the cost of dispensing is in the $10 to $11 range. We are willing to work with the government to do a joint study to prove that these numbers are correct. That's what we're basing our figures on.

Mr. Jackson: Was it shared with the government?

Mr. Modestino: Yes.

The Chair: Thank you, Mr. Jackson. Ms. Martel of the NDP.

Ms. Martel: Thank you for being here today. You've come a long way as well. Let me ask about cognitive allowances not compensating for the promotional allowances—the loss of. That's where you were heading before you were cut off. Do you want to respond in terms of what else besides the increase in the dispensing fee to $10 or $11 is going to be necessary to have this fee revenue-neutral, as the minister promised?

Mr. Modestino: All of it has to be looked at. One of the topics that has been thrown around here is the 8%. One of the issues is that there isn't clarity on what that 8% is going to be based on. That's one thing that we've been seeking: clarity as to whether pricing such as the

wholesaler price will be included in the formulary pricing. That's one of the things that we need.

One of the biggest issues we've had with the bill is clarity. We're trying to get clarity and work with the government to get that clarity. Coming up with a figure off the top of my head is just—I cannot do that.

The Chair: Thank you, Ms. Martel, and to you, Mr. Modestino, on behalf of the committee.

PRESTON MEDICAL PHARMACY

The Chair: I would invite now our next presenter, Mr. Brian Hummel, owner of the Preston Medical Pharmacy. Your written materials have already been distributed. Mr. Hummel, your time begins now.

Mr. Brian Hummel: Thank you, Mr. Chair, committee members and guests for this chance to speak on Bill 102 and its ramifications for my business and patients. My name is Brian Hummel, and I'm a pharmacist-owner of Preston Medical Pharmacy in Cambridge. I've been a pharmacist for 27 years and owner of my own pharmacy for the past 20 years. I was educated right next door at U of T, where I also received my Master of Business Administration after graduating from the faculty of pharmacy. I presently sit on six different regionally based, health-care-related committees in the Waterloo region.

I run an independent pharmacy that interacts with over 200 patients each day. Preston Medical Pharmacy derives 100% of its income from medications and home health care supplies and equipment. I employ 40 well-trained, loyal but underpaid employees. Preston Medical specializes in home infusion, palliative care, diabetic training and compliance packaging. We're one of less than 30 home infusion pharmacies in Ontario, with antibiotics and cancer pain pumps making up the majority of our infusion volume.

Preston Medical Pharmacy works daily with various departments of the Cambridge Memorial Hospital, the Grand River Regional Cancer Centre, the Waterloo regional CCAC and Lisaard House, which is our regional hospice. We help to keep patients out of hospital to receive their treatments at home. Cambridge is an underserviced area, with over 25,000 of its residents without a family doctor.

All health professionals realize that our health care system is currently unsustainable, including our drug program. I applaud the government for making an attempt to improve the system after extensive fact finding.

Here's my story. Over the last 20 years as a pharmacy owner, I have seen my gross profit fall from 40% to 20%. This has been a result of four main factors:

—no government fee increase for the last 13 years;

—the rapidly increasing prices of new medication; for instance, home infusion prescriptions average over $380 each;

—shrinkage of the legislated 10% markup due to unrestricted price increases by manufacturers; and

—industry's switch to wholesale distribution, which adds about 5% to drug acquisition costs for pharmacies.

As in any business, my expenses also have increased every year. It currently costs over $11 to dispense a prescription at my facility. This is before my full salary, any return on investment or taxes. Both the foregoing shortfalls have been covered in the past by promotional allowances. I look forward to the wider use of generics and to the fee increase. After 13 years, that will still be one of the lowest in Canada. Enforcement of drug prices is also welcome after all these years. What the whole profession is excited about is the chance to finally be providing expanded services, which they have been long trained for, such as medication audits and disease education and management. Unfortunately, dollar-wise, this will probably be a break-even situation in the short term, because we will need more staff to take on these new roles while continuing to serve our current patients.

For pharmacists to be able to provide extended patient services, the province requires a viable pharmacy industry. Unfortunately, this bill is not revenue-neutral. The Preston Medical Pharmacy will gain $14,000 in new fees but will lose $7,000 in home infusion alone, with a 2% mark-up reduction. With $150,000 lost in promotional support—and this is assuming a 20% cap on allowances—I'll be forced to cut up to $143,000 of staff wages and patient services.

The chart in front of you lists the anticipated service reductions and their effects on my patients. Most of them you've heard over the last two days, so I will zero in on a few that may be unique to home infusion pharmacies.

Preston Medical Pharmacy will reduce its pharmacists' 24-hour on-call service back to 12 hours, as per our CCAC contract. Any cancer patients whose pain pumps run dry, malfunction, leak or even run out of batteries between 9 p.m. and 9 a.m. may need to go to the emergency department, possibly by ambulance, to keep their pain under control until they or their nurse can contact us the next day.

During the past few years, we have reached 99% compliance with the USP 797 infusion standards coming out of the United States. This has cost thousands of dollars. None of the hospitals in our region have attempted this yet because of funding difficulties. Now we have to lower our standards below best practices to save the cost of extra IV rooms, sterility and technician training that are required by these new standards. These standards were put in place after patient deaths from infection, the result of a lack of sterility in some home infusion products in the United States.

Presently, when Preston Medical Pharmacy doesn't have an infusion medication in stock, it means an extra visit to the emergency department for the next dose or an extra day in hospital for the patient until we can get the medication from our suppliers. This will happen more often as a result of this bill.

If I am forced to work more hours in the pharmacy, I will not have the time to work the approximately four hours a week I now volunteer on the various regional health care committees.

Elinor Caplan recommended that all CCAC providers become certified. The initial certification process has cost two of my colleagues over $100,000, with ongoing costs of $10,000 to $20,000 per year. I will not be able to pursue this without funding from some source.

I hope this committee realizes that none of the listed services or quality control standards our patients now enjoy are government mandated or funded, but this government bill will be the reason for their demise. These services will be missed and will have consequences on the health of Ontarians, on wait times and on patient access to health professionals.

I am fortunate to have a large, established pharmacy practice. Two smaller clinic pharmacies very close to me are not so lucky. If they fail, my own business may not suffer, but as I learned in business school, less competition is not good for employees, patients or the taxpayer. I remember not so long ago when the government of the day thought we had too many nurses and physicians. Look at the results of that decision.

The main point I am trying to make is that if this government is truly serious about getting pharmacists more involved in patient care and education to take the stress off of other health professionals and the system as a whole, they cannot cut our funding. You cannot start a new business model without investing in it first. I'm not opposed to this bill, but amendments with regard to generic allowances, fee increases and allowed markups all need to be addressed. This will enable pharmacists to be in a position to contribute more to the health care system, as suggested by so many policy experts and politicians across the country in the last few years. I hope this government, in working with the OPA, can move forward carefully on a fair, innovative pharmacy model for Ontario.

Right now, there is no incentive to get patients off medication; there is tremendous waste in the system; rational, cost-effective prescribing has a long way to go; and the consumer has no idea of how much the taxpayer pays for their medications. Hopefully, by continued dialogue with the OPA and pharmacists who work in the system every day, things can be improved.

In the past, Preston Medical Pharmacy has had the privilege of helping to train new pharmacists from the University of Toronto with the help of promotional allowances. They are certainly ready for the challenge of additional patient services, such as monitoring warfarin levels, doing home medication audits, professional detailing to physicians to get the real story—not the brand story—and smoking cessation programs. None of this will happen without a viable pharmacy infrastructure to support them.

1740

After 27 years, one of the things I'm most proud of is that over all these years, in every opinion poll I've ever seen, pharmacists have been ranked number one as the most trusted profession. The people of Ontario believe what we tell them and trust us. I hope this government will as well.

I'd be happy to answer any of your questions now or at a later date. Thank you for your time and attention.

The Chair: Thank you, Mr. Hummel. We have about 30 seconds each. Mr. O'Toole from the PC side.

Mr. O'Toole: Thank you for your presentation and for your vision of the profession. I hope that what you say is true, that they do work with the OPA and make amendments. It's a critical part of the health care dilemma, and the potential underuse of pharmacists, I think, is one of the good parts of this bill. I hope they listen to you. That's all I can say.

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

Ms. Martel: Thank you for driving here today from Cambridge. I just want to focus on one point: your saying that the loss on infusion products alone is $7,000 with a 2% reduction in markup. Do you want to clarify that for this committee?

Mr. Hummel: Luckily, the way the infusion products work at ODB, their program doesn't—it believes what we tell as our true cost, so we always get our 10% on IVs, which we get on no other products. We get more like 2% or 3%; I'm not sure what the exact number is. But on IV products, we do get 10%, luckily. So I can look at exactly how much I'm going to lose, and it's $7,000 for one year, based on just that reduction from 10% to 8%.

The Chair: Thank you, Ms. Martel. To the government side: Dr. Ramal.

Mr. Ramal: Thank you, Mr. Hummel, for your presentation. I want to thank you on behalf of our government and the people of Ontario for the job you do by serving many people in a rural area. I want to talk about something you mentioned. I know that a lot of Ontarians, all Ontarians, trust pharmacists. We also do as a government. That's why we're bringing this bill forward, in order to have some clear understanding of the relationship between pharmacy and the government.

The Chair: Thank you, Dr. Ramal, and thank you as well, Mr. Hummel, for coming forward and for your deputation today.

CANADIAN DIABETES ASSOCIATION

The Chair: I'd invite now on behalf of the committee our next presenters, from the Canadian Diabetes Association: Karen Philp, executive director of public policy and government relations, joined by Gary O'Connor, executive director of the Ontario region. As you've seen the 10-minute protocol, I'd invite you to begin now.

Mr. Gary O'Connor: Thank you, Chair, and committee members for inviting us to speak in support of Bill 102 and to recommend your consideration of a few amendments. I'm Gary O'Connor, area executive director responsible for Ontario. Here with me today is Karen Philp, executive director responsible for developing our pharmaceutical public policy and policy development in general, nationally and in Ontario.

The Canadian Diabetes Association represents more than 11,000 members in Ontario, including Ontarians

living with diabetes, the families affected by diabetes, diabetes researchers, endocrinologists, doctors, pharmacists, nurses, dietitians, dentists, diabetes educators and other health professionals involved in diabetes care across the province. From this broad perspective, we're here today to tell you that for more than 800,000 Ontarians living with diabetes, the current pharmaceutical policy and drug system does not work. That is why our association encourages members of this committee to approve this bill, with minor amendments.

Dr. Karen Philp: I'm here today to say that the status quo doesn't work for Ontarians living with diabetes. You need to do something. Of the 17 diabetes medications approved for sale and approved by Health Canada as safe and effective, only five are available in Ontario at this point in time. That's even lower than Prince Edward Island. There is a major problem here for people with diabetes, and we're hoping and relying on you to fix it.

We think the current structure fails the majority of Ontarians who rely on medications, and we think that Bill 102 will make a real difference. That's why we support it, for the most part. It's a significant step forward, in our view, not only in Ontario but also across this country, and will be leading the way in what we hope will be reform of the common drug review, particularly in the creation of greater transparency and public involvement.

I'm not going to go over our paper that we provided you. I hope you take some time to read it. I would like to spend a couple of minutes, because I know you're all probably getting a bit tired and it's late, outlining our concern.

Our concern is that the process for the appeal of a decision on the listing of a medication on the provincial formulary remains unclear. This is a problem in other jurisdictions across Canada, and we would encourage you to look at how Ontario might amend that.

While we have complete confidence and trust in the current leadership of Ontario's drug system policy, increased transparency can only enhance the broader public support for this legislation and for the decisions of the executive officer in the future. For example, Bill 102 could enshrine an independent process for a final appeal of decisions on formulary listings that includes individuals not engaged in the initial recommendations to the executive officer.

Three individuals, including at least one practising clinician—and we think it's very important that a practising family doctor be part of the appeal process—could, for example, be nominated by the citizens' council to hear an appeal from industry and be appointed by the Minister of Health when required. The appeal should be accepted based on scientific and economic evidence only, and could be funded from the executive officer's annual budget if successful and from the organization or company making the appeal if unsuccessful.

The recommendation on an appeal could be reported directly to the Minister of Health for consideration and implementation, as well as posted publicly within six weeks of the recommendation being made to the Minister of Health. We think this would increase transparency in this legislation, which we wholeheartedly support and, again, encourage you to pass as quickly as possible. Thank you.

The Chair: Thank you very much. We'll now move to the NDP side. Ms. Martel.

Ms. Martel: Thank you very much for being here today. We've met on other occasions. I would hope that the bill is going to be better for patients, particularly those you represent, but I've got to tell you, I look at this bill and I see all of the areas where there are absolutely no details on what's going to happen, and I have to wonder what we're buying into.

For example, you said we need a new section 8 process. There isn't one defined in the bill, so it's hard to say if it's going to be better or not because it doesn't appear anywhere in this bill. Secondly, we should have two additional members on the new committee to evaluate drugs; that's not in the bill either. We should have the citizens' council; there's no provision for it in the bill. We should have the innovation fund; there's nothing in the bill to provide for that. We should have new breakthrough drugs—no definition of "breakthrough," of course. We should have a rapid process for drugs to get on the formulary; that process doesn't appear in the bill.

So from my perspective, I don't know what we're buying into and I don't know if what we're buying into is going to be better than what we've got in place now. I'm not at all confident that we are, given that there are no details with any of these. Maybe you've had some discussions with some other people that would tell us how some of these things are going to work that we as opposition members haven't been privy to. What leads you to believe, when there's so much that's not in the bill, that what's going to replace it, which we haven't seen, is going to be that much better?

Dr. Philp: One, those issues are not in the current legislation either—

Ms. Martel: But they could be.

Dr. Philp: No, but they're not. The second thing is that you cannot tie the hands of future governments; we understand that. Legislation is a framework, from our perspective, on which government hangs its policy. From our perspective, it would be great if those things were in the legislation, and even if they were, government could actually change that at any time in the future. What we want to do is put in the processes. We think the citizens' council creation—

The Chair: With apologies; thank you, Ms. Martel. We'll move to the government side. Mr. Peterson.

Mr. Peterson: Thank you for dwelling on this concept of transparency, because the whole issue is now, if we want to change the formulary, if we want to change the definition of "breakthrough," we have to go through cabinet, which forces it into secrecy. One of the issues is: How much do you put in legislation and how much do you put in policy and regulation? Our attempt is to make all these processes open and transparent and observable.

We're throwing open the process. In so doing, yes, it's creating confusion for people who have no faith in people who administer. Some people are saying that we're destroying our accountability; well, all of these committees would report through to the deputy minister and the minister and we would be politically accountable—much more accountable than we are now in the secrecy of cabinet.

So I appreciate your faith in this. Can you give us your sense of where you would see the most interesting part in terms of better defining some of these areas to give people more faith in the area?

Dr. Philp: I think the citizens' council is an excellent opportunity to increase public understanding of pharmaceutical policy and the problems in Ontario. Let's face it: There are serious and difficult decisions that have to be made, and you do a trade-off in any public policy decision. Government has a hard time of it; we recognize that. But by bringing in the people who are actually living with the results of those decisions, I think you'll create greater understanding not only of what was taken in the decision-making but also an understanding that, yes, we're taxpayers; we're all taxpayers. We have hard choices to make here. And the tradeoffs? "Yes, okay. I'll make that trade-off." I think that will create greater support for this legislation.

1750

The Chair: Thank you, Mr. Peterson. To the PC side. Mr. Jackson.

Mr. Jackson: Have you been assured by the government that the announcement made in the last budget for additional funding for diabetes services is contingent upon the approval of this bill?

Dr. Philp: Absolutely not. We start—

Mr. Jackson: Thank you. Have they informed you in any fashion that the funding to pay for these drugs will come from the drug budget?

Dr. Philp: No.

Mr. Jackson: They have not. Can you tell me: Do you support a disease management strategy for diabetes in this province and in this country? If you do, how can you separate the disease management strategy from the independence of this new stand-alone, unelected, unaccountable drug secretariat?

Dr. Philp: Because for the first time ever, the Canadian Diabetes Association was invited into a consultation. We made our presentation, and our recommendations were reflected in what was reported by the minister at the time the announcement was made.

Mr. Jackson: With all due respect, a whole host of individuals have made the exact same statement but then have said that all of the input that they provided didn't find its way into this legislation. Many of the points you've raised still have not found their way into this legislation. I accept that they're of importance to your agenda and I support that. However, what you may have discussed in consultation hasn't been reflected in the legislation.

The Chair: Thank you, Mr. Jackson, and thank you as well to you, Ms. Philp and Mr. O'Connor, for your deputation and presence on behalf of the Canadian Diabetes Association.

ONTARIO CHAIN DRUG STORE ASSOCIATION

The Chair: I would now invite our next presenters: Ms. Rita Winn, spokesperson, and Ian Lording, member, of the Ontario Chain Drug Store Association, and colleagues. I would invite you to begin now.

Ms. Rita Winn: Thank you for the opportunity to appear before the committee. My name is Rita Winn. I'm a practising pharmacist, general manager and COO of Lovell Drugs, a pharmacy chain that operates in Ontario. I am speaking today on behalf of the Ontario Chain Drug Store Association, which represents 80% of all community pharmacies operating in this province. With me today are Ian Lording, our director of pharmacy services with the Great Atlantic and Pacific Company of Canada, which is a division of Metro Inc. and a member of OCDA; and Art Ito, director of pharmacy services for Hudson's Bay Co.

The OCDA is fully supportive of the Ontario government's initiative to reform Ontario's drug system. We believe that Ontario's drug system does need increased transparency, accountability, effectiveness, and improved patient access to needed care and medicines. We also support the need to manage costs in the system.

We contributed in good faith to the consultation process by the Drug System Secretariat. We offered some very concrete solutions and welcomed changes that would improve health outcomes and better manage drug costs. There is no doubt that the role of prescription medicines in health care is increasing and will continue to do so as the population ages, which presents enormous challenges to managing costs. At the same time, it increases pharmacists' levels of patient service and care. Pharmacists are a key resource in health care cost control on the front lines in appropriate medication use and in patient education.

OCDA is pleased to see the recognition of this role. The government's policy announcements, although not integrated into Bill 102, indicate that for the first time, pharmacists will be recognized and compensated for cognitive services—care that goes far beyond the dispensing of medications and improves patient health outcomes.

However, we take exception to two general areas of Bill 102. The first is the elements that pose a great threat to the economic viability of pharmacy and, as a result, health care for Ontarians. In addition to being a health care profession, pharmacy is also a business. It is not sustainable or even possible to demand more from pharmacists while drastically reducing the funding that makes it possible for them to maintain and expand operations and care.

If implemented as currently written, Bill 102 and the Minister of Health's policy statements would have a serious adverse impact on both the practice and the

economics of pharmacy in Ontario. Based on calculations provided by the government, the Ontario Pharmacists' Association and our members, we estimate that the total package of reforms provided in Bill 102 will reduce pharmacy's funding and reimbursement by at least $500 million per year. This figure could escalate if the policies are adopted by private payers.

The second area is the elements that are not written with sufficient detail so that the impact on pharmacy is either not clear or subject to further adversity in the drafting of the regulations. Bill 102 does not directly implement many of the changes the government has announced it intends to make to the drug system. Some of the changes may be implemented through regulations and policies which have yet to be made public. Since Bill 102 was tabled, there has been a high level of confusion among pharmacists and the public with respect to provisions that are part of the legislation and policy provisions that the minister has announced as government intent. We are offering a series of proposed amendments to the legislation that will address these two areas. In the handout today, you saw a thicker document, which we can't cover in the 10 minutes. Those are our suggested amendments.

While the government policy proposals, if and when implemented, do provide for increased revenues, these provisions cannot offset the grave and profound financial loss that will be brought about by this legislation. As a result, some Ontario pharmacies will be forced to reduce store opening hours, lay off pharmacy staff, increase dispensary wait times and reduce services and care for patients. Many of these will be in areas of the province where community pharmacy is the only source of health care in the community. Access and care will be further jeopardized if some of these pharmacies are forced to close.

From a chain drugstore perspective, this means that many patient care services could be in jeopardy. Chain drugstores have a unique ability to provide many value-added, innovative programs and services: information and advice about important health topics; medication reminder services; 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; clinic days; disease-specific patient consultations; and counselling on over-the-counter medication.

It is the potential adverse impact on patient care that is the most disconcerting aspect of Bill 102. This will only intensify as pharmacy chains will have to focus on increasing the volume of business in order to just survive. We are concerned that this situation will actually cause a significant setback to the practice of pharmacy. We have seen this happen in the United States: Flawed reimbursement models have led to a steep decline in patient care.

The OCDA has developed a number of proposed amendments that are documented in the written presentation we respectfully present to the committee today. I will spend the remaining time providing a summary of our overall recommendations. Briefly, to ensure that the viability of pharmacy is not negatively affected by financial loss and that there is transparency and ethical standards in place, we are proposing that manufacturers be permitted to provide professional allowances, and that the definition of a "professional allowance" is not a rebate but is rather "a benefit in the form of money provided by a manufacturer in the ordinary course of business." We propose that professional allowances can be provided only to companies and not to individuals, and that manufacturers who provide the professional allowances must disclose them to the executive officer of the province.

We would like to emphasize that rebates, or allowances, are an accepted standard practice in most retail businesses. We share the government's concerns that they be used for the purpose intended. The minister has said that there is a need for professional allowances in a free marketplace, provided that they are used for appropriate services and in a transparent manner and only to provide benefit to patients; for example, innovative programs, patient care services, pharmacists' education, and technology. Therefore we propose they be legislated and be permissible in a transparent manner, and that no allowable limits be placed on our ability to collect allowances. Limits on allowances may restrict pharmacies' ability to deliver innovative health care to Ontarians.

The allowances agreed to between the parties represent a significant portion of the overall funding available to pharmacy for value-added services for patients. Professional allowances are vital because there has been no adequate change in the sources of funding and reimbursement available to pharmacy for years. Most provinces, including those in Atlantic Canada, have a higher dispensing fee than Ontario's proposed $7 fee.

1800

The Ontario drug benefit program has the distinction of being the only regressive publicly funded drug plan in Canada, and it has been that way for many years. The program has never been able to keep pace with the rising cost of pharmacy operations in our stores. The only way that Ontario pharmacies were able to offset rising costs and provide more patient services over the past 16 years was negotiating professional allowances with generic manufacturers. Even with the increase of a 46-cent fee proposed in Bill 102, the losses incurred from the prohibition of allowances will not be offset.

The other proposed amendments are intended to ensure that some elements are legislated and not just left up to regulations, such as requiring, by legislation, establishment of a pharmacy council and a citizens' council; clearly setting out the powers of the executive officer to negotiate fees with the pharmacy council; and setting out a regular and rigorous process to review and negotiate the economic model.

It is imperative that the government of Ontario make appropriate amendments to Bill 102 before the passage of this legislation. We would like to offer this committee,

the Legislature and the Minister of Health our organization's co-operation and support in modifying Bill 102 to achieve the stated objective of establishing a more transparent and effective drug system for Ontarians.

I thank you for your consideration of our points.

The Chair: Thank you very much. We really have very minimal time; just a few seconds for each side. We begin with the government side. Mr. Peterson.

Mr. Peterson: Are you members of the OPA and the Ontario coalition of pharmacists?

Ms. Winn: I personally am a member of the OPA. The OPA is an individual pharmacist membership. I believe that the three people sitting here are members.

Mr. Peterson: Do you support the OPA's recommendations as well?

Ms. Winn: I do.

The Chair: Thank you, Mr. Peterson. The PC side: Mr. Jackson.

Mr. Jackson: Thank you for your presentation. Earlier today, the OPA picked a number closer to $11 for the dispensing fee. Is that closer to what you feel is appropriate for your chain stores?

Ms. Winn: That is closer to what we feel would be appropriate.

Mr. Jackson: And is that comparable nationally, in terms of any kind of comparison, since many of you are national providers?

The Chair: Thank you, Mr. Jackson. Ms. Martel?

Ms. Martel: Thanks for being here, and thank you for the definition of "professional allowance"—that it's not a rebate, because "rebate" has become kind of a dirty word during this process, especially when the word "hidden" is in front of it. Do you know if the government gets any rebates from any source when it purchases drugs?

Ms. Winn: That's a good question, actually. I believe they do get rebates into hospitals, and certainly by different companies funding meters and equipment. It's just a natural and business process for one manufacturer to be allowed to provide service that goes along with what might be equipment—

The Chair: Thank you, Ms. Martel, and thanks to you as well, Ms. Winn, Mr. Lording and your colleague for your deputation and presence on behalf of the Ontario Association of Chain Drug Stores.

DELTA COMMUNITY PHARMACY

The Chair: I will now welcome our final presenter of the afternoon, Mr. John Taylor, owner of the Delta Community Pharmacy. You've seen the protocol. You have 10 minutes, beginning now.

Mr. John Taylor: Good afternoon. I appreciate the opportunity to speak to the committee. I want to indicate to you, first and foremost, that I'm very supportive of the Ontario drug benefit program. I believe it to be a wonderful benefit and resource for the citizens of Ontario. Second, I'm also very supportive of the notion of provincial regulatory management. Our Ontario Legislature is responsible for the ongoing development and sustainability of the overall program.

I do not support Bill 102 in its present form. I am another one of the many who support the amendments proposed by the OPA, of which I am a member, and the pharmacy coalition, of which I am also a member.

Three key points: I believe there must be the ability for ongoing manufacturer allowances at the store level. These are currently the difference in profitability for many stores. I recognize that they are skewed and need to be corrected as part of an overall reimbursement adjustment.

Second, I believe that the pharmacy council must have legitimacy and authority. Much work needs to be done before legislation is finalized and enacted, and ongoing changes and revisions will be critical in the years ahead.

Third, the initiative in recognizing cognitive services is significant and worthy of support, as is the increase in professional fees. We don't want to lose sight of the positives in Bill 102.

That's where I'm coming from. But what I'd really like to do in the few minutes we have is tell you a little bit about my store in Delta. I'm wondering just who might know where Delta is. That's the purpose of the maps. If you want to just open it up, please, and look around Kingston.

Ms. Martel: Which side? I'm from the north, so—

Mr. Taylor: Find Kingston, then find Gananoque and go north. You'll find Lyndhurst and the beautiful lake country in eastern Ontario. Delta is a little community of about 350 people. Sorry; I wanted to mention too that the maps are provided free of charge by the Ministry of Transportation. There is no copay—no $2 or any copay for the maps.

Unless Bill 102 is fixed, Delta Community Pharmacy will probably close. At best, it is marginally profitable now. It first opened in May 1996, 10 years ago. While it took some time, it has been embraced by the community. It's not really my store. I operate it, but it belongs to the people of Delta. They worry more about the store's viability and sustainability than I do.

Delta has approximately 350 people; I estimate maybe 1,000 in total in the catchment area. It's a unique concept/vision sort of store. I don't think there's anything like it in the province or possibly in the country. It's 200 square feet. I brought some pictures and I know it's hard for you to look at them, but maybe when we're done you can have a little peek at what the store looks like.

It's open from 9 till 12 noon on Monday, Tuesday, Thursday and Friday. That's it: 12 hours a week. I have a great relationship with the people in the community, with the patients and with the doctors. The fax and the phone answering service run 24/7, and that works very, very well for the store. It's not about me. This whole issue is more about the people in Delta and what they will do.

If you look on your map, Delta is sort of in the middle of nowhere. Off to one side is a little community called Athens. They have a drugstore—just one drugstore; a small independent. It could probably close too. If you go the other way, there's the little community of Elgin. They

have a drugstore that probably will close. Seeleys Bay, a little to the south, has a drugstore. It probably will close. The people in this area are looking at Westport, Gananoque, Kingston, Smiths Falls and Brockville as their sources of medical supplies. I don't think that was ever intended in the legislation. I think it's a circumstance that we can collectively correct, and that's really what I'd like to see us do.

I wish to recognize the support of all my colleagues right across the province. We've all made a tremendous effort to appear before this committee and tell our stories. I congratulate them all.

I wish to thank you for our attention. I really do appreciate the opportunity to be heard. I wish to emphasize just how important this issue is to me and my community. It's been a long drive this afternoon—a beautiful day, but a long drive—and it's going to be a long drive home. But I remain optimistic that it will be worthwhile, and I leave that part to you.

Thank you, and I'd be pleased to take your questions.

The Chair: Thank you, Mr. Taylor. We have about a minute or a minute and a half each, beginning with the PC side. Mr. O'Toole.

Mr. O'Toole: Just briefly—Mr. Jackson probably has one—you have 200 square feet, and you're open 12 hours a week. What's your rebate per year?

Mr. Taylor: Oh, gee.

Mr. O'Toole: You don't know?

Mr. Taylor: Not offhand. Maybe it's $12,000—no, maybe $15,000.

Mr. O'Toole: Is it half your revenue or less?

Mr. Taylor: Oh no, much less than that.

Mr. O'Toole: Is it 30%?

Mr. Taylor: In my store it would be anywhere from zero, depending on the manufacturer, to maybe 30%.

Mr. O'Toole: So it's really not that important?

Mr. Taylor: It's significant. For sure, it's significant.

Mr. O'Toole: What we've heard is that it is the most important thing in this whole discussion. Without it, all the small stores close. That's what we're told.

Mr. Taylor: Well, sir, it's all about total gross revenue, basically. If the fee is adjusted and the rebate goes, then maybe there's something there. But it's more a matter of how much money the store receives. The economy of the dispensing business is what this is about, it seems to me. It's much more than rebates.

Mr. O'Toole: I know it's more than that, but they're telling us that the coalition is saying that without these, they're closing—period, end of argument. That's what they're saying. Absolutely 80% of the presenters have told us—and some of them are sitting here. This gentleman here is going to close his store if that rebate is cancelled.

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

Mr. Taylor: Can I—

Ms. Martel: Sure. You can use my time. Go ahead.

Mr. Taylor: The rebates become less important if the dispensing fees are increased, if there are other sources of revenue, all right? The significance of the rebates pales in the whole scheme of things.

Ms. Martel: But if that represents 30% of your total gross revenue—30% of your total gross revenue comes from promotional allowances, or did I misunderstand that?

Mr. Taylor: Not in my little store. My store doesn't qualify for a lot of big rebates. It's a small independent. The stores without relationships, without banners, without corporate offices or whatever are more at risk than those with.

Ms. Martel: Okay. So if there's a change of 46 cents in the dispensing fee, what does that do for you?

Mr. Taylor: Not a whole lot. My store might do 10,000 prescriptions a year, so what's that—$4,600. It helps.

Ms. Martel: That's not going to take you very far.

The Chair: Thank you, Ms. Martel. To the government side: Ms. Wynne.

Ms. Wynne: Thank you very much for being here and thank you for the map. I think it demonstrates what we're dealing with here. It seems to me that you really get the nub of what we're trying to do here. When you talk about the current rebate system being skewed and that it's about a broader picture of having enough revenue so you can survive, can you just talk a little bit about why you see there is a need for the kind of restructuring we're talking about? You're supportive of the OPA amendments, but what's at the nub of why we need to do this?

Mr. Taylor: Well, it's been being dealt with for too long. The difficulty is in how long it has taken to get us here. I'm not suggesting that what you're considering in Bill 102 is the complete or correct answer, because there are things that the council—I'm not sure what the makeup is, but I'm looking to the OPA and the pharmacy coalition to sort that out. Certainly, the business side of our business needs to be heard and understood. I think that's what these hearings and the stories are all about: trying to explain the impact on our individual stores and communities.

The Chair: Thank you, Ms. Wynne, and thank you, Mr. Taylor, for your deputation today. We'll have to take it on faith that it was a beautiful day, as we haven't seen it ourselves.

There's no further business before this committee. This committee stands adjourned until Monday, June 5, at 9 a.m.

The committee adjourned at 1813.

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