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Monday 5 June 2006

Journal des débats (Hansard)

Lundi 5 juin 2006

**Standing committee on
social policy**

Transparent Drug System
for Patients Act, 2006

**Comité permanent de
la politique sociale**

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

Chair: Shafiq Qadri
Clerk: Trevor Day

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**STANDING COMMITTEE ON
SOCIAL POLICY**

**COMITÉ PERMANENT DE
LA POLITIQUE SOCIALE**

Monday 5 June 2006

Lundi 5 juin 2006

The committee met at 0900 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.

The Vice-Chair (Mr. Khalil Ramal): Good morning, everyone. Welcome to the third day of hearings on Bill 102. We have many presenters today. I'll tell you a little bit about procedure. Everyone has 10 minutes. You may wish to speak for the whole 10 minutes, or you can divide it between speaking and questions and answers.

ACTION NEUROPATHIC PAIN ONTARIO

The Vice-Chair: First, we have Action Neuropathic Pain Ontario. Do you want to state your name for Hansard?

Dr. Allan Gordon: I'm Dr. Allan Gordon. I'm a neurologist at Mount Sinai Hospital. I deal with neuropathic pain. This is Rachel Weisz, who is a consumer with neuropathic pain. I'm very pleased that we can speak before you this morning, including to my MPP, whom I've never met, but you'll be hearing from us.

I represent a volunteer organization called Action Neuropathic Pain Ontario. This is a group of physicians, pain researchers, nurses, physiotherapists and consumers who have neuropathic pain, who wish to change the way neuropathic pain is managed in this province and to improve access to treatment. I'm also a member of the Canadian Pain Society, a special-interest group, and also something called the association of pain management directors.

Neuropathic pain is caused by a number of conditions, including shingles, multiple sclerosis, stroke, diabetes, trauma, post-surgery and cancer. It's hard to know how many people have it, but up to a million people in country and perhaps 400,000 people in this province. It can be quite severe. Because of it, people can't walk,

they can't talk, they can't have sex, they can't sleep properly, they're very anxious—not about the last part, Mr. Ramal.

If you can imagine, people with this have pain in parts of their body, which interferes with their lives. It's not just the symptoms, but also there's a huge economic input from this. In fact, it's so debilitating that we've done some studies on it. One study that I'm a co-author on looked at neuropathic pain patients in Quebec, Ontario and Alberta. We found that the three-month cost, both direct and indirect, to the system and to the patient was about \$2,500, which is like \$10,000 a year, if you think about it. So if there are about 400,000 patients in Ontario with neuropathic pain, exponentially that's a lot of money, and only part of that is direct drug cost.

We're here because there are significant issues of how pain management should occur. Pharmacotherapy is an important part of pain management, and we're very concerned about how our patients can get access to medications they need to be treated. Full treatment requires full access to clinics, but also to medication. Interestingly enough, things are not quite as good in Ontario as they are in Quebec. In Ontario, only about 20% of compounds are properly funded, whereas in Quebec, 40% are funded.

The other thing is that there are certain aberrations. I spend a lot of time applying to something called section 8, which is part of the ministry's special access program for medication. Many of our patients are seniors or are on disability, so the only way they can use these medications is to get them funded by the government. There are some anomalies. For a long time, a drug called Gabapentin wasn't funded at all. Now Gabapentin is funded, and a drug called Lyrica, which is approved for neuropathic pain, is funded only in the absence of effectiveness of Gabapentin or something else.

I think Bill 102 promises to change all that, although I think the devil is in the details. We're not exactly sure how it's going to change that. Hopefully it'll change it for the better.

We want to make sure that if there is funding, the funding not be based only on cost, but also on effectiveness of the drug, familiarity with the literature and the evidence, existing practice guidelines, expert opinion, respect for the reliability and reputation of the practitioner making the request, the aspirations of the patient

requiring the medication, and also a sense of compassion and common sense.

Transparency must be maintained at all cost. If reviewers are to be used under the new system, the names should be public rather than confidential. We should know who's reviewing these drugs. We've offered already to act as consultants to this process, my colleagues and I. But also, true consumer input is essential. Question: How can we make sure this occurs under Bill 102?

Before I introduce Rachel Weisz, I want to talk about the fact that the cost of pain medication is only part of a larger system issue. I've left you something that was produced in Quebec. The province of Quebec has recognized that chronic pain is an important condition to look at, to treat properly. This is not on the agenda today and I'm just leaving it more for information than anything else.

Those of us in the academic pain management community wish to work with either this committee or the ministry to improve the lot of patients with neuropathic pain, hoping to improve drug access and also other kinds of treatments. I would ask that Bill 102 be carefully examined, and changed if possible, to ensure that all patients with neuropathic pain have fair access to the medications they need and that their concerns I have mentioned be addressed.

I'd now like to introduce Rachel Weisz.

Ms. Rachel Weisz: I became ill with a severe case of shingles in March 2000. That is over six years now that I am trying to find relief from the debilitating pain of postherpetic neuralgia.

During the first year, I was totally housebound due to the severity of the pain. Later I had epidural injections and when that did not work, I was prescribed OxyContin. Scared of becoming addicted, I searched for other means of relief. I tried biofeedback, naturopathy, alternative medicines; none of them helped.

In 2002, I was accepted for treatment at the Wasser Pain Management Centre at Mount Sinai Hospital. There, Dr. Gordon changed my medication to Gabapentin. I also tried self-hypnosis and laser therapy. After using Gabapentin for close to two years, I became worried about the side effect of memory problems.

In 2004, I heard that some physicians were using a new treatment successfully for pain relief. As I was unable to afford the cost of it, Dr. Gordon made a request to section 8. Since then, there has been a most frustrating and lengthy correspondence of requests, explanations and refusals. Gabapentin is an expensive drug, and when looking at the cost of a new medication, it should be taken into consideration that the expense of Gabapentin will be eliminated. Dr. Gordon graciously obtained the donation of a free dose for me. That provided the proof that it helped me.

I am particularly angry about the way section 8 is disrespectful of Dr. Gordon's qualifications, extensive experience and authority as director of the Wasser Pain Management Centre.

0910

I have two concerns with Bill 102. Will the drive to reduce costs deprive me of the Gabapentin, that is already in a generic form and still expensive? It also creates scary side effects, which the original drug probably does not have.

Will a rapid review of breakthrough drugs eliminate the two-year hassle with section 8 I have just described, or make it even more inflexible? Also, the reduction of paperwork does not guarantee that the restrictive and narrow definitions will not remain.

Pain is not visible like an injury or physical challenge, so please believe me when I say my chances of a normal life have been destroyed. I am just one of a large group of people who deserve to be provided with the relief that is available. Thank you.

The Chair: Thank you very much. We have one minute left. Why don't we give you one minute for one party and then we'll rotate it. Mrs. Witmer?

Mrs. Elizabeth Witmer (Kitchener-Waterloo): Well, I guess there's not much more time than to thank you, Dr. Gordon, and also Ms. Weisz, for coming here today. I understand what you have just said. However, I would say to you that at the present time, there would be nothing in Bill 102 that would mean that the situation that you're experiencing is going to change, because there is no definition of "breakthrough drugs," and we don't know what section 8 is going to be replaced by. Whether or not there's going to be anything done to address your concerns presently—there's no indication that there will be, but I hope the government hears what you've said today. Thank you.

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

BAYER CANADA

The Vice-Chair: Now I want to call on Bayer Canada: Philip Blake, chief executive officer. Just so you know the procedure, you have 10 minutes. If you wish, you can speak the whole 10 minutes, or you can divide it. Go ahead.

Mr. Philip Blake: Good morning. My name is Phil Blake and I am the president and CEO of Bayer here in Canada. My colleagues Grant Gunn and Ben Faienza are also with me here today.

I've had the good fortune of spending 27 years involved in the development of pharmaceuticals, the research of pharmaceuticals and bringing pharmaceuticals to patients. I've worked in Japan, I've spent time in Germany, I've worked in the United States, I've worked in the United Kingdom, and now, since 2000, I've been here in Canada. I've observed in all of those jurisdictions the importance of health policy, but also that health policy and the delivery of health care involve highly complex and interrelated phenomena, and if you make a simplistic, simple change in one part of the health care system, you usually see a perverse and unwanted outcome in other parts of the system. I've seen that in all

of those jurisdictions. I'm here today to help Ontario avoid making mistakes.

New Zealand, Quebec, Norway and Australia have all attempted to control drug costs through manipulating the price or the cost to consumers of newer advances to medicines. In all cases, ladies and gentlemen—all cases—the result has been an increase in total costs to the health care system. In New Zealand, even more disappointing, manufacturers ceased the supply of cancer drugs following a rollback in pricing.

Bill 102 will roll ODB prices back to the levels of more than a decade ago. It's very difficult to understand why our government would do this. Not only have companies like mine experienced significant increases in the cost of doing business—and 95% of my costs are people costs. That's the basis of our industry. We're an information-generating industry, and people generate those costs. Those costs have continued to rise, but Canadian prices are already so low that busloads of Americans come to Canada to get access to Canadian prices. So there's something wrong here, something that I think we all need to understand.

Ontarians already have an excellent deal on drug prices. The proposed price reductions are not only bad policy, but by abandoning the current made-in-Canada pricing system—and I have to say, from all my experience, this current made-in-Canada pricing system works very well for Canadians—you will be introducing, fundamentally, an American-based system in Bill 102. That is going to lead to a discriminatory two-tier system where the weak suffer and the strong get stronger, to higher distribution costs—instead of the monies from your taxes going to patients for drugs, they go into the distribution system—and ultimately, to higher costs for all Canadians.

Let me point out the following: Canadian drug prices are currently 9% below the international median. That is, currently you have a great deal here in Canada and in Ontario. Your drug prices are 9% below the international median. When we compare Canada to the United States, US pricing is almost 80% higher. The multi-price system in the United States has led to higher distribution costs, much higher than the low distribution costs that the made-in-Canada solution has led to. This is a complete waste of money. This is money going to middlemen that should be spent on medicines for patients. We clearly do not want to encourage that here in Ontario.

In addition to the policy flaws, there is a jurisdictional challenge to pricing provisions in Bill 102. Pricing in Canada is and will continue to be regulated under the made-in-Canada system of the federal Patented Medicine Prices Review Board. In their recent consultation paper, *Consultations on the Board's Excessive Price Guidelines*, published in May 2006, it is clear that the board is fundamentally opposed to the pricing elements introduced in 102 and claims sole jurisdiction in this area.

In closing, since the proposed pricing regulations in Bill 102 only impact the ODB—Ontario drug benefit—reimbursement of medicines, you should demand that the

government recognize and evaluate the impact of introducing a US-based procurement system on other parts of the system. You need to consider the impact on other provincial plans. What's going to happen in Manitoba, Saskatchewan and PEI when Ontario uses bully tactics and their purchasing power to drive prices down? The prices in the other jurisdictions will go up. How are people without coverage going to manage when the prices go up to US levels, those people who pay out of pocket and the privately insured?

The sponsors of this bill need to answer the following. You have to demand that the sponsors answer the following:

How will a multi-tiered price system in Ontario operate without the emergence of middlemen that drain value out of the system?

How long will it take before the introduction of a US procurement model in Ontario, the DVA model, leads to US pricing in Ontario?

Under the NAFTA, GATT and TRIPS agreements, we live in one common market here. Of course, you'll suck US pricing in as soon as you move away from the made-in-Canada model, which has relied on our solidarity.

Finally, if the ODB uses its buying power for short-term gain, how will the impact occur on the smaller provinces which don't have that buying power?

You need to consider these before you allow Bill 102 to go forward.

But there is a way forward. There is a much more sensible way forward, how we can jointly work in a partnership to enhance the health care provision here in Ontario.

We understand the government need for a drug budget which has predictability and sustainability. That's clear. We understand that. I understand that as a CEO of a major global corporation, because we also need a stable and predictable commercial environment to do our best work. Our best work is bringing innovative medicines to patients to help treat these difficult diseases.

Our needs are aligned. A wise government would take some time to properly understand the impact of the pricing proposals in Bill 102 to avoid these perverse occurrences that we see all around the world when you tinker with pricing without thinking it through. A wise government would take the opportunity of sponsoring a true partnership with our company and our industry.

I thank you very much for the time today to address this committee. Of course, we're here to welcome any questions you may have.

The Vice-Chair: Thank you for your presentation. Ms. Martel, we have three minutes. We can divide it three ways.

Ms. Shelley Martel (Nickel Belt): Thank you for your presentation. I'm interested in the Patented Medicine Prices Review Board. I admit I don't know very much about that. Who sits on that? Do they represent all of the provinces? Do you know how that works?

Mr. Blake: It's a federal-level board that represents the pricing in Canada. It's designed to prevent excessive pricing in Canada.

Ben, do you want to add to that?

Mr. Ben Faienza: Only to say that the appointees on the board are appointed by the Minister of Health.

Ms. Martel: Are all provinces represented?

Mr. Faienza: All provinces, yes.

Ms. Martel: And appointment is by the Minister of Health?

Mr. Faienza: Yes.

Ms. Martel: Thank you.

Mr. Tim Peterson (Mississauga South): Thank you very much for coming in. Are you manufacturing in Ontario?

Mr. Blake: Yes, we do manufacture in Ontario.

Mr. Peterson: Could you give us a little description of your company and just exactly what your activities are?

Mr. Blake: Our company is called Bayer. You probably know us best for Aspirin.

Mr. Peterson: I know the name, but I don't know the details of your operations.

0920

Mr. Blake: We manufacture products for haemophilia, for a whole range of serious diseases. We introduce products for cancer. We have a diagnostics facility. We manufacture in Ontario. We do research and development in Ontario.

Mr. Peterson: So most of your products are covered by the federal patents on drugs? When you talk about these severe price decreases, are you talking about the off-patent pricing?

Mr. Blake: No, I'm talking about the proposed roll-back in prices here in Ontario under Bill 102, which will impact our patented products.

Mr. Peterson: So if these prices are not rolled back but are negotiated with you, as we anticipate they would be, then this would be a suitable way to work with you on them?

Mr. Blake: It's important that our prices are allowed to continue under the PMPRB regulations, which regulate price.

Mrs. Witmer: Thank you very much for your presentation. Certainly, we share your concerns about the impact that this legislation is going to have on companies like yourself. You mentioned a few times it's going to lead to higher distribution costs, and I just wonder if you could explain that—what and how.

Mr. Blake: The specific proposal is that the ODB will negotiate, as you heard the other member describe, with manufacturers prices for the ODB patient. So this will lead to the emergence of multiple price levels in Ontario: one price for an ODB-reimbursed patient, another price for patients in private plans and another price for patients who pay out of pocket.

We see that exact occurrence in the United States: multiple price levels, which require high levels of information technology investment in pharmacies so they can

manage those multiple pricings; high levels of investment in the distribution service, so they have to have different channels; and you have to have monitoring of the pricing across all the pricing channels. It's a very expensive thing to do.

The United States market can afford it because of the 20-times-larger market that exists south of the border. The problem is that you get the unfairness, as it's called in the United States. So patients have very different pricing to pay, and you see the emergence of the inequity there in the United States. It also leads to much higher drug costs in the distribution area, since you have to have multiple distribution channels to manage all of this.

The made-in-Canada solution that we currently have has a solidarity aspect to it, regulated by the PMPRB, which ensures that there is one price across Canada, which is currently 9% below the global median and 80% below the United States. The concern is that by initiating this new multi-price system, you'll have competitive bidding going on and you'll have this emergence of the additional costs in the supply channel and, under NAFTA, GATT and TRIPS, the emergence of a competitive market where the prices will rise to the prices in the North American continent.

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

WEST HILL PHARMACY AND COMPOUNDING CENTRE

The Vice-Chair: Now we call on West Hill Pharmacy and Compounding Centre. Do you mind stating your name, sir, before you start?

Mr. Neil Bornstein: Good morning, ladies and gentlemen. My name is Neil Bornstein. I am the pharmacist-owner of West Hill Pharmacy in Scarborough.

Today I've brought with me my two pharmacy students. On my right is Shafin Dharsi. Shafin has completed his second year of pharmacy and his sixth year of university education. On my left is Laurie Cook. Laurie has just completed her first year of pharmacy and also her sixth year of university education. These two students still have two or three years of university education remaining before they will become licensed pharmacists. They are already highly skilled, and by the time they graduate, they will be prepared to deal with complex health issues and drug therapies. They would like to know why our society creates highly educated drug experts with vast skill sets if our legislators are about to create an environment where their skills cannot be utilized.

For myself, I have been practising community pharmacy for the past 25 years and have dedicated my career to providing excellent health care. For the past 16 years, I have been the owner of West Hill Pharmacy. Our dedication to excellence is reflected in the national and provincial awards that we have received both on an individual basis and on a store basis. I have these awards with me today.

Our pharmacy has always strived for excellence in the provision of health, and I believe that the secret to that is to have and retain a motivated, highly trained and customer-focused staff. I am not alone. Many of my pharmacist colleagues are true leaders in the health care industry.

Community pharmacy in general operates at the most efficient level. We are the most accessible health care practitioners. You don't need to make an appointment to see a community pharmacist and rarely have to wait more than a few minutes.

The Ministry of Health has never provided any equipment, any facilities or any support for the services that I provide. Yes, they pay when I fill an ODB prescription. They pay me 43 cents to fill a prescription for a senior whose income is above a relatively low threshold. The ministry pays me \$4.54 to fill a prescription for the lowest-income seniors, for welfare recipients, for the disabled and for Trillium patients. It is my clients who pay the balance of the \$6.54 fee. Excellence in pharmacy service is not possible at these trivial rates, and it is these patients who have complex health conditions and drug regimens who need a pharmacist's services most of all.

My pharmacy depends upon allowances from generic manufacturers in order to provide excellent service. I need to pay a fair wage and a fair benefits package to recruit and retain quality employees. I need to continually invest in training programs, to invest and reinvest in equipment, in computers and in software. I have to pay my occupancy costs and staff my pharmacy with a sufficient number of employees so that we can provide superior services.

Bill 102 calls for these allowances to be drastically reduced and to also reduce the markup from 10% to 8%. This will be an immediate hit to my bottom line and will thwart any opportunity to achieve excellence. As a taxpayer, I understand that the ministry wants the best price. I would suggest that paying 43 cents to fill a prescription is already far and away the best price. Raising the fee by 46 cents to \$7 will hardly do anything to offset the other changes and it does absolutely nothing to offset the loss of revenue in the non-ODB market.

I would like you to understand the consequences in my pharmacy if you allow the bill to continue without fixing these problematic issues.

I will be forced to cut one pharmacist, one dispensary technician, both of the two pharmacy students beside me today, and two part-time student jobs. Additionally, we will have to cut our hours of operation, further limiting the health care that we provide. Wait times for pharmacy services will become a real issue, just as they already are for physician services, diagnostic services and hospital services.

As a pharmacist, I will no longer be available to assume the role of a triage team member. I will not be available to provide health care advice and guidance directly to patients. I'll be too busy. As a result, we will see increased visits to family doctors, walk-in clinics and

local community hospitals. This will incur even greater costs to our government and exacerbate wait times.

We will not be able to provide support to the infection control committee or the pharmacy and therapeutics committee at the long-term-care facility that we service.

We will not be able to continue to provide our hands-on blood pressure monitoring service, and we will be directing these clients to a walk-in clinic. This again will add to the ministry's cost of providing physician services and further burden our already overtaxed physicians.

We will be discontinuing our diabetic training services and directing patients to the local hospital, where their program is already underfunded.

We are currently able to provide private consultations by appointment, usually within two days. These consultations assist patients in improving outcomes in smoking cessation, asthma, heart health and opioid addiction, to name just a few. Consultations will now be provided by the pharmacist on duty between checking prescriptions and counselling walk-in patients. Yes, the ministry has talked about providing \$50 million for consultative services, but Minister Smitherman has talked about that money helping to replace the manufacturers' allowances. I simply cannot physically provide consultative services within that \$50-million pool of money when I have to check prescriptions and counsel walk-in patients. I cannot afford to pay a second pharmacist to be on duty. It is essential that the \$50-million pool of money be over and above the costs related to dispensing in order to pay for consultative services for those most at-risk patients who are currently not able to pay me directly.

We currently maintain an extensive library, a lending library of health books, pamphlets and videos for our clients and an extensive resource library of books, digital media and Internet for our pharmacists. We use these resources to assist in patient care and support our physician colleagues. We use it to support our nurses at our long-term-care facility and to support allied health professionals. We simply will not be able to continue to maintain this library.

Many of our clients are physically unable to regularly attend at our pharmacy. I will not be able to continue to provide home visits or extended phone support. Again, those clients who need my services most will have to be managed within the day by the only pharmacist on duty.

Our current extensive support of community events and initiatives will not have funding or time resources.

0930

I am a very proud Ontarian. We have a wonderful health care system. Yes, it's a system that has its challenges, but I urge you to amend Bill 102 so that the excellence in pharmacy services can continue and even be encouraged. You must eliminate the limitation on the manufacturers' allowances and reverse the reduction in the markup from 10% to 8%. Finally, you must foster true growth in health care by ensuring that the \$50-million pool of money is additional money.

Ontarians are looking to you to improve health care. Pharmacists can deliver it, but we need your help. We

would like to know why our society creates highly educated drug experts with vast skill sets if our legislators are about to create an environment where their skills cannot be utilized. Thank you.

The Vice-Chair: Thank you very much for your presentation. We have one minute left. We can give it to you, Ms. Martel.

Ms. Martel: Thank you very much for being here. Can you give us a sense, on the generic allowances, of what kind of services you're providing for your patients? I know you mentioned the lending library as a resource. Are you doing clinics?

Mr. Bornstein: I'm doing private consultations with my patients. I'm doing clinics where they're coming in and being educated about their health conditions. I'm doing extensive patient reviews in terms of what drug therapy they're doing. I'm visiting my nursing home and providing extensive time with them in support of the nurses and educating the nurses about drug therapy. In addition, I'm participating in a pharmacy and therapeutics committee and an infection control committee at the home. There are numerous things, and it isn't just professional services. It pays the very staff salaries of people who work in my pharmacy.

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

MEDICAL PHARMACIES GROUP

The Vice-Chair: We have the Medical Pharmacies Group with us here today. Do you know the rules and procedures?

Ms. Carole McKie: Yes, thank you.

The Vice-Chair: Go ahead.

Ms. McKie: Good morning. My name is Carole McKie and I am vice-president of pharmacy services for the Medical Pharmacies Group. On my right is Richard Sevazlian, who is CEO, and on my left is Syd Shrott, who is senior vice-president of pharmacy operations. All three of us are pharmacists.

Medical Pharmacies' network of 38 pharmacies stretches across Ontario, from Windsor to Ottawa and north to Sudbury. Together, 580 people work in our pharmacies. It's a pure pharmacy operation, without any front shops. Our business is dispensing medicine, and that alone. We generate 98% of our revenue from prescriptions, much more than any other pharmacy, including local independents. You can find our pharmacies in professional medical buildings and urgent care centres, and half provide pharmacy services to long-term-care residents. Although we operate only in Ontario, we are the largest provider of pharmacy services to long-term-care residents in Canada, and that's an area on which I'd like to focus now.

We provide prescriptions and clinical services to about 35,000 seniors in more than 325 long-term-care homes across the province. This includes about 40% of all seniors living in nursing homes and homes for the aged in Ontario. If your parent or grandparent happens to live in

a home in Peterborough, Mississauga, Sudbury, Kitchener, Burlington, Durham, London, Halton, Toronto, Niagara and many other locations, chances are we fill his or her prescriptions and we make sure that the prescriptions are used right.

Long-term-care pharmacy is vital to the health care of Ontarians. Right now, we're watching the boomer generation move into its retirement years, a trend that will culminate in 25 years when one in five Ontarians will be 65 or older. Our retirement and long-term-care home programs will be expanded and comprehensive services like those that Medical Pharmacies provide will be in greater demand. It's important then that we get the balance right to enable us to deliver the sort of pharmaceutical care that Ontario's seniors and soon-to-be seniors need. That's why I want to thank Minister Smitherman, ministry staff and members of this committee and also those of the Drug System Secretariat who met with us. You understand that our drug system has to evolve if it's to survive and meet current and future needs. You took action to move this very complex system towards a sustainable basis, and for that you should be commended.

But we do have concerns with the legislation that's been tabled, and I want to raise these concerns and offer to work with the government and our professional association—the Ontario Pharmacists' Association—to craft workable alternatives that will meet the government's objectives and still sustain long-term-care pharmacy in Ontario.

Providing health care to seniors is more complex, time-consuming and, in the end, expensive than for younger people. There are many reasons for this, but the most important factors are that seniors, and especially those already living in nursing homes, often have several very severe chronic conditions that must be managed carefully. Also, they're more frail.

Drug therapies become more complex, and getting the delicate balance right requires skill and specialized knowledge. That is why we use clinical consultant pharmacists embedded right in the long-term-care homes to work with the staff and the patients. This is a professional service we see as a standard of care for our seniors, and one that is not paid for by the government, even with the professional fees suggested by the minister. It's also why we invest heavily in electronic patient records, to make sure the right patient gets the right drug at the right time.

E-health is widely considered to be the linchpin of our health care system. It's a tool that will revolutionize patient care by delivering continuity and enabling all health care providers to work closely together as a team. We are very proud that we are an early contributor to the development and the implementation of this technology, but I really must stress that we do not receive any funding for this.

Why are consultant pharmacists and e-health important? While drugs can save and extend lives, they can also shorten them, and in rare cases they can kill. Medications have to be administered carefully and professionally, and especially when the patient is a frail senior.

I've attached a copy of some unsolicited testimonials at the back from some of our long-term-care clients and I've also included a listing of pharmacy services to long-term-care facilities.

We at Medical Pharmacies rely on our partners in health care—who are our suppliers—to help us defray some of the costs associated with maintaining pharmacy operations and continuing to meet the needs of the long-term-care residents. We are very concerned about the government's plan to remove allowances or rebates from the system, as it will curtail the source of funding for the services that are keeping Ontario's seniors safe and healthy. In the absence of any comparable and sustainable funding source, companies like ours will no longer be able to meet the needs of Ontarians living in nursing homes and homes for the aged. We are also concerned that the government, in its briefing on Bill 102, hinted at a new payment model for long-term-care pharmacies but provided no detail in the legislation.

Members of the committee, I submit to you that no senior living in a long-term-care home should receive a lesser amount of pharmaceutical care than a senior living at home in the community.

For committee members, ministry staff and even Minister Smitherman, I recognize that today marks the end of what must have been for you a very gruelling process. No doubt you are asking, "Why does everyone just present their problems with the bill, and why won't anyone come forward with workable solutions?" So I'm very happy to bring you two workable solutions.

First, let's agree that seniors, regardless of where they live, deserve at least the same amount of pharmaceutical care. Therefore let's amend the legislation so that the reimbursement levels for long-term-care pharmacy are at least the same as for community pharmacy. We've brought a draft amendment with us today, and I've included it on page 6 of your handouts.

Second, let's acknowledge that the value-added services or rebates that our suppliers provide help us to deliver the much-needed medication management services to Ontario's seniors. Therefore let's work not on eliminating these rebates in one fell swoop, but instead on addressing the need for clarity and accountability in their use.

Let me be clear: The allowances are not the problem—they are, in fact, funding services that the government is unwilling or unable to fund—rather, the problem is the lack of visibility that causes concern.

0940

Members of the committee, in my years of personally delivering pharmaceutical care to our seniors, I've seen how drugs can make a real difference in people's lives. They keep people healthy and independent longer; they reduce, prevent and help manage disease. As health care planners, we know drugs can save money by reducing the need for hospitalization and other health care services.

As the minister has tellingly pointed out, we need a sustainable drug system if we are to continue to benefit from medications. We need a system that is sustainable

for every participant, including long-term-care pharmacy providers.

That's why I urge you to consider the amendments I've mentioned today and to join with us and the Ontario Pharmacists' Association in building a more workable solution.

We need your support and urge you to endorse the Ontario Pharmacists' Association's amendment to Bill 102 in subsection 11(2), under "Alternative payments," where we're asking for the addition of the clause: Payment ... shall not be less than the amount paid for a community senior."

We're eager to work with you, and we hope you will take up our offer. Thank you for your attention. Any questions?

The Vice-Chair: Thank you very much for your presentation. We have no time left.

Ms. McKie: We have no time left?

The Vice-Chair: Sorry.

Ms. McKie: I'm very sorry.

Mr. Richard Sevazlian: We will be available if anybody wants to talk to us.

The Vice-Chair: Okay.

Do we have Axis Lawrence Pharmacy? I guess not here.

We can move to the second one on the list. Is Joseph D'Cruz here?

PORT ROWAN PHARMASAVE

The Vice-Chair: Port Rowan Pharmasave.

Mr. Glenn Coon: Good morning. My name is Glenn Coon. My wife, Pam, and I own Port Rowan Pharmasave in the town of Port Rowan, Ontario, which is in Norfolk county in the southwest part of the province.

Our town is a small town, made up of primarily retirees. Most live in an active adult development commonly referred to as The Villages, as well as the community of Long Point, which is 15 minutes to the south of Port Rowan. The nearest towns and pharmacies are 30 minutes away to the north and northeast. They are Tillsonburg and Simcoe.

Our town, like many towns in rural Ontario, is deemed underserved. We have one doctor and require at least one and a half more doctor positions to meet our needs. Our one doctor gave our town notice two years ago that he would be retiring four years hence. We have been searching to find a replacement for Dr. Long with absolutely no success.

Let me continue to paint a verbal picture of our town. A few years ago, a devastating ice storm hit the north shore of Lake Erie. In a matter of hours, all of normal life in Port Rowan and the surrounding community came to a halt. Over the next several days, emergency resources necessary to cope with the crisis were very slow to make their way to Port Rowan. Communications with local and provincial governments were almost non-existent. It was obvious that emergency preparedness in the west end of Norfolk county was not high on any authority's list.

So, last fall, with the emerging threat of avian flu and, as we have seen in recent weeks, the potential outbreak of a pandemic flu virus, Dr. Long, myself and another community member spearheaded a grassroots, community-based group to plan for a disaster, be it bird flu, ice storm, chemical spill in Long Point Bay, the destruction of hydro transformers or possible terror attacks. We have listened to our government say, "Get prepared."

We now have a structured committee made up and chaired by local citizens, and we meet monthly. We work closely with the Haldimand-Norfolk Health Unit, which is absolutely thrilled with our community's proactive stance on emergency preparedness. We will have in place community volunteer members trained to step in when the government resources fail. The water treatment plant, the lagoon sewage system, a flu-free emergency triage unit, a beefed-up mission food bank, a community on patrol security surveillance, alternate communication systems—internal and public—are just a few things our community will have in place for us in the first few crucial months of a disaster.

There is such a sense of community living in Port Rowan, it is infective. People choose to live in rural Ontario for good reason, and there are pharmacists willing to provide them with health care.

You have heard it for weeks now. Bill 102 will take non-taxpayer money, the so-called generic rebate, and replace it with taxpayer money at a much-reduced amount to the pharmacist. No expert would have come up with that. Bill 102's expert had me actually losing money in providing high-cost medication to my cancer and HIV-infected patients until the Minister of Health removed the \$25 cap. How did that get into the act in the first place?

This bill is flawed, and I am absolutely frightened by the expert's regulations to the act, because there is nothing transparent about this bill except how it is going to hurt rural Ontario health care. The National Post's article on June 1 entitled, "A Bill to Kill," outlines how murky this legislation is and how I will not know the full financial impact until well after the bill is passed. So I can only be general when I give you dollar numbers; you can't expect otherwise.

If this bill passes without the amendments proposed by the various pharmacy associations, at fiscal year-end 2007, I will not be paying any corporate income tax. Given the new bill's income sources, less the old outlawed income sources, I expect to lose between \$120,000 and \$150,000 in revenue. I fully expect to operate at a loss in fiscal 2007. That kind of loss may be able to be withstood in busy urban pharmacies or in pharmacies with big front shops.

I have partnered with many suppliers to create an environment where my patients can come to get confidential, professional advice and service for their health care needs.

I provide more than a dozen community seminars annually. I have partnered with the Ontario Provincial Police and the Grand Erie District School Board for more than 15 years in the values, influences and peers—VIP—

program given to grade 6 students in various Norfolk schools, outlining the importance and dangers of prescription, non-prescription and illicit drugs. Lions, Lionesses, women's institutes, men's groups, church groups and our own five-times-a-year Pharmasave community wellness seminars and clinics, held at the Community Church Fellowship Hall, are all part of giving back to the Port Rowan community. A well-educated community is a healthy community.

Although Port Rowan Pharmasave does not have the customer base to be open late hours or open on Sundays, except in the summer tourist time, my patients know that I am available 24 hours a day, seven days a week to fill their emergency prescriptions. As well, they know they can call on me at home to answer their health questions, and they usually do. If I can intervene on their behalf with Dr. Long, I have 24-hour access to him. He is sure to let me know how to reach him if he is away from his office.

Port Rowan's town festival, which celebrates our community every year on the Labour Day weekend is called Bayfest. Port Rowan Pharmasave is sponsoring the opening ceremonies and bringing Canada's own international touring artist, Fred Eaglesmith, to the event this year.

Our partnering goes beyond Port Rowan. Pharmasave has sponsored for many years a young couple doing mission work for YWAM, Youth with a Mission, overseas. We are now partnering with a local group of about 16 people who will be travelling to the AIDS-ravaged nation of Mozambique in March 2007 to build an orphanage in 14 days. We will be providing medicinal and first aid supplies to go with the group, as well as providing cash to buy building supplies.

Partnering is usually, but isn't always, received. I made an offer to our local government to partner with Norfolk pharmacies in a program to help ensure that the community's unused and outdated medicines were disposed of properly and would not enter landfill or the water supply. That offer was hardly considered. They must have an expert, too.

By killing the key component financially—generic partnership revenue—and replacing it with 46 cents and the mystery cognitive services fee, our aging population in rural Ontario is in for a greater reduction in services.

Specifically in Port Rowan, it is going to be very hard to cut. I love my town, my patients and my staff too much to give them less. If you do not understand that statement, you don't know the compassion and feeling of community associated with Port Rowan living.

I hope it is not too late for you to fix the bill with rural Ontario in mind. Because if this legislation passes as is, although I am a thriving, established, going concern business, I cannot continue to operate in a deficit position for long, depending on how great my loss is and how understanding my bank account manager is.

I will continue to be in business caring for my patients in Port Rowan, but I can't and I won't if I don't have the revenue. I will continue to be involved in the advancement of health education in Port Rowan, but I can't and I

won't if I don't have the revenue. I will continue to protect Port Rowan from the threats that Ontario's future holds, but I can't and I won't if I don't have the revenue.

I will have to be leaner and meaner in every possible way for my business, and as for my fairly compensated pharmacy staff positions, a reduction is pending. One full-time pharmacy technician and a quarter pharmacist position will be cut, starting October 1. I am wondering if I am going to even have the time to take advantage of the cognitive services revenue, whatever that is. I will not stop helping the less fortunate in Port Rowan and those abroad, but I will have to stop if I don't have the revenue. I will not stop promoting Port Rowan and its salt-of-the-earth people, but I will have to stop if I don't have the revenue. I will not stop being available to them 24/7, but I will have to stop if I don't have the revenue.

0950

Bill 102 does not address how important a vibrant retail community pharmacy is to the health and welfare of small-town Ontario. Rural Ontario, without front-line, real-world pharmacists, is a step in the wrong direction for our health care system. The government will lose an integral part of their health care structure if patients have to drive a long distance to urban areas for basic prescription health care needs.

I will do everything this humble little heart can do for rural Ontario's access to good health care until I have to provide my professional care, which is building a healthy community, in a province that does not take financial advantage of their pharmacists. It's a shame that too many of Ontario's health care providers have already figured that out.

Sincerely, Glenn Coon, citizen of Port Rowan, Ontario.

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

Now I want to call on Axis Lawrence Pharmacy. Not here.

JOSEPH D'CRUZ

The Vice-Chair: Joseph D'Cruz. Welcome, sir. You know the procedure.

Mr. Joseph D'Cruz: Yes. I'm going to limit my remarks to about five minutes to allow time for questions.

I'm going to speak to the provisions in Bill 102 regarding reimbursement for generic drugs. If you look at the IMS database on drugs, which is the standard database we use to analyze the pharmacy system, you'll see that the average billed invoice price for a prescription using generic drugs is \$23.33. That's the average for all drugs in Ontario last year. The government reimburses \$32.20 for that, and that consists of the dispensing fee of \$6.54 and a 10% markup, which is \$2.33. Underneath that, there are the so-called rebates that generic manufacturers offer to pharmacies. Those rebates run anywhere from 40% to 60% of the billed price. Let's use the low number, 40%. That means that the pharmacy gets \$9.33 from the generic drug manufacturers. When you add all of that up, it means that the net cost to the pharmacist is

\$14 for that prescription, whereas the government is reimbursing for that prescription \$32.20. In other words, what they're doing at the moment is making a markup of 130%, which by any reasonable standard is excessive.

Under the provision of Bill 102, that average billed price is going to go down because you're going to lower the price for generics to 50% of the branded drug. It will go down to \$18.52, for which the government will reimburse \$27—in other words, the net amount that the pharmacy will pay for that drug, assuming that the rebates go down from 40% to 20%, which is a reasonable level by commercial standards. Assuming that, the pharmacy will pay \$14.81 for the drug and make a markup of 82%, which is still a very reasonable markup by any standards. So, because of the provisions of Bill 102, what is going to happen, number one, is that the government is going to pay significantly less for those drugs. The generic drug manufacturers will have their prices lowered, but at the same time will lower the amount of rebate that they spend, and consequently the pharmacy sector, the chain drug stores and the individual pharmacists, will make a smaller profit but still a very reasonable profit.

So I think this set of provisions of the bill is very reasonable and that in fact all parties will do well out of that.

I'm now open to questions for the rest of the time.

The Vice-Chair: Thank you, Mr. D'Cruz, for your presentation. I have a question for you. Are you a concerned citizen, a pharmacist?

Mr. D'Cruz: I'm a strategy professor in the business school at the University of Toronto, and I'm also the chair of pharmacy management at the Leslie Dan school of pharmacy at the university.

The Vice-Chair: Thank you very much. We have six minutes, a lot of time, two minutes for each party. We'll start with Mr. Peterson.

Mr. Peterson: Thank you very much for your positive approach. There was much concern by the people who came in from the Medical Pharmacies Group that we are eliminating rebates and that they're going to be—obviously, one of the problems in doing this is that the rebates under the previous regime were not defined and there was no code of conduct surrounding them. Secondly, they were pretty extreme. Some rebates were indicated to be somewhere between 40% and maybe sometimes as high as 70%, and that made the government think they weren't getting good value here.

In terms of balancing this, the government wants to keep the pharmacists front and centre as caregivers. They want to do that by not allowing price increases over and above the formulary price. Previously, the large pharmaceuticals would set a price and then they'd increase the price and the pharmacists would have to eat it. So when they talk about the 10% and 8% rebate, it was kind of academic because they're only getting maybe two or three points of the 10 points. We're trying to cut it back to eight and give them a full 8%. We're also looking at introducing cognitive service fees so that the service they give to the people in the community, like this last gentleman spoke so eloquently about and what a great job he

does—he actually be reimbursed for those fees, for which he is not charging now.

I appreciate your coming at this from a business point of view. Where do you see the biggest pressure on the government?

Mr. D’Cruz: Clearly the biggest pressure will come from the retail pharmacies, because they will be getting less out of the system. The question you have to address as legislators is whether this is reasonable or not. In my opinion as a professor of management, I think what is being proposed in the legislation is very reasonable.

Mr. Peterson: But if we address their concerns and move toward leaving some rebates in to keep them whole through a definition of “professional services” or of “educational services”—different words have been bandied about—then hopefully we could keep the distribution system, the front-line workers, the druggists, whole, and look at savings because of the volume the government is buying, not on the backs of the hard-working front-line workers.

Mr. D’Cruz: Though what is critically important is that code of conduct, because you have to limit the amount of rebates the manufacturers will be allowed to give. If you set a limit and then you enforce it, the whole system is workable.

Mr. Peterson: As a strategic business thinker, have you seen any other distribution systems where rebates equal 40% to 70% of the price of a product?

Mr. D’Cruz: No, this is extremely unreasonable. If you look at other retail—for example, the grocery sector—rebates run 30% to 35%. If you look at other countries—I was just looking at Germany, for example; the rebate is capped at 20%.

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Mrs. Witmer: Thank you very much for your presentation, although your presentation seems to be at odds with what we’ve been hearing from community pharmacists who have been telling us in a very passionate way—Mr. Coon just told us the impact on his pharmacy, and we’ve been hearing that on an ongoing basis in the limited time this government is allowing for discussion on this bill. We’ve heard that pharmacies are going to lose as much as \$150,000 per store, that we’re going to see maybe 300 pharmacies totally eliminated in the province. We know that many of these pharmacies are in small communities such as Port Rowan, that there will simply be no one there to provide that front-line support. So how can your numbers show that this bill—and furthermore, the reality is this bill doesn’t speak to what you’ve said. Most of it is mystery and is going to be in regulations. Are you not concerned about the pharmacists in this province, the pharmacies that are going to be eliminated?

Mr. D’Cruz: It’s really hard to be concerned about a sector that is going to make an 82% markup on generic drugs and will make a markup on the branded drugs as well. The retail pharmacy business is a portfolio of three different kinds of businesses: the generics, the branded, and the front store—the cosmetics etc. that they sell.

Mrs. Witmer: Yes, but not all of them sell front-store.

Mr. D’Cruz: Almost every retail pharmacy has some non-pharmaceutical business. Call it front store, call it whatever you do, they all have some business of that nature. It may be toothpicks. But it’s very hard to feel sorry for a sector that is making an 82% markup.

Mrs. Witmer: I’ve seen the financial data, and obviously there’s a huge disconnect between what you’re saying and the data I’ve been given.

The Vice-Chair: Ms. Martel.

Ms. Martel: There are a lot of people behind here shaking their heads when you say there’s going to be an 82% markup. Would you mind slowly, for me, going through how you arrive at that conclusion?

Mr. D’Cruz: Certainly. The average invoice price is going to be \$18.52 under the new regulations. Of that, the government will pay \$27. So for something that the pharmacy buys for \$18.52, the government is going to reimburse \$27, of which \$7 is the dispensing fee and \$1.48 is the new proposed markup under this bill. In addition to that, the pharmacy will get from the manufacturers a 20% rebate, which is \$3.70. That means that net, the pharmacy is paying \$14.81 and is being reimbursed \$27. So the difference between that is the 82% I’m talking about.

Ms. Martel: The first thing I would note about that is the \$1.48 new markup, because as we’ve heard from other pharmacists, there really is confusion in the bill about what the markup is based on. You’ve put a very specific figure. Is this based on the wholesale price or not?

Mr. D’Cruz: It’s based on the invoice price. That’s the price on which the generic manufacturer invoices the drugstore.

Ms. Martel: But we have heard that the generic manufacturers also take a percentage, have a markup as well, so what I need to know is, is this being applied, in your mind, after the generics have taken their cut or not?

Mr. D’Cruz: This is strictly the economics of the store, not the economics of the generic manufacturer. This is what the store is billed, what the store receives from the government and what the store receives from the generic companies. That’s it.

Ms. Martel: So one of the factors that might be missing, then, is what the generic manufacturer is taking from the pharmacy over and above the invoice, because they’re making some money on this transaction.

Mr. D’Cruz: They’re not taking; they’re giving. The generic manufacturers are giving a rebate.

Ms. Martel: Sorry, the wholesaler.

Mr. D’Cruz: The wholesaler. Yes, if you include—I didn’t include the wholesale markups etc., just to clarify the picture, but this is net of everybody’s markups.

Ms. Martel: But wouldn’t you have to apply what the wholesaler is doing?

The Vice-Chair: Ms. Martel, your time is over. Thank you very much, Mr. D’Cruz.

We’re now going to call Axis Lawrence Pharmacy again. They’re not here.

POLICE PENSIONERS ASSOCIATION
OF ONTARIO

The Vice-Chair: The Police Pensioners Association of Ontario is here. I imagine you know the procedure. You have 10 minutes. You can speak for the whole 10 minutes, or you can divide it by speaking and answering questions. Go ahead, sir.

Mr. Paul Bailey: With me today in the audience is the president of the Metropolitan Toronto Police Pensioners Association, Bruce Priestman, and his colleague Bernie Kapalka.

Committee members, my name is Paul Bailey and I'm president of the Police Pensioners Association of Ontario. We represent over 5,000 police retirees from every area of the province: Ottawa; Sudbury; all through the GTA, including Toronto, Halton, York and Peel. We also have associate members out in Windsor, Sarnia, and places like that.

I want to thank the committee for allowing the association the opportunity to provide comments on this extremely important piece of legislation. Given the time allotment, I will get right to the point.

First, I believe it's important to know and acknowledge that this legislation will impact the most vulnerable members of our society: senior citizens and the disabled. It will also impact drug manufacturers, pharmacists and other stakeholders, and potentially all Ontario citizens. A significant number of our 5,000 members are seniors over the age of 65, and many are disabled.

Second, the baby boomers are presenting in the health care system, and a significant number of these will move onto the Ontario drug benefit program. The wave of seniors will put tremendous pressures and strains on all aspects of health care, including some equally important issues such as the chronic shortage of doctors. And recently a statement was made that by 2011 we'll have a shortage of nurses in the area of 100,000.

After careful review of the legislation, and having spoken to various stakeholders in this consultation process, a number of things need to be said in support of this legislation.

The Police Pensioners Association of Ontario was very pleased to hear the minister say in his House statement of April 13, "With respect to coverage for Ontario drug program recipients, there will be no changes—not to copayments, not to deductibles, not to eligibility." Committee members, this statement by the minister is very reassuring to many of my senior members, people in their 70s, 80s and 90s who in most cases have only one source of income, their pensions. As you know, any increase in costs would have serious financial impacts on these individuals.

We are supportive of legislation that will allow drugs to be approved for use in a more timely fashion. This is particularly important for patients with chronic illnesses.

We also agree that we need better drug pricing and a more efficient and accountable drug system that utilizes tax dollars in an optimum fashion.

I add that some parts of this legislation are troubling to our members and require further dialogue.

First, the bill creates an executive officer to take charge of Ontario's drug programs and outlines this person's functions and powers. Under the bill, the Lieutenant Governor will appoint the executive officer, who will then assume responsibilities that had rested with the minister.

This officer will have wide-ranging powers, which include setting and removing "interchangeable" designations and maintaining the formulary published by the ministry. The executive officer will also be able to add and remove drug products listed on this formulary without a regulation, as is needed now, and to establish clinical criteria required for payment regarding certain drug products or classes. This officer will also have the power to fine manufacturers and pay pharmacies for services provided, along with the authority to undertake audits. The bill will also establish some rules on how the executive officer must make an order or notify the manufacturer.

It is also our understanding at this point in time that the Statutory Powers Procedure Act will not apply to the executive officer's orders, meaning that the executive officer need not follow statutory rules of due process which other Ontario proceedings must apply. So should a drug manufacturer disagree with the executive officer's decision, they will not be afforded the right to appeal, but only to apply for judicial review, which is available only on limited grounds. It's worrisome to us that the executive officer can manage outside established protocols.

This creates, in our view, two important concerns. The first is that this person has far too much authority for such an important piece of legislation. Secondly, we feel the responsibility to manage and make decisions affecting so many vulnerable people should rest with an elected official, the Minister of Health and Long-Term Care. We don't understand why the minister would want to divest himself of such significant power to a non-elected individual. Perhaps valid reasons exist for the creation of this officer, but a more detailed explanation would be helpful for a better and more focused understanding of why this part of the legislation was introduced. There is also a worry that the costs associated with setting up another level of bureaucracy would strain the already strained budget.

We would also feel more secure if some of the statements the minister made, especially the "not to copayments, not to deductibles, not to eligibility," were enshrined or embedded in the legislation and not governed so much by regulation.

1010

We are in the process of determining new and important drug policies that will last into the next decade or perhaps even longer. The decisions and changes to this policy will have a profound impact on seniors and the disabled, drug manufacturers, distribution firms and pharmacists, not to mention all residents of Ontario. The question needs to be asked, "What's the rush?" If the majority of us see this legislation as important and nec-

essary, why not take a step back and have more meaningful consultation and discussions with all stakeholders? A 10-minute presentation in Toronto doesn't provide effective dialogue with all stakeholders. Our members live all over the province, and coming to Toronto poses some hardships on people who want their voices heard.

We hear concerns in the media that this bill will impose unprecedented restrictions on the sale of brand name products in Ontario and impact the ability to invest in biotech research. We hear the pharmacists are extremely concerned about the financial impact that Bill 102 will have on their businesses—store closings, layoffs and so on. Members of the committee, we believe history has shown time and time again that whenever a supplier of services is financially negatively impacted, they could resort to other measures to ensure survivability. Currently, pharmacists in Ontario provide a number of services to the public and seniors without charge, services like disposing of syringes and medications. There is nothing to prevent the pharmacists from introducing user fees or consulting fees in order to recoup lost revenue. Should that happen, medications would be flushed down toilets or thrown into the garbage along with syringes and other hazardous waste. We don't want good legislation like this having a negative impact on other areas of government, like the environment.

I believe we all agree that over-the-counter drugs play a significant role in the health of seniors and the disabled. What prevents these manufacturers or pharmacists from increasing the price of OTC drugs to recoup lost revenue, which in turn would negatively impact those most vulnerable in our society: seniors with health problems?

In closing, let's all take a step back. As I have said, much of this legislation is needed in order to sustain the Ontario drug benefit program. However, to change a drug policy in a matter of months with limited consultation and agreement will result in acrimony and distrust, and probably a range of unforeseen issues that will have a detrimental effect on most citizens of Ontario.

I want to thank the committee for their time today.

The Vice-Chair: Thank you very much for your presentation. We have one minute left. We'll give it to Mr. Peterson.

Mr. Peterson: Thank you for your presentation, and thank you for your concern. This process has actually been undertaken for over a year, and they've had over 300 meetings and met with over 150 different stakeholders. I'm not sure if I've got those numbers exactly right, but it has not been a rush to judgment here. So if you don't feel you've been included in the process, I'm always happy, as the parliamentary assistant, to hear more from you, but we think we've done a pretty extensive consultation.

The reason for appointing the executive officer is a way to get away from cabinet secrecy, because right now cabinet has to make all the changes to the formulary, and that means it's bound up in secrecy when it should be an open, transparent process. With the executive officer, it should be a transparent process. I guess what you're

saying is that it should be subject to appeal; there should be some mechanism for checking on his judgments. I think that's something that we've heard from other people and we'd be looking at seriously in terms of having some mechanism.

Some people are also concerned that the accountability of the minister and the ministry in this process would be obviated, but our intention is that if this executive officer reports to the deputy minister and the deputy minister reports to the minister, there will be full political accountability here and the process of approving new drugs and the process of rapid breakthrough drugs and the process of getting drugs on the formulary would all be an open, transparent process.

If you have any further comments on this, I'd appreciate hearing them. Thank you very much for coming in. We look forward to maintaining a dialogue with you.

The Vice-Chair: Thank you, Mr. Peterson, and thank you, Mr. Bailey.

BRAMPTON HEALTH COALITION

The Vice-Chair: The Brampton Health Coalition. You can start when you're ready.

Ms. Dora Jeffries: My name is Dora Jeffries, and I'm here today representing the Brampton Health Coalition. Our group is linked to the Ontario and Canadian Health Coalitions, and is part of a network of over 70 local health coalitions across Ontario.

The Brampton Health Coalition was hesitant at first about speaking at this hearing, because we are not as familiar with Ontario's drug system as we are with hospital issues. However, we elected to speak today for two reasons. First, our group has often been critical in the past of government initiatives and decisions, but in this case we can support the goals and many parts of Bill 102. This hearing provides our group with a good opportunity to show that our aim is to advocate for public medicare and to support initiatives that will strengthen it. Secondly, we believe that the standing committee on social policy truly wants to hear from ordinary people, not just experts.

We do not have any vested interest in this legislation and feel we can respond to it simply as ordinary citizens of Ontario who are committed to a sustainable, publicly funded and delivered health care system.

The first of the two main goals of the Brampton Health Coalition is to advocate for transparency and public involvement, and to oppose secrecy in decision-making in all our government initiatives. The divisive and negative effects of the public-private partnership—P3—Brampton hospital deal have been keenly felt in our community. The Brampton Health Coalition, along with the Ontario Health Coalition, CUPE, SEIU and OPSEU, has been in court for over three years trying to get full disclosure of the financial arrangements and the extent of the privatization of services in our hospital. Therefore, we applaud the goal of Bill 102 to ensure that patients

will be involved in priority setting and drug funding decision-making.

Secondly, we want our government to contain spiralling costs in all areas of health care so that one sector does not drain a disproportionate amount of our health care dollars from the whole system. We want our government to protect the comprehensiveness of health care. By doing this, we will ensure that money is available to fund a continuum of services. Only by containing costs and spending our money wisely can we maintain the full scope of health care. We fully support the Canada Health Coalition's pharmaceutical strategy and believe that our public medicare system should be expanded to include pharmacare. A few facts about the pharmaceutical industry illustrate the pressing need for a national pharmacare program: Costs for Canadian prescription drugs rose 62.3% from 1994 to 2004; drugs now rank second after hospitals as a share of total health care spending.

The Brampton Health Coalition views this legislation as an important first step in controlling the cost of drugs in Ontario, widening of the use of generics to replace the higher-cost brand name drugs, reducing the markup on drugs and ensuring that the provincial government pays pharmacies for the actual cost of drugs.

(1) Widening the generic substitution of more expensive brand name drugs: All credible studies and medical experts agree that this will cost less and not harm patients.

(2) Stopping the payoffs—called rebates—to pharmacies by generic companies. These “rebates” are given to the pharmacies by drug companies as a pay-off for stocking drugs or prominent product placement. The government pays the pharmacy the full cost of the drugs and then the pharmacy pockets the difference between the amount they charge the government and the amount they pay for the drugs. This means that the Ontario drug program is subsidizing for-profit pharmacies, especially the big chains. In fact, big chain stores receive about 75% of the rebates. The government's intent is to use its bulk-buying power to get lower costs from the drug companies for the people of Ontario and eliminate these so-called rebates. The chain drug stores have created a coalition to oppose this. This week a spokesperson for the Coalition of Ontario Pharmacy was interviewed by Paula Todd on Studio 2. The spokesperson for this lobby group actually called these rebates “investments” in the pharmacy. I was left wondering if this coalition was a front for the large chains.

If small, independent drug stores will suffer financial hardship when the rebates are eliminated—and they may, because I go to a small, independent drug store in Brampton and I know my pharmacist is worried—then this must be dealt with separately. Big chains are likely the biggest threat to small, independent pharmacies. Generally, in countries where pharmacy licences are more tightly regulated, the number of pharmacies has been rising.

Also, we must look at the group that is so vociferously opposing this, the big pharmacies. Pharmacies in Ontario

and Canada are doing quite well. StatsCan reports their gross margin—total operating revenues minus cost of goods—to be a healthy 31.4%. Recently in the news, Shoppers Drug Mart is reporting robust profits. Earnings have been reported up by 20% to 21%, sales up by 9%, profits up. “Shoppers Profit up 20%”—Globe and Mail, May 5, 2005.

(3) Controls on pricing and markups for drugs—dropping the price of generics by 20% to 50% of brand name drugs. Currently, the first generic on the market costs 70% of the brand name; the other generics cost 90% of the 70%. These guidelines were meant to be price ceilings, but now they've become floors. We believe this will reduce costs without harming patients. One other option for drug pricing is to be found in Canada, in British Columbia, where they use reference-based pricing. In BC, only the cheapest of a class of drugs is covered by the government plan. Patients wishing a more expensive product must pay the difference. If there is a genuine medical need for the more expensive product, the government will pay for it in full. Studies in BC have never demonstrated any adverse health outcomes from this policy.

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Brand name drug companies argue that generic substitutions will threaten research and development jobs and will harm patients. Neither is true. There have been several peer-review studies done of British Columbia's reference-based pricing system, involving much wider generic substitution than that proposed by Ontario, which have found that patients are not harmed by the substitution. Despite the research and development claims of drug companies, the evidence is that the non-profit sector and governments spend and perform more research and development than the extremely wealthy drug companies. Moreover, the vast majority of the new drugs pushed onto the formulary by the drug companies offer few therapeutic advances and are very costly to our limited health care dollars.

This morning I read Ian Urquhart's column in the Star, and he addressed this problem of research and development. When we look at these threats from the large pharmaceutical companies, we do have to look at the statistics, some of which I've already read to you. Here are some more:

—The top US drug makers spend 2.5 times as much on marketing and administration as they do on research.

—At least one third of the drugs marketed by the industry leaders were discovered by universities or small biotech firms.

—Statistics Canada reports that universities and teaching hospitals are by far the largest performer in health research and development, at \$3.7 billion in 2005, compared to the business sector, which includes the pharmaceutical industry, at \$2 billion.

—Of the 117 drugs with new ingredients introduced in Canada between 1998 and 2002, only 15 provided substantial improvement over existing drugs. The rest are

“me too” drugs with few therapeutic advances, but are responsible for 80% of drug expenditure.

—I found this particularly shocking: Drug companies spend more than \$20,000 per year for every doctor in Canada on drug samples, sales rep. contact, conferences, trips and giveaways. The Canadian Health Coalition reports that this figure can be as high as \$37,000.

—The top 10 pharmaceutical companies make more in profits than the rest of the Fortune 500 combined.

—The 2006 Fortune 500 ranks pharmaceuticals as the fifth most profitable industry, just behind crude oil and banks.

When you’re hearing cries of, “Poor me,” and “We can’t continue,” and “We can’t have research and development,” from the pharmaceutical industry, take it with a grain of salt.

The section of the legislation relating to rapid review of breakthrough drugs may or may not be a good thing. It could get more drugs that do not provide additional benefits on the formulary, as I’ve mentioned in my facts. This depends on how rigorous the controls are. The need for rigorous protection of patient safety and assurance of the efficacy of drugs needs to be balanced with patient needs and demands for access to drugs in urgent cases and in cases of rare conditions. This truly is a moral dilemma.

Any additional initiatives to control the drug industry lobby would be very positive, including increased democracy and transparency, reduced corporate donations to political parties and additional steps regarding drug company influence over physician prescription practices. Money being saved through the measures that are contained in Bill 102 should be reinvested in health care or social programs.

We also have some concerns about the creation of the executive officer. The EO will have powers cabinet used to have to determine what is on and off the formulary. The EO will also negotiate deals regarding price and bulk buying, a role formerly not done by anyone in the ministry. On principle, we believe that the decision about what is listed and not listed on Ontario’s formulary must be one that is accompanied by democratic accountability, and I’m glad that you addressed that. In shifting the responsibility to determine what is listed to the executive officer, we would like to see clearly that the responsibility for the contents of the formulary remains with our elected government.

The Vice-Chair: There’s no time left.

Ms. Jeffries: Okay. Thank you. I think my conclusion was contained in the body.

Thank you very much for listening. I’ve learned a lot, by looking at this bill, about what the government is trying to do. As our group said, we applaud the intent and we can support many of the initiatives. However, we do have concerns.

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

ARTHRITIS SOCIETY, ONTARIO DIVISION

The Vice-Chair: Now we have the Arthritis Society. Before you start, if you don’t mind, just state your names.

Ms. Jo-Anne Sobie: I’m Jo-Anne Sobie, with the Arthritis Society.

Thank you, Chair, and good morning. It is certainly a pleasure to be here today. Joining me is Mary Kim, Ontario co-chair and representative of the Arthritis Society’s national patient group, the Canadian Arthritis Patient Alliance. I have asked Mary to join me today because, as an arthritis consumer, she can share with you, the committee, a first-person perspective on how Bill 102 will affect arthritis patients.

Let me begin by saying that the Arthritis Society applauds the government’s inclusion of two patients as full voting members on the committee for the evaluation of drugs. We applaud the creation of a citizen council on drug policy and are thankful that the section 8 mechanism will be restructured. These are timely and major improvements to a system that has been failing patients for a very long time.

The Arthritis Society recognizes Bill 102 as the foundation of the government’s drug system reform package. We believe that it is critical to achieving the goal of a public drug system that provides the right drug to the right person at the right price. With this in mind, I would now like to address the Arthritis Society’s concerns with Bill 102.

First, the definition of “interchangeable” as proposed in Bill 102 must be changed. In subsection 5(2), the description of “interchangeable” has been broadened by providing that interchangeable drugs can have “the same or similar active ingredients in the same or similar dosage form” The inclusion of “similar” in the definition of “interchangeable” will enable the dispensing of medications that are not bioequivalent as determined by Health Canada. Physicians will not know which generic form of the medication was dispensed and the patient-physician relationship will be inappropriately encroached upon.

Expanding the definition of “interchangeable” will negatively impact on the physician-patient relationship, diminishing the physician’s capacity to ensure that their patient is receiving the right medications for their unique condition. The Arthritis Society feels that the legislation must be amended to remove the word “similar” from the definition of “interchangeable” as it pertains to active ingredients.

Our second concern with Bill 102 is found in section 3, which proposes that where “a prescription directs the dispensing of a product that is not an interchangeable product ... the dispenser ... dispense the interchangeable product” that contains a drug or drugs in the same amounts of the same or similar active ingredients or dosage form. Generic-first prescribing can be an effective cost saving tool, but the physician must be aware of the generic substitution, and the generic substitute must be bioequivalent. The dispenser’s ability to substitute generic medica-

tions that are similar may result in complications that neither patient nor their physician is anticipating. Section 3 should be removed in its entirety and the current legislation maintained.

Our third concern with Bill 102 is that the legislation seeks to reduce costs through competitive agreements. We agree that Ontario needs to negotiate a better price for many of the drugs purchased through our public drug program. Competitive agreements as they are used in the United States Department of Veterans Affairs have had a limiting effect on the number of medications that patients can access. Physicians need to have options within a class of drugs to ensure that each patient is receiving optimal benefit from their medications. Limiting the available medications within a class will not meet the patient's therapeutic needs.

This type of therapeutic limitation will pass many of the system costs on to the patient. For those who can't afford the correct medication, their health outcomes will be poorer, resulting in a need for patients to access more expensive treatment elsewhere within the health care or social service system. Competitive pricing should not limit access to drugs for patients. The government must commit to ensuring that patients have access to the medications they need and not use the limitation of the number of medications available within a class of drugs as the basis of their price negotiation.

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Finally, Bill 102 proposes to create an executive officer of Ontario drug programs, a new and powerful position. The executive officer will assume administrative and decision-making responsibilities for Ontario's drug system.

To ensure that the best interest of patients is met, an expanded appeal process must be built into Bill 102. The appeal process should not impede on the ability of the executive officer to approve medications rapidly—this is vitally important—but must look at all negative listing decisions to ensure that all details were evaluated thoroughly. This review could take the form of a drug system Ombudsman or a small panel of independent medical and patient advisors.

We at the Arthritis Society strongly believe that timely access to modern medications results in a reduction in the need for more expensive uses of the health care system, including physician and hospital visits, and has the potential to reduce the long-term economic and social costs of arthritis-related disability.

I would like to thank you for your time. I hope our recommendations expressed here today and within our written submission will be helpful in ensuring that Bill 102 is right for patients.

I'd now like to ask Mary to share with the committee her arthritis patient perspective.

Ms. Mary Kim: I'd like to thank this committee for the opportunity to present as a person living with arthritis. There are 1.6 million Ontarians living with arthritis, a majority of whom take medications to control their symptoms, as there is no known cure.

I'd like to speak on the role of the pharmacist. As a patient who lives with a chronic disease like arthritis, I recognize the vital role pharmacists play in the management of their disease. The community pharmacist, especially, has truly become a front-line health care worker, a health care worker who is indispensable to the management of my disease. With her constant monitoring of my prescription and over-the-counter medications, my pharmacist has played an important role in maintaining my health.

As a result of my rheumatoid arthritis, I take several prescription medications, which can interact with over-the-counter medications that I may need from time to time. Several years ago, I took an over-the-counter cough suppressant for a severe cold. That night, I experienced a rapid heart rate and shortness of breath. I thought I was having a heart attack and I was about to go to the emergency department when it settled down. The next day, that experience came back again and I was able to contact my pharmacist. She went over my medications and said that the over-the-counter cough suppressant I was taking was interacting with my daily dose of anti-inflammatory medication and recommended a different cough suppressant. Since then, I have always consulted my pharmacist before going on any over-the-counter medication, as well as any vitamin, mineral or herbal supplement.

As you can see, the role of the pharmacist is and should be very complementary to the role of the physician and the patient-physician relationship; however, it should never usurp it. While pharmacists have extensive knowledge of medications, they have limited knowledge of individual patients. They may not have access to the results of patient diagnosis, treatment and/or monitoring tests and other factors that are considered when a physician prescribes medication.

Therefore, when medication is interchanged, it should be done only with medications that are considered bio-equivalent as defined by Health Canada. Physicians and patients need to be aware and informed about any changes to their medication and what it might mean to the health and well-being of the individual patient. Bill 102 must ensure that the public drug system respects the physician-patient relationship, defines an appropriate role for the pharmacist and does not allow the definition of interchangeability to include the word "similar."

I would also like to speak today on the rapid review process, especially on what the government considers breakthrough drugs. I would like the government to expand their current definition of "breakthrough" to include quality-of-life medications, which are most important to the people living with chronic illness like arthritis.

In 1985, at the age of 25, I was diagnosed with rheumatoid arthritis. It took me several months to be prescribed the right medication at the right combination, taken in the right way. The delay caused permanent joint damage, so that within three years of my initial diagnosis, I was using crutches. Within four years of my initial diagnosis, I was basically bedridden. Within five years, I was

having my first joint replacement surgery. Between 1990 and 2000, I had eight total joint replacement surgeries over seven joints. It was expected that I would have my ninth replacement surgery sometime later in 2000. However, that ninth joint replacement did not come until four years later.

So what happened between 2000 and 2004? In 2002, I was given a new medication called a biologic—at the time the new advancement in arthritis medication that modifies the biologic that targets the inflammation process in my joints. The biologics reduced the stiffness, the fatigue, the pain and the inflammation of the arthritis, which in turn slowed the progress of my rheumatoid arthritis. Also, the reduction of these symptoms allowed me to improve my exercise—

The Vice-Chair: Thank you for your presentation. I guess you've passed your time. Thank you very much.

Mr. Peterson: I would like unanimous consent that we allow her to continue. Does anybody object?

The Vice-Chair: Is there consent to let her continue? Okay. Go ahead.

Ms. Kim: Thank you. The reduction in all these symptoms also improved my exercise regime, which further improved my overall health. I think about what could have happened to me if these biologic breakthrough drugs were available back in the 1980s. I think about what can happen and is happening to patients currently who have access to these medications early in their diagnosis. With the reduction of their symptoms, patients are able to stay active in their community, with work, study and play. This will mean a reduction in the demand for joint replacement surgeries, hospitalizations, doctors' visits, allied health professional visits, home-care service utilization and long-term-disability assistance.

My experience convinces me that the inclusion of quality of life in the rapid review process is vital to all Ontarians. Thank you.

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

CANADIAN HEALTH COALITION

The Vice-Chair: Now we're going to call on the Canadian Health Coalition. Canadian Health Coalition is here with us? If they're not, we're going to move to the Employer Committee for Health Care—Ontario. Is the coalition here? Okay. You can start when you're ready.

Mr. Michael McBane: I'd like to thank the committee for the opportunity to appear before you. I'm Michael McBane, national coordinator of the Canadian Health Coalition. We're a national organization with member groups across Canada, including the Ontario Health Coalition and their local groups. We don't normally appear before provincial Legislatures, but Bill 102 has important national implications.

A couple of quick messages: First, we fully support the goals and objectives of Bill 102. It's extremely important that public drug plans be run on the basis of value

for money and evidence-based decision-making when it comes to drug utilization.

As you know, Canada has a serious drug problem. The amount spent on prescription drugs in 2005 alone was \$20 billion. That doesn't count what we're spending in nursing homes and elsewhere. The rate of drug increase, as you know, is rising three times as fast as the rate of inflation. In a sense, Canada's drug problems can be summarized in three ways: overuse, underuse and misuse. That's why we need much more serious management and approach towards pharmaceuticals.

What's interesting in the brief I handed out—there is a chart that shows drug expenditures rising exponentially. Underneath is a chart showing medicare expenses, which are flat at 4% since 1980. So it's very odd that there are advocates saying that medicare is unsustainable and we should have more private insurance, when it's private insurance that's not sustainable. Therefore, it's time to expand medicare, to expand public drug coverage.

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We would like to urge this committee to reject the proposed amendments from Rx&D, the multinational lobby organization on behalf of the pharmaceutical companies in Ottawa. Their proposed partnership has four principles, which we have done a reality check on. We would like you to reject out of hand the notion that drug plan managers should be partnering with drug companies. As you know, drug companies are in the business to make a profit. In contrast, managers of the Ontario drug benefit system are mandated by law to act in the public interest to provide access to the best medicines at the best price for the most people. Public health legislation, federal and provincial, removes the delivery of health services from market rules to ensure the same right of access to health services based on need. The public health legislation means unprofitable services, populations and regions are not abandoned.

Pharmaceutical corporations are traders. Traders exploit vulnerability. Public health officials are guardians. Guardians protect the vulnerable. No partnership with drug companies on the running of the Ontario drug program.

It's interesting that the chairman of Rx&D has severely criticized Bill 102, and is critical of the fact that you're trying to get value for money. I would submit to this committee that the CEO of GlaxoSmithKline and chair of Rx&D does not practise what he preaches to this committee. If he did and failed to use the size and economic power of his corporation to secure the best prices from his suppliers, he would be fired.

A couple of quick comments on some specific proposals: We do not believe that the goal for the Ontario drug plan should be speedy drug approvals. The issue is quality. Speed is not your primary objective when you're assessing the effectiveness of new drugs. New drugs are inherently not safe. Drug companies are known to suppress scientific data. Quick reviews are not necessarily in the public interest if they're not of high quality. New drugs are being rushed to market on dubious and exag-

gerated claims that are not supported by independent assessment. Let me give you a recent example.

Since speedy drug approvals started happening at the FDA in the United States, 18 major drugs have been recalled due to safety concerns. Here's the pattern: Speed up the approval, the drug crashes and thousands of people die needlessly. That should never be the objective of the Ontario drug plan.

The list of the 18 drugs includes Baycol, Raplon, Lotronex, Propulsid. And of course we know about Vioxx and Bextra. Members of this Legislature will recall that Propulsid is the drug that killed Vanessa Young in March 2001. The approval of these new drugs and the subsequent tragic loss of life they are suspected to have caused were entirely needless. In the case of Vanessa Young, the manufacturer knew its product was killing patients. It suppressed the information and continued to market the drug.

I therefore recommend that the Ontario government protect the integrity of the drug program, continue to work with the Common Drug Review at a national level and maintain this process to ensure that safety and cost-effectiveness standards are maintained on a national basis. Quality reviews should be the goal, not speed. Please do not abandon the Common Drug Review process. Ontario must not go it alone on assessing drug safety.

Secondly, we would urge that the Ontario government work with its provincial, territorial and federal counterparts to develop a national independent research network, arm's length from the drug industry, to evaluate new and existing therapies in the real world.

A new proposal that I'd like to comment on as well is the issue of requirement to provide information. It's important that the Ontario government require drug manufacturers to provide the following information: (a) full descriptions of all clinical trial protocols; (b) full reports of all clinical trials; (c) full report of safety data collected outside of the clinical trial setting, including details of all reported adverse events, serious adverse events and deaths in other jurisdictions where the drug is already marketed. If you don't have those data, you should not be paying for these drugs.

All clinical trial data should also be made public.

On the issue of interchangeability and generic substitution, I would support what the Brampton Health Coalition has just said about reference-based pricing and the excellent experience of the government of British Columbia and other jurisdictions.

Interchangeability, substitution and various forms of reference-based pricing programs reduce the profits of pharmaceutical manufacturers. That's why they are before this committee on this bill, opposing these measures. Drug companies took the government of British Columbia to court over this and the arguments were rejected.

I recommend, therefore, that the Ontario government consult effectively with physicians, nurse practitioners and pharmacists on procedures to handle exemptions and

the overall administration of an interchangeability and substitution program.

Secondly, on this issue, I recommend that the Ontario government prepare for an aggressive lobbying campaign, funded by big pharma but carried out by seniors, disease, patient and phoney consumer groups. You should plan public relations campaigns to educate the public about the interchangeability of drugs involved, the actual cost savings and the ability to reinvest those savings in expanding drug coverage.

On the issue of using the money to expand coverage, we would urge that the Ontario drug plan use savings to expand coverage for the most vulnerable citizens in Ontario, including people who are on social assistance who would be working if they could get drug benefit coverage for their medical conditions.

In conclusion, the Canadian Health Coalition supports the objectives of the bill. We strongly encourage Minister Smitherman and the Ontario government to continue its work within the context of a national strategy for pharmaceutical management, utilization and access. Ontario is the senior partner in federal-provincial-territorial work.

Bill 102 is an important part of the work to improve and sustain Canada's success story: our public health insurance system. It's time to expand it. Ontario and the rest of Canada need a national drug plan that pays only for drugs that have been independently established to be cost effective and safe. It should pay the entire cost, single-dollar coverage. This will save lives and millions of dollars.

Thank you very much for your time.

The Vice-Chair: Thank you, Mr. McBane, for your presentation. There's no time left.

EMPLOYER COMMITTEE ON HEALTH CARE—ONTARIO

The Vice-Chair: Now we move on to the Employer Committee on Health Care—Ontario. You can start whenever you're ready. I imagine you know the procedure. You have 10 minutes to speak. If you wish, you can speak for the whole 10 minutes, or you can divide it between questions and speaking.

Ms. Sandra Pellegrini: Mr. Vice-Chair and members of the committee, good morning. My name is Sandra Pellegrini. I am a principal at Mercer Human Resource Consulting. I'm here today with Annie Boulianne, manager of pensions and benefits at Inco Ltd., representing the Employer Committee on Health Care—Ontario, otherwise known as ECHCO.

We would like to thank the committee for inviting us to contribute to the deliberations on Bill 102, An Act to amend the Drug Interchangeability and Dispensing Fee Act and the Ontario Drug Benefit Act. We are here in support of Bill 102, the Transparent Drug System for Patients Act.

We address three points of consideration today, as they affect Bill 102 and the development of public policy concerning pharmacare:

(1) Employers' objectives and roles as stakeholders in the health care system;

(2) The components of Bill 102 identified by ECHCO as fundamental to a cost-effective drug system; and

(3) Continuing challenges and concerns.

ECHCO represents Ontario's largest employers committed to the continuing financial health of our health care system and the health and productivity of Ontarians. ECHCO believes that as a stakeholder, its objectives are most closely aligned with government on the issue of health care, where the health and productivity of Ontarians in the most cost-effective manner is the objective of the health care programs. A structure of collaboration between government and employers is critical.

The competitive advantage of our province is impacted by the current and future senior dependency ratio, and therefore on the health and productivity of actively employed Ontarians who will work to support our senior population. Ontario's provincial drug program is funded in large part by the employer health tax. These points, more than any others, speak to the need for Ontario's private and public plans to work together.

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Economically, the health care system remains one of the only competitive advantages to Ontario employers. Drug expenditures constitute the most significant portion of an employer's health plan liability, subject to the greatest inflationary pressure and often without the ability to affect changes under legacy programs and/or collective agreements.

Our presentation today is made on behalf of the employer interest. Our submission to the Drug System Secretariat in December 2005 proposed a more active and distinct role for employers as a group to play in the development of public pharmacare policy. This new role for employers recognizes the dual health care mechanism as one that must work together in order to achieve long-term cost efficiencies and competitive advantage.

Private payers critically need a legislative framework that addresses cost containment and market efficiencies. Overall, we believe the intent and direction of Bill 102, the Transparent Drug System for Patients Act, supports the interest of employer-sponsored plans as well as the long-term interest of the ODB program. We formally commend the Drug System Secretariat, led by Helen Stevenson, not only for the scope and depth of their review, including collaboration with employers as a stakeholder, but also their ability to assimilate the data in the form of a practical and doable package of reform.

ECHCO concurs with the following remarks made by Minister George Smitherman to the Economic Club on May 15, 2006:

(1) "We need to make our drug system more efficient. We need to make it more accountable and transparent. We need to get better pricing—pricing that reflects the volumes of drugs we purchase."

(2) There are "huge opportunities to improve patient access to drugs, and for Ontario to receive better value

for money we spend on the provision of prescription drugs."

(3) Drug costs are recognized as "the single fastest-growing area of health care in Canada."

(4) "The private sector needs government support to help manage drug costs, the most significant factor in company drug plans and a matter important to Ontario's economic competitiveness."

Ms. Annie Boulianne: Employers are experiencing double-digit exponential cost increases that are not sustainable long-term. We are relieved by the minister's remarks in as much as they recognize a fact not historically understood: It is employers, not insurance companies, who provide and fund the private health care plans that complement the government plans such as ODB.

ECHCO fully supports the proposed changes under Bill 102 regarding:

—the designation of products as interchangeable where they have the same or similar active ingredient, and in a same or similar dosage form;

—the designation of Health Canada approved generic drugs as interchangeable with brand name drugs. These two changes alone will represent a saving for the major employers of \$30 million a year;

—an improved conditional listing, where the result is improved access to new drugs as well as other drugs requiring special criteria to be met, such as the current limited use program;

—the intention to secure more competitive drug prices in the Ontario marketplace;

—the elimination of manufacturer rebates to wholesalers, operators of pharmacies or companies that own, operate or franchise pharmacies when those rebates are directly tied to the net cost of the drug product;

—the new payment structure for pharmacy services; and

—prescribing guidelines that will promote appropriate use of medications.

ECHCO believes that sustainable programs, whether privately or publicly funded, are best addressed by improving health outcomes and economic efficiency. As the population ages, there will be a shift in needs from acute to non-acute types of services and greater demands for longer-term care.

We leave the standing committee a copy of our 2005 submission to the Drug System Secretariat, where the following concerns with the current system were addressed: lack of accountability and excessive consumption; the lack of transparency surrounding the design and administration of the ODB formulary; drug pricing; inefficiencies in the delivery system, or no opportunity for off-formulary interchangeability; and the cost of catastrophic drugs.

Challenges and concerns: Bill 102 responds to all of the above-noted concerns with the exception of catastrophic drug coverage. This is a major issue, respectfully tabled today as an ongoing concern.

Except in unique circumstances, employers are not health care experts. Outside perhaps personal experience,

we don't know about cancer, diabetes, chronic pain or the right medication for a particular medical situation. Drug plan coverage, especially catastrophic drug plan coverage, is a societal issue. While Bill 102, in our opinion, offers opportunity for cost-effective systemic changes, catastrophic drug costs remain a highly significant issue.

The recent NPS—National Pharmaceuticals Strategy—stakeholder sessions identify this issue as one of the top priorities nationwide, together with the issues of expensive drugs for rare diseases, a common drug formulary, drug safety and effectiveness, as well as drug pricing and purchasing. We strongly encourage the Ontario government to incorporate, where possible, the NPS analysis in their work on the redesign of the ODB program.

In closing, we appreciate and thank the standing committee, as well as the Drug System Secretariat, for ECHCO's contribution to this process. Government can learn from business. Business needs a legislative framework. There is a wealth of information between the two programs, that is, the public and the private sector. We look forward to further collaboration. Thank you very much.

The Vice-Chair: Thank you very much for your presentation, but I'm going to ask you to state your name for Hansard.

Ms. Boulianne: It's Annie Boulianne.

The Vice-Chair: Thank you very much.

We have one minute left. We're going to give it to the Conservatives.

Mr. John O'Toole (Durham): Thanks very much for your presentation. Having spent some time in personnel in a large company, I'm familiar with some of the implications of both current and future employees, contract negotiations and future liabilities. It's a huge issue going forward, because you really don't know what you're agreeing to fund going forward with cancer and all these kinds of micro improvements in pharmaceutical.

I have a couple of very specific questions in the limited time I have. One is, who invited you? Second, do you support the bill? Third, a comment, and I'll start with that. You said in here the employer health tax pays for a lot of the pharmaceuticals. It is a huge and pressing issue, pharmaceutical costs, both public—but for the most part, pharmaceuticals are not covered unless you're a contract employee, on disability or a senior. They're not covered; they're private, and have been always. So for the most part, most of us pay out of our pockets, unless you have a drug plan, like a large company where you work.

Ms. Boulianne: And that's what we're representing, yes.

Mr. O'Toole: The second thing is the tax also—

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

Mr. O'Toole: —the employer tax—

The Vice-Chair: Thanks. You're out of time. Mr. O'Toole, your time has expired.

Mr. O'Toole: Unanimous consent for a couple more questions?

Interjections.

Mr. O'Toole: They're shutting down debate, so they really don't want—

The Vice-Chair: I'm not shutting down debate. Thank you very much for your presentation.

GREAT ATLANTIC AND PACIFIC CO. OF CANADA

The Vice-Chair: Now we have the Great Atlantic and Pacific Co. of Canada. Welcome. You can start when you're ready.

Mr. Ian Lording: Good morning, and thank you for allowing me to appear before this committee to discuss Bill 102, the Transparent Drug System for Patients Act.

My name is Ian Lording, and I'm the director of pharmacy services for the Great Atlantic and Pacific Co. of Canada. I'm a working pharmacist, after graduating from the University of Toronto in 1998.

Our history in this province is deep and goes back to the 1920s, when the first A&P store opened here. Our roots in community pharmacy are almost as deep: We opened our first pharmacy in Ontario a few kilometres from here in Etobicoke almost 30 years ago. We employ over 500 staff members, inclusive of pharmacists, pharmacy technicians and support personnel. We are members of OPA, OCDA, CACDS and CPHA, all professional associations that represent pharmacy practice and business here in Ontario and across the country.

Let me make it clear from the start that A&P is non-partisan. I'm here today to represent the interests of our pharmacies, our employees and, most importantly, the patients we serve.

Most of you will know A&P as a grocery store. You've probably been in one of our 237 stores across Ontario, whether an Ultra Food and Drug, Food Basics, The Barn, Super C, Loeb or a Dominion. But we are also a major provider of pharmacy services, operating 77 pharmacies from Brockville to Thunder Bay to Windsor.

We are committed to pharmacy in this province. We see it as an integral element of our business model, that of one-stop shopping and presenting an environment where pharmacy and nutrition coexist—two important pillars to overall health and wellness.

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What's unique about us is that we're a mid-size pharmacy retail chain, sort of the Everyman of the pharmacy world. It's for this reason that people studying the potential impacts of changes like Bill 102 use us to model effects on average or median pharmacy operations.

You've heard a lot about the expected effects of Bill 102 on our profession and on our businesses, and I won't repeat that now. Instead, I would like to correct some of the myths people have about chain pharmacy and offer solutions.

One commonly held misconception is that pharmacies in retail outlets are loss leaders that fund and drive traffic into our stores. This is far from the truth. Our business model mandates that our pharmacies must be sustainable

if we are to keep them open. If Bill 102 goes through unchanged, we will lose this sustainability and we will be forced to consider options such as reducing hours, charging for services we currently provide for free, increasing dispensing fees for cash-paying customers and potentially closing some pharmacy locations. It is a bitter irony that those pharmacies most at risk are those that provide a high level of patient care in underserved communities.

Let me also clarify a recent commentary suggesting that large chains can increase prices in other areas of the shop—over-the-counter products, health and beauty aids and so on—to offset the losses created by Bill 102. Our pharmacies derive almost all—80%—of our sales from prescriptions. Only 20% of our business is non-prescription. It's obvious, then, that this is not an option for us. But, fundamentally, it's not an option because it's not fair for patients and consumers. What this suggestion means is that we would, for example, increase prices on baby food and incontinence products in order to make up for the shortfall from the ministry underfunding the services it demands of us. Members of the committee, pharmacy services should not be subsidized on the backs of seniors and working parents.

Pharmacy has had an inherent tension since its birth in Ontario and the first attempts to regulate it in the 1850s. This is the relationship between the professional side—working with physicians and health care providers to help them make the best prescribing choices, and helping patients understand the medications they are taking, their risks and their benefits—and the business side.

People trust pharmacists. Some 77% of patients in a recent study had more confidence in their pharmacists than in any other health care provider. Pharmacy is unique, because no other business that I know of uses its revenue from the business side to subsidize the professional services side. This is especially important because, although the patients we serve recognize the value of our services and turn to us time and time again when they need help, this government does not fully understand the contributions we are making to front-line health care across Ontario. We wouldn't expect doctors to run a retail operation on the side to pay for the patient care they deliver, but somehow we have come to expect this from pharmacy. But we have taken on this role and have structured our businesses to enable us to deliver patient care with, until now, no dedicated funding from the government. In an age of constrained budgets and ever-increasing demand for health services, health care providers of all types are doing the same. We all know that health care funding is limited and, just like Minister Smitherman, we are working to get more value for the money we spend.

Throughout the health care system, here in Ontario and in the entire developed world, health care providers like pharmacies are making arrangements with their partners to get more for their money in the interest of patient care. These arrangements must be transparent if we are to protect the interests of all participants in the health care system.

That's why A&P has implemented what we consider the gold standard in our supplier relationships. Our manufacturer supplier agreements clearly outline expectations, ethical guidelines and a code of conduct ruling such transactions. The control mechanisms as a publicly traded company are in place and can withstand rigorous public and regulatory scrutiny, including that of the Sarbanes-Oxley Act. It's tough and it's demanding, but it gives us the sort of transparency we think is needed to protect our business, our suppliers, our partners—like the government—and our customers.

The Minister of Health calls these value-added programs or rebates we receive nefarious and murky, but as you can see, in the case of A&P, this is simply not true. The minister also says that rebates are keeping generic drug prices high, but we know this is not the case and that there is in fact no demonstrated link between pricing and rebates. In fact, under proposed legislation, the executive officer strictly controls price increases, eliminating this possibility.

I hope I have gone some way to convincing you that they are nothing close to nefarious, and that solid controls are in place in our pharmacies to prevent them from becoming so. That is why my colleagues and I have developed an approach that will enable the government to capture information on value-added programs in pharmacy and to validate it. I've already explained how the rigorous processes work at A&P. I am confident that together, pharmacy and government can build a solution that delivers the same clarity and accountability.

Members of the committee, it is high time we make Ontario's publicly funded drug programs work better for patients, health care partners and taxpayers. It is time to fix the business side of pharmacy so that pharmacists can spend the time to work with patients to save this system money. It is time to introduce clarity into our drug system. It is time to work with all health care partners.

Now is not the moment to take draconian action that will do a disservice to patients. I therefore urge the McGuinty government to take the time to understand the implications of this legislation. It is complex and far-reaching. It merits careful study and considered implementation. Take the time to listen to and understand stakeholders and work with pharmacy to comprehend the complexity, value offerings and uniqueness of a business that not many understand. Take the time to amend this bill to enable community pharmacy to survive in the towns across Ontario and to continue to deliver the patient care we've come to be recognized for.

Our organization has worked closely with OPA, OCDA and CACDS in developing amendments that address the concerns of government and allow pharmacy to remain sustainable. Our offer of assistance is on the table. The profession wants to help, it can help and we can make a Bill 102 that works for everyone.

The Vice-Chair: Thank you very much. We have one minute left. We will give it to Ms. Martel.

Ms. Martel: Thank you for being here today. I want to focus on your point, "The minister also says that re-

bates are keeping generic drug prices high, but we know this is not the case and that there is in fact no demonstrated link between pricing and rebates.” Can you give us some more information about that, please?

Mr. Lording: I’m not familiar with any particular study that shows that the payment of rebates adversely affects drug prices and them going higher. The reference I made further was that under the new legislation, the executive officer controls price increases. So regardless of what the generic manufacturers may or may not pay, inevitably the drug prices will not go higher.

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

ALLIANCE OF SENIORS

The Vice-Chair: The Alliance of Seniors is here. You can start when you’re ready, sir. You know the procedure. You have 10 minutes.

Mr. Jack Pinkus: Thank you for giving us this opportunity. My name is Jack Pinkus. I’m past president of the Alliance of Seniors. I have with me today Mr. Derrell Dular, our coordinator and executive officer.

The Alliance of Seniors was founded in 1993 and it is an active, diverse, and growing non-partisan coalition of individuals and organizations representing the concerns of over 300,000 older adults residing in the greater Toronto area. Our mission is to preserve and enhance Canada’s social programs on behalf of present and future generations; to promote a society where all persons have an equal opportunity to live with dignity, to realize their potential and to participate in the democratic process; and to educate and raise public awareness about the values, life experiences and lessons learned by Canada’s older citizens.

As a coalition, the alliance does not presume to speak for individual organizations nor represent their specific positions. Rather, the Alliance seeks to build consensus upon the shared values amongst these groups when addressing issues of mutual concern.

Alliance of Seniors participating organizations include: Association of Jewish Seniors, Bernard Betel Centre for Creative Living, Canadian Institute of Islamic Studies and Muslim Immigrant Aid, Canadian Pensioners Concerned, Care Watch, Caribbean Canadian Seniors, Concerned Friends of Ontario Citizens in Care Facilities, Congress of Union Retirees of Canada, Elder Connections, Habayit Shelanu Seniors, Jamaican Canadian Association, Korean Inter-Agency Network, Older Women’s Network, Ontario Coalition of Seniors Citizens’ Organizations, Ontario Federation of Union Retirees, Riverdale Seniors’ Council, Toronto Seniors’ Assembly, Yee Hong Centre for Geriatric Care.

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Mr. Derrell Dular: Our concerns regarding Bill 102, the Transparent Drug System for Patients Act: The Alliance of Seniors, its affiliates and friends endorse the principles of the Canada Health Act: comprehensiveness, universality, accessibility, portability and public adminis-

tration. We recognize the important role of prescription medicines in health care and support the preservation and enhancement of the Ontario drug benefit program and the Canadian Health Coalition’s proposals for a national pharmacare plan.

We also recognize that prescription drug costs constitute the fastest-rising component of health care costs in Canada and seriously threaten the sustainability of existing provincial drug plans. For many years, the alliance has advocated at both federal and provincial levels to contain rising drug costs and for faster access to affordable medicines for all Canadians.

Bill 102 appears to address a number of our concerns. We are very pleased that in Bill 102 the government has chosen not to increase fees or copayments for seniors. We’re also pleased that Bill 102 does not reduce the number of medicines covered by the government’s drug plan. Many seniors are on fixed incomes, and government decisions to cut benefits and increase user fees would have a dramatic impact. We would be happier still if such fees were eliminated altogether.

We also support the government’s move to remove barriers to the interchangeability of equivalent, lower-cost generic drugs and its intention to negotiate better prices from both brand name and generic drug companies. The government pays over \$3.5 billion a year for drugs, and it should be able to use that buying power to save taxpayers’ money that can be reinvested in other aspects of health care.

With regard to drug pricing, marketing and related costs, we are concerned that the new regimen proposed by Bill 102 be sustainable without a reduction in accessibility or quality of pharmacy services. Does Bill 102 make adequate provision for alternative compensation for the health care professionals who advise and deal most frequently with the users of prescription medications?

While we are critical of the practice of drug price rebates from drug manufacturers to pharmacists, we are also aware that in order to remain viable from a business perspective, pharmacists must receive sufficient compensation to realize a livelihood and to cover their inventory and operating costs in order to continue to provide health care services that communities rely upon.

Over the past 20 years, the pharmacists’ dispensing fee, as regulated by government, has been increased only a fraction of the rise in the consumer price index for the same period. It could be argued that the difference has been made up and the real costs of their professional services deflected by the manufacturer rebates. We would prefer a fairer, more transparent form of compensation for our pharmacists.

Mr. Pinkus: I would like to add a comment that’s not in our regular brief. I’m rather in a unique position as a senior and as a retired pharmacist, so I can look at perhaps the two sides of the question.

As a statistical example, seniors represent 12% of our population but consume about 40% of medications. Therefore, pharmacists play an important role in their medication system. The government should realize that

seniors always see the same pharmacist for medications. We do this because our medication needs are complex. Any system change that would threaten this would be problematic for our members.

We thank the committee for this opportunity to express our support for and concerns about Bill 102.

The Vice-Chair: Thank you very much for your presentation. We have about three minutes left. We can divide it three ways. We'll start with Mr. Peterson.

Mr. Peterson: Thank you very much for your presentation. You obviously, as a pharmacist and as a senior—and I'm quickly approaching that age myself—have run into this tough paradigm of huge costs, increasing, to not just sustain life but also sustain a quality of life. The problem is, you're putting government in the role of deciding both quality-of-life and sustainability-of-life questions. These are pretty tough questions for us personally, let alone for a government to make decisions. Have you got any insights on a mechanism or any ways that we can make sure that everybody is fairly treated without having total runaway costs in the pharmaceutical area?

Mr. Pinkus: Well, that's perhaps a difficult question to answer. Certainly I have spent many years behind a pharmacy counter and that situation does perhaps come up. I think, from the seniors' perspective, we trust the information the pharmacists give us. We need that information. We need the support that pharmacy has to offer. As far as putting the government in that position, we would like to certainly help in that matter if we can.

The Vice-Chair: Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. You've indicated that you are concerned about the fact there may be a reduction in the accessibility or quality of pharmacy services. Certainly, we've heard from many, many people—pharmacists, those in pharmacy—that that's exactly what this is going to do. In fact, I have a petition here from students at the school and they are very concerned that Bill 102 is going to create, as they say, additional barriers that would prevent them from helping Ontarians in the way that they can and that they should. They are nervous about their future as pharmacy practitioners in Ontario. So the threat is real.

What would you encourage this government to do to make sure we don't see the closure of pharmacies and we don't see the elimination of pharmacists in the province doing the work that they love to do?

Mr. Pinkus: I'm sorry. Could you—

Mrs. Witmer: The work that they love to do: What should the government do? This bill, as it is, is going to reduce the number of pharmacies, according to the data that we've been presented with.

Mr. Pinkus: I see it as a big problem, certainly, and a problem for seniors in having accessibility. Certainly it would be very difficult for seniors to travel over long distances if some of the rural pharmacies close. That would be a real chore for them to access their needs, much more so than any other segment of the population.

Mrs. Witmer: I agree.

The Vice-Chair: Ms. Martel.

Ms. Martel: Thank you, both of you, for being here this morning. I just want to highlight two of the concerns you raised: Does this bill make adequate provision for compensation for these health care professionals, i.e. pharmacists? And it could be argued that the difference in what pharmacists have not seen over the years and their real cost is being made up by some of the rebates.

I think that during the course of the public hearings we have heard that repeated by a number of pharmacists, particularly small, independently owned. My concern remains that unless we see some significant changes in how compensation is going to be dealt with, we are going to see a significant loss either of small pharmacists or in the services that they're providing.

I agree with you that those are very significant concerns. In many cases, these front-line professionals are the only health care providers in many of our smaller communities. We need to be sure they're compensated properly so they continue to provide that service.

Mr. Pinkus: And since seniors are the ones who access them more often, it would be particularly hard for them.

Ms. Martel: I agree.

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

I want to call on the Canadian Centre for Policy Alternatives. Is anybody here? No?

ONTARIO FEDERATION OF UNION RETIREES

The Vice-Chair: Then we'll move to the Ontario Federation of Union Retirees. You can start when you're ready. Before you start, please state your names for Hansard.

Mr. Orville Thacker: Good morning, Mr. Chairman and members of the policy committee. My name is Orville Thacker. I'm president of the Ontario Federation of Union Retirees. With me this morning is Joyce Cruickshank. She is the secretary of the Ontario Federation of Union Retirees.

Our main purpose for being here this morning is to let you know that we're concerned about our public health care in the province of Ontario. We're here to support portions of Bill 102 because we feel that anything that can reduce the costs of public health care, provided it doesn't interfere with services, is a step in the right direction. I'm going to let Joyce present our brief now.

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Ms. Joyce Cruickshank: As you can see from the brief, if you have it in front of you, our organization of union retirees has many, many affiliates throughout the province. Most of them are union retiree organizations, and they span the auto workers, steelworkers, public workers—the whole gamut of retired union workers across the province. We have affiliations, of course, with the Ontario Federation of Labour, the Canadian Labour Congress and the Congress of Union Retirees of Canada. We're not funded at any level by government, not funded

by business, and we really have nothing to do with pharmaceutical companies at all. We want to protect our health care system from being downgraded, and this continual escalation of drug costs is not going to help that at all. We want to ensure access to the system while ensuring protection against dangerous or unnecessary drugs.

As Orville has said, we're in favour of some aspects of Bill 102 and not in favour of others, so we want to very simply and clearly make you aware of what those are. Patient safety is an overriding concept throughout our whole presentation.

We support the government's efforts to control the cost of drugs in Ontario. One of these ways, of course, is widening the use of generic drugs and widening the scope of what will be considered equivalent to brand name drugs. As well, dropping the price of generics by 20% to 50% of the brand name products is commendable and should work to lower the cost of prescriptions without harming patient care in any way. Although some of the people we represent still have a drug benefit package that is associated with their former employment, many do not, and any lowering of their health care costs helps them in their senior years as well.

We support the elimination of rebates for pharmacies, which would allow the government to pay the actual transaction price and save money. If some pharmacies, particularly in northern and rural areas—I've heard concerns expressed about that—are arguing that this reduction in their revenue will cause them to close, there's got to be another way to ensure access to pharmacies. Their financial viability should not be based on rebates from drug companies. There has to be some other way to do that.

The government should be able to save large amounts of money by buying in volume and being able to negotiate over prices, although I don't know if negotiating with the major pharmaceutical companies would be a very fun thing to do—kind of like negotiating with the boss. Decreasing the markup on drugs from 10% to 8% will reduce costs without harming patients.

I think the representation of patients on councils regarding the formulary is a very, very good idea, but we need to make sure that those patients have protection against being influenced by the drug industry. The drug industry is so powerful already that it needs no help in this quarter.

Some of the things we don't like in the proposed legislation: the appointment of an executive officer by order in council. That person would report back to the very government that appointed him or her and not be accountable to the public. They're not elected; they're appointed. The very sweeping nature of the powers given to this executive officer is scary. They will have the ability to set prices for drugs, decide on interchangeability, and add or remove drugs from the formulary, just to mention some of the areas and the powers. I think that to place this much power in the hands of an unelected official is wrong, very simply wrong. We would support additional

initiatives to ensure that this executive officer operates with the utmost in public transparency, with a minimum of influence from the drug industry.

There is no mention of what will be done with any savings realized from this legislation. Any savings should be reinvested in health care or other social programs, and this information should appear within the legislation.

We would support the government to advocate at the federal level for a national pharmacare program to help improve our access to drugs necessary to maintain or improve health right across the country. Most industrialized countries have a national pharmacare program; we do not, but should have one.

If we were to look into the future, without something being done about controlling the rising cost of drugs, some of the implications are: Faced with ever-rising costs, employers scale back their workplace benefit packages. Who do you think their target will be? We already know: The target is retirees. Retirees can't vote on contracts in most cases, and they aren't visible in the workplace, so they have difficulty being seen and heard. I do know that one company has already reduced the benefits they give to their retirees by not allowing any increases to cover cost of living. That's happened in my own area, so I know first-hand what that has done to people. As well, it's easy to convince people that retirees use up a disproportionate amount of benefit package dollars just because they're older and more likely to be sick, even if that's the wrong attitude, and probably inaccurate as well. When retirees cease to be covered by a private workplace-related benefit package, they must fall back on the public system, and we all pay for that.

If we do nothing, drug costs will continue to soar, forcing government to further cut the number of the types of drugs covered by its plan. This will only force low-income individuals, families and seniors further down the economic ladder, making disastrous decisions about prescriptions versus food, versus shelter. They shouldn't have to do that.

We urge you to resist the lobbying efforts of the drug industry and their cohorts and work towards improving Bill 102 in the ways we are suggesting. Thank you very much. Questions?

The Vice-Chair: Thank you for your presentation. Yes, we have three minutes left that we can divide three ways. We'll start with Mrs. Witmer.

Mrs. Witmer: Thank you very much, Joyce and Orville. You always make a good presentation. I do appreciate your being here on behalf of the Ontario Federation of Union Retirees. You certainly make some very good points. One of the concerns I've had you do share. You talk about the appointment of the executive officer and the amount of power. This individual can make decisions, but there's no appeal process and there's no transparency. Do you have suggestions as to what the government should do to make that process and that office more accountable?

Mr. Thacker: I don't think we have any final suggestions. It appears to me that there is machinery in place

now to do that job. It doesn't have to be another bureaucracy set up.

Mrs. Witmer: Okay.

Ms. Martel: Thank you very much for being here this morning, both of you. I want to focus on the appointment of the executive officer. What's interesting is that there's already a director of the drug programs branch at the ministry. I don't know why the director, that position, is not staying in place, because then we're going to have some accountability. If that person stays in place, the accountability or the checks and balances also come with making sure that some of the things do continue to appear in regulation, rather than the executive officer having that power and being accountable to nobody. There are some very significant powers that are being added here. Can you say why you are concerned about that and why you'd like to see some checks and balances on that particular power?

Ms. Cruickshank: I don't think it's a good thing for any one position to have the volume, just the sheer amount of power that this person will have, and they're an unelected official, a bureaucrat. They are not in any way reporting back to people who put them in place, other than the government who appointed them. It just goes against the grain.

I would much prefer to see the current type of position that's there. I believe that you call it "director of—"

Ms. Martel: Director of the drug programs branch.

Ms. Cruickshank: Even if that has to be massaged or adjusted in some way, shape or form. I understand that through the regulations and for some of the kinds of decisions this executive officer would make, they have to go back to the government to be approved there. So there is a check and balance there. People in government are accountable to their electorate.

The Vice-Chair: Thank you.

Ms. Kathleen O. Wynne (Don Valley West): Thank you very much to both of you for being here. You made a statement about the representation of patients on councils regarding the formulary: You're happy about that. You think that's a good way for the community to have input. But you made a comment about protection for those patients against being influenced by the drug industry. Could you talk about what you're envisioning there?

Ms. Cruickshank: In what way?

Ms. Wynne: What form would that protection take? Had you thought about what that would look like? Our assumption is that the patients have good opinions and good information to bring to the process. You're saying that there should be some protection built around them. I just wondered if you'd thought about what that would be.

Ms. Cruickshank: I don't know if it would have to take the form of legislation. Not banning the drug industry from having input, by any means—of course they should have to—but not allowing them to influence patients who are there.

Many of our drugs aren't covered under the formulary. If a patient were to be on the council and assisting with decisions, and were offered the kinds of drugs that they

really need to have at a better price, I think that's undue influence.

Ms. Wynne: So there should be controls around conflict of interest, that kind of thing.

Ms. Cruickshank: Absolutely.

Ms. Wynne: Okay. Thank you.

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

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CANADIAN CENTRE FOR POLICY ALTERNATIVES

The Vice-Chair: I believe the Canadian Centre for Policy Alternatives is with us here. If they're ready, they can come forward and present. Can you state your name, please, before you start?

Ms. Armine Yalnizyan: Good morning. My name is Armine Yalnizyan. I am representing the Canadian Centre for Policy Alternatives. Thank you very much for making the time to hear my presentation.

I want to send a very clear message to all of you from all the parties that I think this is a bill that should be supported, why you need to support it now, not later, and why this is a model not just for Ontario but for the nation and the leadership role that this government can play on the national stage, using this kind of legislation.

Everyone on this committee knows, everyone in each party knows and every consumer knows why this kind of legislation is very timely. First of all, the efficiencies that can be gained are huge, and the potential for improving equity is also incredibly important.

As elected officials of three separate parties, your interest should be firmly behind this initiative. The Conservatives tried to introduce price-volume controls in 1998. The NDP stand for preserving and enhancing access to basic services. The measures in this bill meet both tests of fairness and pragmatism, seeking efficiency and equity.

I don't need to go over the growth curves, the growth rate in drug spending, the growth rate in health care spending versus the growth rate of the economy and provincial revenues. Quite apart from those mathematics, which simply put more pressure on you to act, to manage, not just spend, these are the following facts:

Ontario is the largest purchaser of drugs on the continent, just behind the veterans health administration in the US. The VA provides health care to 5.5 million veterans of the US wars out of 7.5 million veterans. They spend about \$4 billion a year on drugs, and they cover 24,000 pharmaceutical products. Here in Ontario, we spend \$3.5 billion a year on drugs instead of \$4 billion. We're the second-biggest purchaser on the continent. We cover 2.5 million people instead of 5.5 million people, and we spend that \$3.5 billion on just 3,000 products, not 24,000 products.

My question to you as a woman, as an economist, as a single mother is: Why pay retail? There are huge dis-

counts that are at our disposal here if we use the muscle power that this kind of a purchaser has behind it.

Some 33% of all your drug costs that you spend on an annual basis goes to two pharmaceutical classes: cardiovascular and those drugs that reduce cholesterol. There are huge savings waiting to be made here, as we know from the Cipro case in the wake of the anthrax scare just after 9/11.

The major strokes in this bill address the real issues: We pay too much for generics. Our only price control legislation is the 70% rule on their price vis-à-vis brand name products. That is being brought down to 50% in this bill. That's very reasonable, and it's about time that we're looking at those kinds of price controls on generics.

We also pay too much for patent drugs. While the PMPRB regulates the price per unit, we do not take full advantage of price-volume agreements like they do in the US. We have tried in the past because of the regulations that were brought in by the Conservatives in 1998, but we can see that with the VHA, purchases are made at discounts ranging from 24% to 60% below drug manufacturers' most favoured, non-federal and non-retail consumer pricing.

So we have room to move here and if you use your bulk purchasing ability, you can achieve significant savings. In fact, it has been estimated that this bill will lever almost \$300 million a year in cost savings. That's almost 9% of our bill. Why would any government turn that down? We're growing at a rate of over 9% a year. It is responsible governance to introduce this type of a bill, and governments can do things that individuals and single insurance companies cannot because of their sheer economy of scale.

The sustainability arguments are huge behind this particular legislation. It speaks to the issues that virtually every elected official in this country wraps themselves in, which is that they're for universal access to health care, that we must protect and sustain public health care. This is a way to do it. You have to control the costs.

But it's true that it's not just about spending, which is what we always focus on when we talk about the unsustainability of health care. The revenue side is also incredibly important. For example, between 1997 and 2004 federal and provincial governments together reinfused health care with \$108 billion in new spending. That's true. They also took out \$250 billion worth of tax cuts in the same time period. You can't say you've got a sustainability problem if you're not willing to hang on to the revenues that you already have.

You can't hang on to the principle of access for all citizens without admitting that we're going to have to pay more over time. So these measures are incredibly timely, but that doesn't mean necessarily that our drug costs are going to drop, and I'll explain to you why very briefly: because the majority of the market that you spend on in the ODB is for those people who are 65 years of age plus, not under 65 and not the Trillium drug plan. This is going

to be a growing part of the population, and they are being aggressively marketed.

That leads me to my second point: Why do you have to do this now? As of December 2005, CanWest filed a court case with the Superior Court of Justice in Ontario to declare that DTCA, the legislation governing a ban on advertising for drugs, violated a charter privilege, I think under section 2. There's no date yet determined for when it will be heard, but this fight is on the agenda partly because the federal government is reviewing its Food and Drugs Act.

When you open up the legislation that asks, "Can we advertise directly to consumers?" you get a whole new demand-side push. You've been hearing all the reasons why we can't deal with this on the supply side of it. We're about to enter a whole new era about where that demand is going to come from, and they are marketing 65-plus—they're marketing 45 to 65. Now it's not going to just be drugs to treat you, it's going to be drugs that make sure you don't get sick in the first place. If you want to hang on to the controllability of these costs, you must act as soon as possible, and that does speak a little bit to who the councils are that talk about this.

On the supplier side, much more aggressive marketing is on the horizon. IMS documents show that 2005 was globally a slow year in growth. Why? Generics were on the rise, and every single government is looking to do cost-containment exercises as you are doing at this jurisdictional level. They believe that they have an opportunity here to market in a brand new way. If you look at their websites, it's actually quite astonishing. The period between 2000 and 2003 saw spending on simple promotion in only the US rise from \$15 billion on promotions of drugs to \$31 billion in 2003. That's the last year. That's double in three years.

Be prepared. If DTCA blows down those walls on who gets targeted by marketing—like when you put aside \$158 million in your last budget for cancer drugs, be prepared to see more and more demand on the part of the consumer, saying, "I want access to this latest shiny thing." So we've got a real issue on how we are going to control the growth in drugs as not just treatment but management and prevention therapy.

The last issue I want to raise with you—because I do want to have time for an exchange—is that this model of governance talks about what governments can do for people, that taxes are not just a black hole but actually a way of harnessing collective purchasing power in a way that no individual, no business and no insurance company can do.

This is something that we should actually all be moving towards, with economies of scale, setting rules in a way that private sector players can't and making sure that the benefits of these changes are distributed for all citizens, not just some subset of citizens.

Now, we've been talking about uploading pharma since 2004. At the Niagara-on-the-Lake first ministers' meeting at the end of July 2004, the issue came up. It was raised by BC. It was also supported by Ontario. This

document was written for the Canadian Federation of Nurses Unions. I'll leave it with the clerk. It talks about the need for pharmacare. This document came out a couple of months later with Canadian Healthcare Manager. I'll leave it with the clerk if you wish to view it.

The issue of uploading the costs of health care to the federal level is important for two reasons: First of all, if we've got economies of scale at the provincial level, we've got even more economies of scale at the federal level, and that could actually save taxpayers money across this country and buy greater equity across this country. You could be the role models on how to achieve that at the national level.

Secondly, we've been talking about fiscal imbalance till the cows come home, and we have a Premier of this province who has been using this as their calling card. The fiscal imbalance story will be determined fairly forthrightly in 2006 in the fall when the federal government makes some proposals on how to realign those fiscal responsibilities between the federal level of government and provincial. We can expect that a good deal of that reallocation will be through tax room.

Every one of you at this table knows that there's huge tax competition in this country, and so even if you liberate tax room to the provinces, the ability to raise revenues to meet people's service needs is severely cramped by the desire on the part of governments to not look like they're tax-raisers. This is a proposal that can use some of that fiscal surplus at the federal level to actually deliver the goods for citizens across this country without paying another penny of taxes. In fact, it is a way of making that fiscal imbalance less unbalanced by actually using the surplus resources we have paid to buy us better value for money. So I hope that you will work with citizens to improve access to pharmacare in this country and go with your Bill 102.

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

1140

STEELWORKERS ORGANIZATION OF ACTIVE RETIREES

The Vice-Chair: I believe the Steelworkers Organization of Active Retirees is with us here today. If you are ready, you can come forward. You know the procedure: You have 10 minutes. When you are ready, you can start, sir. Before you start, if you could state your name.

Mr. Dan McNeil: Dan McNeil. I guess I'm going to start.

I want to thank the committee that we're able to be here today on such an important issue. Perhaps what we're saying has been said a lot, and I ask you to have patience with us if we are repeating anything.

Health Minister George Smitherman announced a package of reforms to curb rising health care costs. We applaud Mr. Smitherman's decision to use the government's considerable power to win more reasonable prices from pharmaceutical suppliers. Mr. Smitherman would

give pharmacists more authority to replace expensive brand name drugs with cheaper generic equivalents. He wants to regulate the prices of these generics to ensure the public is paying a more reasonable amount than the cost of their brand name equivalents. We feel this is also a wise decision. Mr. Smitherman's reforms would also save money for private workplace drug plans. We applaud that.

According to the Toronto Star, the generic industry employed 7,500 people in 2005 and spent \$300 million on research. Some \$1.58 billion worth of generics were bought by hospitals and drugstores, and retail pharmacies in Ontario filled 56.8 million generic prescriptions.

In comparison, brand name drugs employed 9,000 people and spent only \$360 million on research and development—sad. Hospitals and drugstores bought \$5.66 billion of brand name drugs, and retail pharmacies filled 70.5 million brand name prescriptions—clearly not a very level playing field.

According to the generic lobby, the majority of brand name drugs consumed by Ontarians are shipped into Canada, while the majority of generic drugs are made right here in the greater Toronto area. Therefore, a dollar spent on a generic drug in Ontario supports more jobs in Ontario, more research and development, and more pharmaceutical manufacturing capacity.

My friend will take over here.

Mr. Henry Hynd: My name is Henry Hynd.

However, we do know that a few generic drugs do not perform as well as brand name. While this problem is unusual, it is real. My wife, Margaret, has an irregular heartbeat, which was controlled by a brand name drug. When she reached age 65, it was automatically transferred over to a generic drug. My wife had serious difficulties. I had to contact her physician, who indicated clearly that there should be no substitutes. So I don't think that we can just switch people over, because humans are different, and a generic drug that may work for the vast majority of people may not work for everybody. There has to be a recognition of that, and this piece of legislation must enshrine that.

We must support a physician's direction when a patient experiences an adverse reaction to a generic replacement. We caution the ability of the pharmacist to change from a brand name drug to a generic drug. This should only happen in conjunction with the patient's physician.

Last year, the government spent \$3.4 billion on the government's drug plan. We believe the government has considerable buying power and must be the most important customer to brand name and generic companies. An inquiry into the development cost and production of brand name drugs would be an essential ingredient in lowering the cost of brand name drugs. This inquiry would provide us with vital information and allow the government to investigate the cost of production of generic drugs at a reasonable and rational cost.

Since we only have a short time left, we wish to speak about the new executive officer or officers who will

administer the Ontario drug program. This position should keep, maintain and publish the formulary. We understand this is currently a mainstream power that will be transferred to the new executive officer. While we could speak to the other duties that are transferred to this new executive officer, we would like to move through to our concerns about this delegation of responsibilities that are the new duties of an elected officer, which in many ways are removed from government control.

We believe that the government of the day wishes to accomplish a savings or reduced cost of both generic and brand name drugs. The most influential body to accomplish this is the government itself. We applaud the ideals of the new legislation but have serious concerns regarding the points we have raised. We hope these concerns will be implemented.

Don't give up your power in government to those outside of elected officials. We have in the recent past witnessed how many things can go wrong when those who are elected hand over power to officials outside of government. Considerable savings, we believe, will be better achieved directly through government. More importantly, the health of the people in Ontario will be better protected by provincial politicians.

Thank you for the opportunity to appear before the committee and for hearing and supporting our concerns.

Submitted on behalf of the Steelworkers Organization of Active Retirees.

The Vice-Chair: Thank you for your presentation. We can start with Ms. Wynne. We have three minutes. We can divide them equally.

Ms. Wynne: Thank you very much, gentlemen, for being here. A couple of things. I certainly support your concern about doctors being able to indicate no substitutions. That is the situation, if this bill is passed: Doctors will be able to indicate no substitutions.

I wanted to talk about the executive officer position for just a minute, because you're concerned about the powers being transferred. The executive officer model is essentially the same as the current model for the general manager of OHIP, who of course has a much broader mandate. But the executive officer will report directly to the Deputy Minister of Health and Long-Term Care. Do you see that as adequate control? Our feeling is that that model will work for the executive officer, as it does for the general manager.

Mr. Hynd: We believe that won't work. The greatest concern—and seniors are the ones, as we grow older, who need it more than anybody. By the numbers, I should say; not more than anybody.

We think that it's much better for government to be accountable to the citizens than to have one individual who has all this power to work with companies. I know if I was representing government—I used to do a bit of negotiation in my day. I know that if I had the support of the government behind me, negotiating with the brand name companies and the generic companies, I'd be able to do a very good job. However, there might be a huge

temptation, because I'm the only person—it would be different than now. That's what concerns me.

1150

Mr. Cameron Jackson (Burlington): Thank you for your presentation. Your retiree group would have bargained your benefits upon retirement, so you do have a drug plan currently.

Mr. McNeil: Some; some don't.

Mr. Jackson: Some do and some don't.

Mr. McNeil: Not all of us. Not everybody.

Mr. Jackson: Very good. And—

Mr. McNeil: For some people who have it, it's very low, too, very low coverage, unfortunately.

Mr. Jackson: Okay. Your personal experience with—I get your point about having an elected individual being held accountable, especially in Ontario, where you have two or three political parties to advocate for you at any one time. Have you found any other examples across Canada where there's this large disconnect between the elected people and the drug plan?

Mr. Hynd: I can tell you from my own life experience working in the union that I know I could never get from my membership, on a vote of the membership, control of how we would negotiate a collective agreement, for example, how we would work out wages and benefits, and I think that's worked best for our union. What happens in that process is, the members are involved in the negotiations from that facility, and when we report back, we report back to the people who work in that facility. They determine whether it's a good agreement or not.

For me, there's a real concern about somebody having the ability to work with a pharmaceutical, brand name and generic, to try to work out some price—

Mr. Jackson: Without you ever knowing about it.

Mr. Hynd: That's our biggest concern.

The Chair: Ms. Martel.

Ms. Martel: Thank you for being here. I want to focus on the same issue.

I know the government says that the model for the executive officer is a model taken from the manager of OHIP. As far as I know, the manager of OHIP is still a government bureaucrat; it is not a political appointee. Secondly, even the manager of OHIP doesn't have the ability to list or delist items from the OHIP schedule. That still has to go through cabinet, so that government officials, at the end of the day, are accountable. Not only is there a problem that this person is appointed, the executive officer, but many of the checks and balances around things being done by regulation, so cabinet has to approve it ultimately, are also taken out of the bill.

I appreciate you focusing on this particular concern, because there are very significant differences between what is being proposed here and what is currently in place at OHIP. I would submit to you that the bureaucrats who are running things at OHIP do not have any significant similar powers in the same way the government is proposing this. There are checks and balances: that things have to go through regulation, have to be done by the Lieutenant Governor, which still takes these import-

ant decisions back to cabinet to approve in the first place. That's not happening with the executive officer.

The Vice-Chair: Thank you very much for your presentation. Your time has expired.

CANADIAN ASSOCIATION OF CHAIN DRUG STORES

The Vice-Chair: I now call on the Canadian Association of Chain Drug Stores, if they are with us here. You can start when you are ready. Before you start, please state your name.

Ms. Virginia Cirocco: Good morning. My name is Virginia Cirocco. I am a licensed pharmacist in Ontario and senior vice-president of pharmacy for Shoppers Drug Mart. I am appearing before the committee this morning in my capacity as chair of the board of the Canadian Association of Chain Drug Stores, or CACDS. I'm joined by Andy Giancamilli, who is the chief executive officer of Katz Group Canada and vice-chair of CACDS.

I thank you for the opportunity to bring a perspective from Canada's chain drugstore industry, which operates more than 5,600 pharmacies across the country, and 80% of the drugstores in Ontario.

My remarks today will focus on three areas: first, the likely impact of Bill 102 and its related policy statements; second, changes to the legislation that chain pharmacy proposes in order to minimize the negative impact; and third, the need to engage pharmacy in a productive way as the reforms to Ontario's drug system are further developed.

I'd like to start by saying that CACDS members welcome reform to Ontario's drug system. In fact, we believe that changes are needed. CACDS participated extensively in the review of the drug system and offered very detailed, practical, and what we believed to be effective proposals for the government to consider.

We were hoping and expecting that the legislation's provisions would address the problems based on the reality of the current system, and we anticipated that the reforms would represent a significant step forward for the pharmacy profession in Canada, and ultimately for patient care.

In many ways, some of the proposals put forward by the government do have merit, and CACDS supports them: for instance, the government's intent to move toward a more transparent, accountable and accessible drug system in Ontario.

Two of the announced policies in particular are welcomed by community pharmacy. They are excellent, forward-looking and long-sought initiatives, and properly recognize the unique front-line role of pharmacists in the health care system today. One is to move to compensate pharmacists for clinical services. It will, for the first time, recognize the expertise pharmacists bring to services that extend well beyond dispensing. The other is the policy to establish a Pharmacy Council. This council will ensure that the knowledge and skills of the pharmacy industry are involved in the development of future pharmaceutical

and health policy. In fact, it is so important that it must be included in the legislation and thereby enshrined in law.

In spite of these praiseworthy initiatives, however, CACDS is disappointed that very little of what we offered as solutions is reflected in the new bill and the policies. We're concerned that the overall effect of Bill 102 and the associated drug system policy announcements will be harmful both to the practice and to the business of pharmacy, and to patient care not only in Ontario but across the country.

If there is a belief that the Ontario government's current plans to reform the province's drug system will not affect chain pharmacy, that is inaccurate. CACDS agrees with the estimate of the Ontario Chain Drug Association—the OCDA—that the reforms would reduce overall pharmacy funding to the point that it would render current levels of pharmacy service and care in Ontario unsustainable. The chain drug industry's unique programs and services would be in jeopardy. There is the real potential for staff layoffs, reduced hours of operation, increased patient wait times in pharmacies and significantly reduced investment in patient education programs.

The concern about the likely impact on this province is considerable enough, but more alarming is that it will have a ripple effect on pharmacy economics right across this country. As a national association with members who operate in every province, we are very concerned that the policies as announced by the Ontario government will be adopted not only by public drug plans in other jurisdictions but also by private drug plans. We do not believe this was the intent. The negative consequences and the \$500 million of lost income already discussed before you would in fact be dwarfed if this were allowed to happen.

We would like to emphasize that the government should consider other, more productive opportunities to further enhance the system, rather than just attempting to extract cost-savings from pharmacy. Overall, the government's proposals highlight a missed opportunity for Ontario to take a leadership role in leveraging pharmacists' ability to enhance pharmaceutical care and manage costs.

Pharmacy is not a leading cost-driver. According to the government's figures, in the last 10 years, prescription drug costs have increased by nearly 150%. By comparison, since 1993, pharmacist dispensing fees have increased by only 2%, and inventory allowances have remained at the static percentage of the cost of acquiring and stocking drugs.

Pharmacists are uniquely qualified to drive innovation, improve health outcomes and help better manage health costs. Given this fact, it is imperative that pharmacists—health professionals expert in pharmaceuticals—play a larger, more central role.

Specifically, pharmacists should play a leading role in first ensuring that prescription medicines are used properly and safely, avoiding adverse events, and enhancing patient adherence to treatment protocols; second, manag-

ing rising drug costs resulting from increased utilization, multiple-medication regimens and the more frequent use of newer, more expensive therapies.

The CACDS submission, which I have circulated to the committee, includes several specific recommended amendments to Bill 102, as well as recommended pharmacy policy solutions designed to improve patient care and control total health care costs. We believe that in order to avert serious negative consequences to the profession and the business of pharmacy, as well as to patients, the government must amend Bill 102 and reconsider certain announced policies associated with the drug system reform plan.

We support the advocacy initiatives and the role of the Ontario Pharmacists' Association as we continue to work collaboratively with them. Our submission endorses the analysis and echoes the recommended amendments put forward last week by the Ontario Chain Drug Association: (1) the recommendation to consider the inclusion of the definition of "professional allowances" in Bill 102 to preserve the economic viability of pharmacy. We completely support the removal of unacceptable practices associated with manufacturer rebates. We ask, though, that the commonly accepted practice of negotiated support that exists between pharmacy retailer and manufacturer be allowed since it is such a critical source of funding. Recommended definitions and limitations around allowances are included as well in our submission; (2) enshrining in law that a Pharmacy Council be established and that chain pharmacy have official representation on that council; (3) formalizing the process to review and enhance the economic model for community pharmacy; and (4) amending other specific policies that have been announced that would also be detrimental to the economic viability of pharmacy.

Finally, we want to strongly urge the government to agree that community pharmacy must be engaged in the further development of policy regarding the drug system, especially given the fast-paced legislative process for Bill 102. CACDS encourages the Ontario government to consult with us as the regulations for Bill 102 are developed. We are the experts on the Ontario drug benefit program and experts on the dynamics of our industry.

There are many successful examples from other jurisdictions that the government can take from. Governments in provinces across Canada and other countries have worked in collaboration with pharmacy to create novel programs that improve patient health and provide cost management. Our submission outlines a number of these success stories.

Our position is that government must consider partnering with us on initiatives to improve the drug system. We have been and will continue to be open, eager and enthusiastic about the prospect of the needed system reform.

The Vice-Chair: Thank you very much for your presentation. We have one minute left. I'm going to give it to Dr. Kuldip Kular.

Mr. Kuldip Kular (Bramalea–Gore–Malton–Springdale): First of all, thank you very much for your presentation. The question I have is, how would you define "professional allowances" if I asked you?

Ms. Cirocco: As in the definition that we proposed in the amendment, it would be investments that would be made with pharmacy providers to support patient education programs, patient service programs, things that are focused directly at patient care—the clinical services that exist today, focused on care.

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

Ladies and gentlemen, thank you very much for your attendance and co-operation. I believe the time for the morning session has expired. We're going to recess until 3:30 sharp, or after question period if question period passes 3:30. Thank you again.

The committee recessed from 1202 to 1535.

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

CARP

The Chair: We'll proceed immediately to our first presenter. I'll call, on behalf of the committee, Mr. Bill Gleberzon, director, and Judy Cutler, also director, of the Canadian Association of Retired Persons, CARP/50Plus. I would invite you to please come forward. As you've likely seen the protocol from previous testimony, you have 10 minutes in which to make your combined presentation, beginning now.

Mr. Bill Gleberzon: Thank you very much. I'll be doing this by myself. Ms. Cutler is not with me today.

CARP's primary message in regard to Bill 102 is, slow down the process. The impact of the bill is too wide and deep to be rushed through without a thorough examination and consultation, because the devil is always in the details. But if the government is insistent on fast-tracking the bill, then CARP recommends the adoption of the recommendations presented in this brief.

Although there are some aspects of the bill which CARP endorses, there are elements that have generated concern and, therefore, require reconsideration or clarification.

CARP supports the provisions in the bill that expand the input by patients, including the Citizens' Council to advise the new executive officer. Citizen participation in the Committee to Evaluate Drugs is also welcomed by CARP. CARP is pleased that the co-payments and deductibles for the dispensing of prescription drugs paid for by seniors has not changed.

The elimination of limited use and section 8 categories is welcomed by CARP, provided that the new conditional listing category and exceptional access mechanism speed up access and ensure affordability.

Increased information and advice for patients on the appropriate use of medications by pharmacists is a good move, and will increase their role as front-line health care providers without diminishing the doctor's role as the final decision-maker for patients.

CARP understands that the ministry is proposing to amend the bill to remove the \$25 cap on rebates, which will enable pharmacies to continue to provide the range of drugs required by patients. CARP is also pleased to hear that the ministry is proposing to amend the bill to ensure a re-review process when the executive officer has rejected the listing of a drug. Having said that, we have a number of concerns which I'd like to turn to now.

The bill focuses on cost containment, but this should not be accomplished by jeopardizing the optimal prevention and care for patients. The legislation should clearly prohibit any type of cost containment using reference-based pricing, maximum allowable cost or therapeutic substitution.

There are clear threats in the bill, in our point of view, to implement a system of therapeutic substitution by having pharmacists substitute not just "the same" drugs but "similar" drugs that are prescribed by their doctors. This is unacceptable to the principle of ensuring that patients receive the drug their doctor knows is best for them. However, we understand that the ministry is prepared to amend the legislation with regard to limiting the term "similar," for the purpose of interchangeability, to non-active binding agents—that is, excluding chemical ingredients—and to removing the clause that increases the power of the pharmacist to substitute the drugs prescribed by doctors for their patients.

The proposed changes to the interchangeability rule open the door to reference-based pricing and similar policies that have bureaucrats deciding what's best for patients. No patient should have any reduced coverage for any medication, nor should they have the medication they currently rely on switched due to Bill 102.

1540

Interchangeability of brand and generic drugs is not a decision to be made by pharmacists or bureaucrats, but only by doctors. CARP continues to receive complaints from its members that generic drugs are neither always less expensive nor always as effective as brand drugs. In fact, patients who have been switched to the generic "equivalent" of a brand drug often need to get more refills because of the lack of effectiveness. This actually increases the cost to either the patient or to the government.

The bill should establish a specific and reasonable length of time for Ontario to review a new medication after it is adopted by Health Canada. We recommend the Quebec model, which ensures that all new drugs are reviewed within six months after they are approved by Health Canada.

The bill's promise of faster access applies only to breakthrough drugs, but the term "breakthrough" is not defined and could drastically limit the number of new drugs that get reimbursed.

Any drug that works for patients to prevent or treat illness is a breakthrough for those patients and should be made available to them. Apparently, small differences between drugs can make crucial differences to patients, which is why physicians must have the final say about as broad a range of therapies as are deemed safe by Health Canada. Accordingly, the term "breakthrough" must be clearly defined.

CARP is concerned that the executive officer who will manage Ontario's drug system will be a bureaucrat appointed by, and accountable only to, the Minister of Health and Long-Term Care. CARP believes that this should be an arm's-length position that is directly accountable to the public and a panel of independent experts.

Although, as previously noted, CARP supports the establishment of a citizens' committee to advise the executive officer, we are concerned that this committee will be strictly advisory and that its recommendations need not be heeded by the executive officer. Therefore, CARP recommends this committee and the executive officer work together in partnership. Otherwise, the committee is just window dressing.

The government must adopt, as a basic principle in its negotiations with pharmaceutical companies and pharmacies, that patients' access to prescription drugs must not in any way be jeopardized, reduced or limited as a result of negotiations.

The policies outlined in the bill could severely limit access to drugs and pharmacies by Ontarians, especially those who live in small towns and rural communities serviced by a single pharmacy. These pharmacies could be forced to close their doors because their income will be greatly reduced.

It is estimated, we understand, that as many as 300 pharmacies could be closed as a result of the changes in income structure—that is, the rebates—caused by the bill. Those who do survive could end up reducing the range of drugs they carry, forcing patients to wait for special orders. Even large pharmacy chains could be negatively impacted.

There is a fear that more restrictions on, and not enough incentives for, the pharmaceutical industry and their research—including funding—may hamper the development of this industry in the province and that many jobs will also be lost. Rather, Ontario should follow the example of Quebec and other provinces, like Manitoba, that encourage this industry.

The bill should include the establishment of drug management programs and enhance other aspects of preventive care that will make taking drugs even more effective, such as nutrition counselling, exercise programs and timely access to tests to monitor progress. Patients need more information to make them more involved players in their own health care.

Doctors' having the final say in prescribing drugs, better compliance by patients in taking their prescription drugs, and greater support services such as just listed above will ensure better all-round health and improved

cost-effectiveness for the province's investment in prescription drugs.

The bill must recognize and support the core role played by drugs in Ontario's home care system which, in turn, frees up hospital beds. In this way, waiting lists as well as general health care costs will be reduced. At the same time, recovering patients can be made more comfortable within familiar surroundings. However, if the availability of drugs is in any way limited, the effectiveness of the home care program will be severely reduced with a corresponding lengthening of hospital stays and increased returns.

In summary, we recommend the following changes:

- the clear prohibition of any type of containment using reference-based pricing, maximum allowable costs or therapeutic substitution;

- the establishment of a specific and reasonable time on the length it will take Ontario to review a new medication after it is approved by Health Canada;

- a clear definition of the term “breakthrough” drug;

- the adoption as a basic principle in negotiations between government and pharmaceutical companies and pharmacies that patients' access to prescription drugs must not in any way be jeopardized, reduced or limited;

- the Citizens' Advisory Committee and the executive officer should work in partnership;

- the establishment of drug management programs and enhancement of other aspects of preventive care that will make taking drugs even more effective, such as nutrition counselling, exercise programs and timely access to tests to monitor progress; and finally,

- recognition and support for the core role played by drugs in Ontario's home care system, which in turn frees up hospital beds and the concomitant reduction of waiting lists as well as general health care costs.

The Chair: Thank you, Mr. Gleberzon. We really have just a handful of seconds per side. We'll begin with Mrs. Witmer, please.

Mrs. Witmer: Thank you very much for the excellent presentation. What can I say, other than that we certainly will be prepared to support your recommendations? They're excellent. I think you've pointed out all of the shortcomings of the bill and I compliment you on that.

Ms. Martel: Thank you for being here today. On page 2, you “understand that the ministry is prepared to amend the ... term ‘similar.’” Can you tell us what you know with respect to that change?

Mr. Gleberzon: That's exactly what we know; that's the extent of it.

Ms. Martel: So you're in the same boat we are.

Mr. Peterson: Thank you very much for being here. Obviously you have a big concern about the interchangeability. Could you give us a little more information on that and your view of the definitions that we've got, that we're looking at.

Mr. Gleberzon: As I said, we understand that the government is taking a very serious view of these issues. I've heard similar concerns from other groups. We're

concerned that—and we get a lot of feedback from our members, who tell us that when they are—

The Chair: Mr. Gleberzon, I will have to intervene, with apologies. Please feel free to communicate that information to us in writing, or even personally after the committee deliberates today. I'd like to thank you on behalf of the committee for your presence, deputation and written submission on behalf of CARP/50Plus.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair: On behalf of the committee, I now invite our next presenter, Doris Grinspun, executive director of the RNAO, the Registered Nurses' Association of Ontario. Ms. Grinspun, I invite you and your colleague—as you've seen the protocol, you have 10 minutes in which to make your presentation. I'd also ask that you just identify yourselves, for the purposes of the permanent record, for Hansard recording. Your time begins now.

Ms. Doris Grinspun: Thank you very much. Good afternoon. My name is Doris Grinspun and I'm the executive director of the Registered Nurses' Association of Ontario. With me today is my colleague Sheila Block, director of health and nursing policy in our association. I would like to thank the committee for the opportunity to comment on this very important piece of legislation.

RNAO's mandate is to advocate for healthy public policy and for the role of nursing in shaping and delivering health services. For us nurses, health care is a human right. And it is in this context that I am making my remarks today.

Nurses know that prescription drugs when used appropriately are essential in sustaining life and in improving the health of people in Ontario. However, nurses have been concerned for some time about the skyrocketing cost of drugs and the effect this expenditure has on the sustainability of our health care system and the impact it has on access to drugs. Over the past 10 years, costs have soared by almost 170%. This growth in drug expenditures has outstripped that of other expenditures in the overall health care budget. If current trends continue, drug costs are certain to keep climbing.

We agree with Minister Smitherman's comment earlier this year that “our drug system has been failing us.” That is why we welcome this legislation. The proposals in Bill 102 address many of the shortfalls in our current drug system: the growth in expenditures I just described; high prices of essential drugs; a lack of transparency across the system; and that we don't do enough to ensure that drugs are prescribed in a safe, effective and cost-efficient manner.

1550

RNAO supports the proposed legislation because it will make good progress on these crucial issues for the health care system, but we also have some suggestions on how to strengthen them.

Governance: In the area of governance, RNAO supports the creation of an executive officer because this

office has the potential to increase the efficiency and effectiveness of our provincial drug system. We caution that Ministers of Health should not try to off-load political responsibility for drug programs onto this office.

Transparency: We also welcome the effort to increase transparency, responsiveness and accountability of the drug system. To this end, we agree with the plan to appoint patient representatives to a Committee to Evaluate Drugs and the creation of a Citizens' Council to help guide public policy. However, we urge the government to set up a transparent process so that appointments to these two bodies and the executive officer are at arm's length from the government and industry. We also recommend regular reporting to ensure accountability. These measures should be enshrined in regulation.

Access: With respect to the measures to improve access, our support is qualified. We know that streamlining approvals for some drugs can save precious time and increase access. However, we caution that the safety of the drug system must not be compromised by making testing less rigorous, and in the interest of transparency and accountability, the public should have access to all information about drug approvals.

Use of generic drugs: RNAO supports greater flexibility to allow pharmacists to dispense a generic drug in place of a brand name drug. However, we recommend that the government continue to fully reimburse "no substitution" prescriptions for people who experience adverse reactions to substitutes.

Pricing of drugs: RNAO supports the proposed measures to control drug prices, and urges the government to strengthen the capacity of the executive officer to control costs by giving this office the power to negotiate a price change for drugs after they are on the formulary, as well as when they are being placed on the formulary.

Appropriate use of drugs: We support the measures to ensure appropriate use of drugs. However, RNAO urges the government to invest a sufficient amount of resources for the best guidelines and innovation research fund to support these efforts.

In conclusion, we believe this legislation represents a balanced attempt to streamline a complex and expensive drug system, making it more effective and more sustainable. It levels the playing field and will support the sustainability of our medicare system. However, one thing is important to remember: Bill 102 does not address a fundamental issue with respect to drug policies. Many Ontarians do not have access to drug benefit plans. Inadequate access to essential medications based on the ability to pay is both unfair and compromises health. For that reason, we continue and will continue to call for a pharmacare program that covers all Ontarians.

I thank you for the opportunity to speak to you today and express my hope that you will consider the recommendations made by nurses today.

The Chair: Thank you, Ms. Grinspun. We'll have about 90 seconds each, beginning with Ms. Martel of the NDP.

Ms. Martel: Thank you, Doris and Sheila, for being here today. I want to focus on your concern that no attempt should be made to transfer political accountability for the drug programs from the minister. Yet, I look in the bill, and subsections 14(1) and (2) transfer responsibility from the minister to the EA. Subsections 15(1) and (2) and subsections 16(1), (2), (3), (4) and (5) transfer that responsibility. Subsections 17(1), (2) and (3) all transfer responsibilities from the minister to the executive officer. Some of these are quite fundamental: the designation of drugs to the formulary; the negotiation of agreements with manufacturers of drug products that used to be done by regulation by the minister, LG, are now going to be done by the executive director. There are any number of provisions in here where that happens. I remain very concerned that that's exactly what's going to happen under this bill. If you want to comment, that would be great.

Ms. Grinspun: What we attempted to suggest here is that the office is very important though at the same time we do not want to see any minister off-load the political responsibility and decisions on the program. It will be important and we will keep a close eye that that be the case.

Ms. Wynne: Doris, thanks very much for being here. On the issue of the model that we're using in terms of the executive officer, the model is analogous to the general manager of OHIP and reports to the deputy minister. As far as we're concerned, that sets up a situation where there will be accountability and there will be enough control over the office. Is that your feeling about the way it has been set up?

Ms. Grinspun: It is our hope that that's the way it will function. It is being set up in that way. But the reason why we say it's our hope is that we caution the Minister of Health not to try to off-load the political responsibility; so at the same time that we want the executive officer to have significant powers, we also need to watch that we don't wash our hands from—

Ms. Wynne: So it's a balance, and that's what we're trying to strike.

Ms. Grinspun: Absolutely.

Ms. Wynne: Thank you.

Mrs. Witmer: Thank you very much, Doris, for your presentation. It's thorough, as always, and you've covered lots of points.

I just want to take a look at the use of generic drugs. Obviously, you support the expanded scope for interchangeability. Then you "recommend that the government continue to fully reimburse 'no substitution' prescriptions for" clients with "adverse reactions to substitutes." So what would you see the process being? Would you see a patient going through and trying all of the generics and having adverse reactions and then being put back on the brand? What would be the process?

Ms. Grinspun: The process will be that the patient will work closely with both his health care provider—that being a physician or a nurse practitioner; both prescribe drugs—and with the pharmacist. In most cases,

there are actually no side effects to most drugs and we know that from utilization. We are saying that in the event a patient experiences an adverse effect and knows it, that patient shouldn't go through 20 different drugs; that patient should be exempted and the drug should be covered. But if you look at the research, the great majority of situations is that, first of all, there are no side effects, and also the impact, which is equally important, is negligent.

The Chair: Thank you, Mrs. Witmer, and thank you to you as well, Ms. Grinspun, and to your colleague for your deputation presence and written submission on behalf of the RNAO.

I would, incidentally, just before we call the next presenter, notify all members of the committee that 12 noon tomorrow is the deadline for written submissions for amendments. As well, there will be a vote in Parliament tonight at approximately 5:50, and we're just deciding what the committee will need to do in terms of protocol for that.

CANADA'S RESEARCH-BASED PHARMACEUTICAL COMPANIES

The Chair: Having said that, I will now invite our next presenter to the podium, and that is Mr. Russell Williams, the president of Canada's Research-Based Pharmaceutical Companies. The written submission has already been distributed. As you've seen in the protocol, Mr. Williams, you have 10 minutes in which to make your combined presentation, beginning now.

Mr. Russell Williams: Thank you very much. It is indeed a pleasure to be here today along with Walter Robinson, the vice-president of provincial affairs of the Rx&D. I'm pleased to present on behalf of Rx&D today.

Let me begin by saying that decisions concerning Bill 102 could affect the quality of life, the economic prospects and the health outcomes of millions of people in the province for years to come. Rx&D member companies believe strongly that Ontario's decision makers should reassess the possible short-term savings with the risk of compromising much greater long-term benefits.

But before I go into it, let me describe briefly who we are. In Ontario, the research-based pharmaceutical community employs 9,000 people in high-paying, knowledge-based jobs and generates about 25,000 jobs in other industries. Each year, companies inject over \$2 billion into Ontario's economy.

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Something people don't know very much about is that there are 40,000 Ontarians who are on clinical trials—40,000 people who are benefiting from innovative drugs quicker than they normally would have. This is phenomenal; a huge impact for the patients, for the health care system—because it's relatively no cost—and for the medical profession, giving them a choice of new alternative medicines.

We collectively invest more than \$360 million in research and development in this province, with \$50 million going directly to universities and hospitals.

Notwithstanding other claims, ours is the only pharmaceutical industry that does research into new medicines and vaccines to bring new treatments and new hope to patients.

Our members adhere to a rigid, transparent and mandatory code of conduct in our relationships with health care professionals. That's something we've worked on and that I'm very proud of and it's important to mention to the members of the committee.

Let me discuss the value of medicines. New medicines and vaccines save lives, relieve pain, cure and prevent disease. They frequently help to avoid the need for invasive procedures and hospital stays and lessen the impact of chronic conditions. Here are a few statistics:

Over the past two decades, death rates in Canada from bronchitis, asthma, emphysema, AIDS, heart attacks, heart disease and chronic liver disease have all fallen dramatically.

Pharmaceuticals in some way have helped to, in the same period, reduce hospitalizations; for instance, 60% for ulcers and AIDS; 40% for diabetes, respiratory disease and chronic liver disease.

And in the same 20 years, life expectancy has increased by four years in Ontario alone. When you think about that in terms of the phenomenal impact on Ontario, I think we should all be impressed.

Patented prescription medicines represent less than 8% of every dollar invested in the health care system. Yes, this proportion has been rising, but that is given to the very important role that we are helping Ontarians live longer, healthier lives. This money is well spent—and I know that this is very important to all of you as legislators—because it has been proven that every dollar invested in newer medicines actually can help save up to \$7 elsewhere in the system.

In Bill 102 there are some positive aspects, and we have been supportive of the need to improve the drug system in Ontario. We have on numerous occasions offered our best ideas and our best suggestions of how to improve the sustainability of our health care system. Let me highlight a couple of the points that are positive in 102:

- more patient involvement. As an ex-legislator myself, I've always been very, very supportive of better-informed patients making better decisions;

- an enhanced role for clinical pharmacy and patient counselling;

- the potential for faster listings for innovative medicines. We still have questions as to how that would happen, but the potential is quite encouraging; and

- reduced paperwork for physicians and pharmacists.

However, we are profoundly concerned about the impact that Bill 102 will have on the quality of patient care and innovation. Let me tell you Ontario's track record. In the last two years, Ontario listed only 15% of

new medicines approved by Health Canada and launched in this country—only 15%.

The legislation should ensure that the value of incremental innovation is recognized for the ability to better treat disease and advance patient care. All incremental research should be recognized, and all research is based on the research of somebody else.

In addition, we have grave concerns about Bill 102 in the following areas:

It opens the door to therapeutic substitution through an expanded definition of “interchangeability”—“same” vs. “similar”—and through the introduction of “competitive agreements” as modeled on the cost-containment framework at the Department of Veterans Affairs in the US. One size does not fit all in health care. This door should be closed.

We are not convinced that the introduction of off-formulary interchangeability (OFI) will actually save employers and patients money.

Bill 102 also reduces the ability of the innovative pharmaceutical industry to invest in research and development by introducing price rollbacks. Already, prices in Canada are controlled federally and are 9% below the international median. There basically has been stabilization of prices for the last 20 years.

The executive officer’s extraordinary powers—we believe that although moving it away from cabinet decision is good, we must make sure that those powers are put in check and balance and that there’s a proper appeal process.

Bill 102 is inconsistent with the Ontario government’s strategy in fostering innovation, innovation in health sciences and creating jobs. The Premier, recently quoted in Chicago: “Places that invest in innovation will be home to the most rewarding jobs, the strongest economies and the best quality of life.” Competition for Rx&D investments is global and extremely fierce. Ontario competes with Europe, the US and emerging markets like China and India to attract those dollars. Presently, the province boasts the third-largest biomedical and technology cluster in North America. If Ontario is not seen as innovation-supportive, if our industry is negatively affected by \$500 million a year, how will the biopharmaceutical community grow? More likely, it will decline, patients would lose, research would lose and Ontario would lose.

Our solutions, as I run through this very quickly: If the bill could be amended, include four principles of partnership:

(1) Improved access to new medicines, respect for the doctor-patient relationships and a primary focus on approved outcomes for patients.

(2) Integration with the province’s innovation agenda to create more jobs and a better quality of life. You know and I know that if you can organize two departments together, they are much stronger.

(3) An integrated approach to health care that looks beyond the silos, so it will understand the effect of pharmaceuticals on the rest of the system.

(4) It has to be consistent with the letter and spirit of Canadian laws, and that innovation is recognized and protected. If it’s recognized, we’ll be able to see great growth.

We hope that the government will go beyond the traditional supplier-customer relationship, that our products are not just commodities. Our industry can help build a stronger economy.

In closing, we urge the committee and the government to look at drug spending and its effect on the overall health budget, not just on silos, and look at innovation in health care and research as an investment for the future. We all know we need a health care system that is sustainable and predictable. We can help the government achieve this goal. But if innovation isn’t rewarded in Ontario, innovation will go elsewhere and we will not help to achieve this goal. The committee has an opportunity to strengthen the bill so it better delivers outcome for patients and builds on Ontario’s knowledge economy.

Ladies and gentlemen, thank you for the opportunity to quickly go through our concerns. I wish you well on the deliberation of this very complex and very important bill facing the people of Ontario.

The Chair: Thank you, Mr. Williams. You’ve left about 40 seconds for the government side.

Mr. Peterson: Thank you for your presentation. I come from Mississauga, commonly known as “Pill Hill,” and we appreciate the quality of jobs that you and your industry have brought in.

One point you make is that higher prices will spawn larger R&D, and that R&D I guess includes clinical trials as well as new product development, yet the generic industry has much lower prices and actually has a much higher percentage of R&D, and their business is actually developing. Can you explain this difference to us?

Mr. Williams: The R&D for new medicines is well over \$1 billion. Generics are in the business of copping our products, and there’s a legitimate role for generics in the health care system, but the investment for research is over \$1 billion. Very few products actually make it to market. Seven out of 10 molecules actually don’t make it to market. So the research—

The Chair: With apologies, I will have to intervene there and offer it to the PC side.

Mrs. Witmer: Thank you very much for your presentation, Mr. Williams. What was your reaction when you heard Mr. McGuinty quoted at the Bio 2006 conference in Chicago that “places that invest in innovation will be home to the most rewarding jobs,” and at the same time the minister had introduced a bill which seemed to be in contradiction?

Mr. Williams: Clearly, the bill and the innovation agenda are incompatible, they are inconsistent, and we have to make sure from the government’s perspective that an agenda for health and an economic agenda are put together. Together, I think we actually can invest in health care, help the economy grow and help patients at the same time. Right now, as written, they are clearly and totally inconsistent.

Ms. Martel: Thank you for being here today. The legislation doesn't say anything about the innovation fund. What would be your recommendation in this regard?

Mr. Williams: I think the innovation fund has to be built in an overall agenda that is partly the fund, but also a number of government initiatives that are very complex so that it helps Ontario take on the rest of the world. It won't just be the fund, it will have to be a number of other issues, and we are very prepared to sit down and follow the committee's recommendation to try to map that out with the province.

The Chair: Thank you, on behalf of the committee, Mr. Williams, for your presence and deputation on behalf of Rx&D, Canada's Research-Based Pharmaceutical Companies.

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ONTARIO MEDICAL ASSOCIATION

The Chair: I would now invite to the podium our next presenters, representing the Ontario Medical Association: Dr. David Bach, the newly installed president of the Ontario Medical Association, as well as Barb LeBlanc and Rachel Roberto from OMA staff. Please identify yourselves for the purposes of Hansard recording. As you've seen the protocol, you have 10 minutes in which to make your address. Welcome and please begin.

Dr. David Bach: Thank you, Dr. Qaadri, ladies and gentlemen. I'm Dr. David Bach. I'm a radiologist in London, Ontario, and I'm the president of the Ontario Medical Association. With me are Barb LeBlanc and Rachel Roberto from OMA staff.

The OMA would like to commend the government on the introduction of the Transparent Drug System for Patients Act, Bill 102, and its effort to transform the province's publicly funded drug system. We believe that government's attempts to improve access and transparency within the system will have a positive impact on the profession and on our ability to care for our patients.

We are pleased to have the opportunity to comment upon those parts of the bill we believe will affect patient care. We will identify areas of interest or concern and will offer some specific recommendations for change, where possible.

The OMA believes that the creation of the position of the executive officer to manage the government-funded drug programs and the transfer of the functions and powers of the minister and Lieutenant Governor in Council to the executive officer to make formulary listing decisions are important developments. The current system, whereby products are listed on the formulary through cabinet decisions, is a long and arduous process which holds up needed approvals by months and denies patients necessary care. We expect that by devolving cabinet's authority to make listing decisions to the executive officer, approval times will be accelerated, patients will have greater access to necessary medications and they will be able to receive more timely care.

The OMA would like to briefly comment upon the proposed clause relating to the definition of interchangeability, such that products may be designated as interchangeable not only where they have the same active ingredients in the same dosage form, but also where they have "similar" active ingredients in a "similar" dosage form. As written, this would permit the executive officer to authorize "therapeutic substitution," so that a drug of the same or of a different class could be substituted for one that is prescribed. This has the potential to put patients at risk, and the OMA would speak strongly against such a move. We understand from ministry staff, however, that the change in the definition of interchangeability is not intended to permit therapeutic substitution and therefore we recommend that Bill 102 be amended to ensure that the new definition of interchangeability does not permit therapeutic substitution and that it accurately reflects the government's stated policy directions.

The OMA understands retroactivity—in section 25, clause 16(5)—to mean that the executive officer may authorize an "exceptional access" drug retroactively and may make coverage for the drug retroactive. If this assumption is correct, the OMA supports this amendment, since under the current section 8 process, patients must often wait weeks and even months until the required section 8 approval occurs and the patient who pays for the drug out of pocket during the period between prescription and approval is not reimbursed. If, however, our understanding of this clause is incorrect, we recommend an amendment to permit retroactive payment.

The OMA strongly supports the proposed attempts to bring better access and efficiencies to the system through the elimination of the "limited use" and "individual clinical review"—section 8—processes with the aim of moving to a conditional listing and exceptional access mechanism. The cumulative effect of the LU and section 8 programs has been one of the most profoundly negative impacts we have seen upon physician practice over the past decade. In 2004 alone, there were 143,370 requests processed through the section 8 mechanism, a program whose original mandate was to provide a means to access unlisted drugs in special circumstances. Over the years, physicians have spent increasingly more time on paperwork, which means less time caring for our patients. We must reverse this trend. The OMA is committed to working with the government to eliminate LU and section 8 as quickly as possible. This issue is of critical importance to physicians, and the OMA will monitor it closely to ensure that the new programs reflect the government's intent to reduce the burden on physicians and improve patient access to necessary medications.

We also note that section 8 and LU programs have been almost impossible to change because key elements are enshrined in regulation. Therefore, we recommend that Bill 102 and its regulations outline only the basics of the conditional listing and exceptional access programs, and that the government leave the mechanics of the new programs to policy so that they are adaptable to change.

The OMA believes that the government should use this legislation as an opportunity to exercise leadership in controlling costs and promoting appropriate prescribing by prohibiting the sale of physicians' prescribing profiles to companies like IMS which, in turn, sell the information to the pharmaceutical industry for targeted drug detailing to physicians. The OMA recognizes that information about one's own prescribing practices can be useful for educational purposes, but the use of this information for marketing is both unprofessional and unacceptable.

The OMA recommends that government prohibit the pharmaceutical industry from utilizing physician-prescribing information for pharmaceutical detailing.

The OMA would also like to note that Bill 102 does not include any provisions to deal with multiple-drug seekers who continue to be a serious problem in clinical practice and in society. There is currently no integrated system whereby physicians and pharmacists can communicate to each other that narcotics have been prescribed to a patient and that a patient is a suspected drug seeker.

Therefore, we recommend that government consult with physicians and pharmacists about options, such as triplicate prescription pads, in an effort to combat the problem posed by patients seeking multiple prescriptions for narcotics and other controlled substances.

In closing, the Ontario Medical Association has long advocated for changes to the provincial drug system. We are hopeful that Bill 102 will facilitate the transformation of the system so that it is less burdensome for physicians and improves access for patients. Of course, many of the changes will come out of the policy recommendations from the drug system strategy review and from future regulations, and we look forward to discussing those as they develop.

Thank you for the opportunity to respond to Bill 102. We'd be happy to answer any questions you might have.

The Chair: Thank you, Dr. Bach. We'll begin with the PC side. Ms. Witmer, about a minute or so.

Mrs. Witmer: Thank you very much, Dr. Bach. You mention there's currently no integrated system whereby physicians and pharmacists can communicate, and that came up last week in a panel discussion I was on. How quickly do you think that system should be established?

Dr. Bach: I think it's necessary now. How quickly it would take would depend on—I don't know the mechanism to establish that.

Mrs. Witmer: What do you think the benefits would be as far as utilization of drugs prescribing?

Dr. Bach: The difficulty is drug seekers who get repeat prescriptions and sell them on the street. That would be one problem. Others would just be abuse. So I think there are real advantages to controlling access.

Do you want to add something, Barb? I think my staff would like to add something.

Ms. Barb LeBlanc: We have demonstrated very positive effects in other jurisdictions, particularly out west, whereby you see both improvements in safety—

Mrs. Witmer: I guess that's what I was getting at.

Ms. LeBlanc: Yes. There are demonstrated—

The Chair: With apologies, I will have to offer the floor now to Ms. Martel of the NDP.

Ms. Martel: Thank you for being here today. I'm working off your page number 2, where you say you'd like to "comment upon the proposed clause relating to the definition of interchangeability." Which section are you operating under when you make that change?

Dr. Bach: That's subsections 3(4) and (5) of the act.

Ms. Martel: Do you want that taken out altogether or the current legislation that's under DIDFA to go back into effect?

Dr. Bach: We'd suggest that Bill 102 be amended to ensure that the new definition of interchangeability does not permit therapeutic substitution.

Ms. LeBlanc: While we recognize where the government's policy intent is, to provide a little bit of latitude that does not currently exist, we think that this language is too broad, so we would suggest an amendment that helps to clarify—

The Chair: Thank you. The government side. Mr. Ramal.

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Mr. Khalil Ramal (London–Fanshawe): Thank you, Dr. Bach, especially since you are up from London. London's a great city, with a great medical centre. Welcome.

Just some questions about section 8; you were concerned about section 8. I'm wondering if you knew that the government's trying to change section 8, to replace it with a better mechanism; you've probably heard about it. The second question is about interchangeability and broad language. If the government tightened the language better than in this bill right now, do you think the bill would go in the right direction?

Dr. Bach: I think if the language were strengthened, the bill would certainly be in the right direction, and the government should be commended for bringing this forward. We support this approach.

The Chair: Thank you to the members of the government side, and thank you as well, Dr. Bach, and your colleagues Mesdames LeBlanc and Roberto, for your deputation, presence and written submission on behalf of the Ontario Medical Association.

PSYCHIATRIC PATIENT ADVOCATE OFFICE

The Chair: On behalf of the committee, I would now invite our next presenters. They are Stanley Stylianos, program manager, and Lisa Romano, legal counsel, of the Psychiatric Patient Advocate Office, and colleagues. You've seen the protocol: You have 10 minutes in which to make your combined presentation. I invite you to begin now.

Mr. Stanley Stylianos: Good afternoon. As mentioned, I'm Stanley Stylianos, program manager with the

Psychiatric Patient Advocate Office, and this is Lisa Romano, our legal counsel.

I'm going to tell you a little bit about our office. The Psychiatric Patient Advocate Office, PPAO, is an arm's-length office of the Ministry of Health and Long-Term Care. The PPAO provides individual advocacy, rights protection and rights advice to clients in the current and former provincial psychiatric hospitals in Ontario. Through its community rights advice service, the PPAO provides rights advices to nearly all psychiatric units of schedule 1 and 2 hospitals throughout Ontario. For more than two decades, the PPAO has advocated strenuously on behalf of consumers of mental health services in an effort to address significant local, regional and provincial systemic issues.

As a rights protection organization, the PPAO is particularly concerned about the protection of vulnerable individuals who are consumers of mental health and other health care services. Access to needed drug therapies is of paramount importance to individuals diagnosed with mental illness who are recipients of drug program benefits and for whom drug treatment is an essential ingredient in their recovery and continued well-being.

We are hopeful that the proposed legislation will never erect barriers to access for our clients and that the cost will never be a determining factor when deciding if clients should have a particular medication. Clients must be able to access the medication that works best for them and achieves the best results.

The planned strategy has the potential to reduce rising drug costs and benefit consumers through specific procedural changes and increased public involvement and scrutiny. Bill 102, as a first step in the direction of reform, begins to lay a framework that requires further development to be fully realized.

The PPAO applauds the government's efforts to stem rising drug costs and develop a system that more effectively meets the needs of consumers. It is anticipated that any savings realized by an overhaul of the existing system may be reallocated to other areas of need within the health care system, providing both immediate and long-term dividends to consumers and the public at large. However, a number of questions have arisen for us regarding the procedural and structural changes captured in the proposed amendments. In our submission, we would like to highlight several areas that require clarification or strengthening.

The first is the executive officer. Bill 102 transfers the authority and the responsibilities of the minister for managing and overseeing the public drug system to an executive officer who will be appointed by the Lieutenant Governor in Council. This represents a significant shift in the administration of this program, giving considerable and broad authority to the executive officer. The powers of the executive officer include, for example, maintaining and publishing the formulary, designating interchangeable products, listing and delisting drug products, negotiating agreements with drug manufacturers, and ensuring compliance with the legislation.

While the Lieutenant Governor in Council may make a regulation "clarifying, modifying or restricting the functions and powers of the executive officer," the legislation is silent on the qualifications and criteria for appointment of the executive officer. Given the scope and authority of this position and the stated goals for reforming the drug program, the PPAO believes that it is critical that qualifications and appointment criteria be articulated within the legislation. Successfully implementing comprehensive reform to Ontario's drug program hinges on selecting the right individual for this important role.

Next, public interest: Bill 102 permits the executive officer to designate a product in the formulary as a listed drug product, or to designate a product as being interchangeable with another product, if it is in the "public interest" to do so. Given the broad powers of the executive officer, there should be a definition for "public interest." It is a well-established principle of statutory interpretation that words or phrases be precise and unambiguous.

Governance principles: The proposed legislation articulates five governance principles in the preamble to the Ontario Drug Benefit Act intended to enhance both accountability and transparency. In summary, these include: serving the needs of consumers and taxpayers; involving consumers and patients in a meaningful way; transparent operations for all stakeholders; ensuring the most effective use of resources at all levels; and basing funding decisions on the best clinical and economic evidence, and openly communicating these decisions.

The inclusion of these principles underscores a commitment to building a system that clearly works in the interest of consumers and taxpayers, involves and informs stakeholders, and makes evidence-based economic decisions; yet the legislation fails to operationalize these principles. This is an important omission. That the minister and executive officer "may" consult stakeholders with respect to matters arising from the legislation falls somewhat short of the mark, where a requirement for regular consultation might be expected.

Elsewhere, the government has made a commitment to involving patients in the drug listing decision-making process, through representation on the Committee to Evaluate Drugs. In addition, a Citizens' Council has been proposed to provide the public with an opportunity to shape drug policy. A Pharmacy Council has also been proposed to assist in the development of policy and reimbursement models for pharmacists.

The PPAO is supportive of the inclusion of patient representatives in the drug evaluation process, and would recommend further that a subcommittee be formed specifically to address mental-health-related medication issues. We would also recommend that guidelines be established for committee and council membership to ensure equitable representation.

We believe it is fundamental to define mechanisms for the inclusion of stakeholders in the decision-making processes within the statute. Similarly, the legislation should

outline mechanisms and guidelines for public reporting of relevant committee work and drug reviews. This will help to ensure transparency and accountability.

Regular reporting on medication usage in Ontario should be established, and will contribute significantly to heightened public awareness and support the aim of meaningful involvement of consumers.

In keeping with efforts to promote the appropriate and safe use of medication, the creation of a database that advises the public about adverse medication events should be considered.

Improved accessibility: Under the proposed legislation, the executive officer will have the authority to add or remove drugs from the formulary without the introduction of a regulation. This will, to an extent, streamline the process of adding and removing drugs from the formulary. Access to interchangeable drugs will be improved insofar as drugs may now have the “same amounts of the same or similar active ingredients in the same or similar dosage form...”

The PPAO supports initiatives to streamline the process of drug inclusion in the formulary and to broaden the scope of what might be considered equivalent and interchangeable, providing mechanisms for the inclusion of consumer feedback in the decision-making process are established. Some consumers have expressed concern that generic products considered to be biologically equivalent to brand name products may prove less effective. Though we understand that empirical findings do not support this concern regarding reduced efficacy for generic medications, we believe that anecdotal evidence from consumers, physicians and pharmacists should be considered.

Many clients of the PPAO have very low or limited incomes as they are in receipt of some form of social assistance, either Ontario disability support program or Ontario Works. We would recommend that clients whose only source of income is provided by the provincial government be exempt from paying any co-payment when having their prescriptions filled.

Complaint process: Neither the legislation nor announced government initiatives have identified a complaint or appeal process respecting decisions of the executive officer. In our opinion, this is a critical omission. There needs to be some avenue to address concerns arising from particular decisions, policies or the management of the public drug program in general.

There is a potential advantage in having a single, dedicated individual such as the executive officer administer the public drug program, providing he or she has the appropriate background and expertise. The overarching authority of this role in decision-making may significantly simplify and streamline decision-making.

However, with the delegation of the minister’s authority there is a potential loss of political accountability. The Lieutenant Governor in Council may potentially change or limit the function and power of the executive officer through the introduction of regulations.

The PPAO holds that there is a need to establish a complaint resolution process as an additional and more

immediate accountability mechanism. Without such a process, stakeholders are deprived of a means of addressing their concerns and tempering the authority of the executive officer.

Finally, the PPAO supports the proposed legislation in the context of the government’s overall strategy to increase reliance on generic drugs, broaden the array of effective, interchangeable medications, increase consultation with consumers and other stakeholders, and improve transparency through public reporting mechanisms.

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

Ms. Martel: Thank you very much. With respect to a complaint resolution process, do you have any ideas how that might work that you could share with the committee?

Mr. Stylianos: We haven’t thought through this very clearly, but I think we would say we would like to see something added to the legislation that would identify the process.

Ms. Martel: As an appeal mechanism.

Mr. Stylianos: As an appeal mechanism.

The Chair: Thank you, Ms. Martel. To members of the government side, Dr. Kular.

Mr. Kular: Thank you for your presentation. I’m a family doctor turned politician; I still do some medical practice. The question I have for you is, because you have said in your presentation that you would like qualifications and criteria for the executive officer, what do you think should be the qualifications and criteria for selection?

Mr. Stylianos: I think there has to be a sensitivity to issues from a variety of stakeholders. Clearly, I think the individual who takes on this role has to have a non-partisan perspective, and there has to be something within the legislation to guarantee that.

The Chair: With apologies, I will have to intervene. Thank you, Dr. Kular. To the PC side, Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. Mine has to do with improved accessibility. You recommend the inclusion of anecdotal evidence in drug listing decision-making. What process would you suggest be used in order to make that happen?

Mr. Stylianos: That’s another issue that I think requires some further thought on our part. There is talk about a consultative process in terms of working with consumers. Perhaps if that mechanism were established, there would be an opportunity to discuss some of that more fully in terms of what mechanism would work best in making some of those decisions.

The Chair: Thank you, Mrs. Witmer, and thanks to you as well, Mr. Stylianos and Ms. Romano, for your presence, written submission and deputation and testimony today on behalf of the Psychiatric Patient Advocate Office, the PPAO.

GORDON PHARMASAVE

The Chair: Now, on behalf of the committee, I would invite our next presenter, Mr. Ron Chapleau, owner of Gordon Pharmasave. Mr. Chapleau, as you've seen, you have 10 minutes in which to make your deputation, which begins now.

Mr. Ron Chapleau: Good afternoon. Thank you for taking the time to listen to me on a topic that will have a major impact not only on myself but on my family, my staff and my patients. My name is Ron Chapleau. I'm a pharmacist and an owner of a small-town pharmacy in Kincardine, Ontario, a town of about 6,000 on the shores of Lake Huron, for those of you who don't get up there that often.

Let me preface my criticisms of this bill by saying that I believe in all honesty that I think it's well-intentioned and it's necessary. I don't think that anybody who practises health care or who is responsible for administering the money to fund it are under any illusions that the present situation is sustainable for the long term. Changes, including cuts, are required, and I and many of my colleagues are prepared to take a hit to our bottom lines in order to maintain or hopefully improve the level of care that citizens of Ontario have come to expect.

However, where this bill falls short, in my opinion at least, is in its execution. I know it will have a negative impact on the quality of health care pharmacies are able to provide and will also lead to a loss of stores, particularly in rural Ontario where the population base is not large enough to support a 10,000- to 15,000-square-foot store with groceries, cosmetics and the like. While I applaud some of the amendments that have been made so far, such as the elimination of the \$25 cap on markups and the proposal of a 20% educational allowance, these do not go far enough to keep some single-town pharmacies operating or to prevent the rest of us from drastically altering our staffing levels and, hence, the level of care we are able to provide.

Let me use my own practice as an example. Our pharmacy is the only one in the downtown core of Kincardine. We have a high percentage of seniors, higher than the average in Ontario; due to the fact that we lack public transportation, most seniors live in that core. We're open seven days a week. We are very busy. I would guess, based on the stats I've seen, we're probably in the top 25% of independent pharmacies. I staff at least two, and often three, pharmacists throughout the day, with four or five assistants, and that's every day of the week with the exception of weekends. My wife, also a pharmacist, and I work between 100 to 115 hours a week, along with the family, so our ability to take on more work ourselves is pretty much nonexistent.

I've been told by reps and by people in my company that we staff generously based upon our volume, but there is a compelling reason for this. We, like many of our peers, work in a town that has a shortage of physicians. As such, much of our day—and evenings, in fact, in a small town—is spent handling queries and

situations that probably fall outside or beyond the scope of our practice as it has been traditionally defined. We do this with the blessings of our physicians, who are all working heavy hours and carrying patient loads that are often well beyond those that are recommended by their college.

We also do this because we are the most easily accessible, and frequently the only accessible, health care worker in our area. Hence, I serve many roles beyond dispensing in my day. I act as a triage nurse, sending some patients to emerg. since we do not have a walk-in clinic and the odds of seeing a doctor in the same week in Kincardine are nearly zero. Far more frequently, I talk them out of a visit to emergency when they could probably help themselves just as effectively. I'm not sure what I save the government in unnecessary hospital visits, but not a day goes by that I do not talk someone who has a run-of-the-mill cold or allergies out of a needless trip to the emerg. There are days when this happens five to 15 times.

As well, frequently we deal with patients who have just been told they have diabetes or some other life-altering diagnosis in the space of a 10-minute office appointment with their doctor. This, once again, is the reality of towns like Kincardine. It's not that the doctors don't care, it's just a fact that they have huge patient caseloads, and if they're going to see their patients in a timely manner, they have to keep things moving. As a result, we frequently spend significant amounts of time sitting in our counselling rooms giving patients the basics of the disease state and the changes they may need to make in order to take control of their own health. This is often followed by one or frequently more phone calls, knowing full well that most of my patients do not fully grasp everything they're told the first time, especially when they may be in an emotionally distraught mood.

Other parts of our day are spent consulting with our home care nurses, offering advice as they see their clients throughout the day. Their inability to get hold of the patient's doctor sometimes in a timely manner has led them to call us with queries or to run situations by us in order to get an opinion as to how necessary it is to get the physician involved. When physician involvement is required urgently, but they're unable to do so before their next client visit, we'll often take over the situation and follow up with the doctor as best we can.

Another part of our day is writing recommendations or concerns to our family doctors about some of the patients whom we see on a day-to-day basis but who may not have appointments for weeks or sometimes even months. It is through this that we are able to intervene on our patients' behalf on an as-needed basis, doing anything from suggesting add-on therapy, modifying existing therapy or, yes, even eliminating some drugs that are causing more harm than good. In this way, patients hopefully get quick resolution to their concerns without having to visit the emergency room and consulting with a doctor who may know little or nothing about them. It also helps to keep our family physicians updated on their

patients and raise their awareness of the need to possibly intervene before the next regularly scheduled appointment.

Added to these day-to-day tasks are the weekly newspaper column we write in our paper about patient-oriented health care and the seminars we give in our community for free about such topics as Parkinson's, antibiotic resistance, fall prevention in seniors, vaccines, and the list goes on and on.

I think the two constants of all of the above roles are, (1) I truly believe they improve the health and well-being of my community and, (2) I receive no direct and, really, no indirect compensation other than customer loyalty. I do not think anything I've mentioned here is really any different than what a lot of my colleagues are doing throughout Ontario. I do not begrudge doing these. They're what make my job more enjoyable and why I bought my store in the first place. But they cost money to perform. I've had a number of sales reps tell me not to worry, that the proposed \$50-million pool for cognitive services was practically made for us. My worries or concerns are twofold. One, I do not know when I'll have the time to fill out the necessary paperwork to prove my intervention and access this money. As I mentioned earlier, I feel strained by my time constraints as it is and I do not want to take time away from patient care to fill out more paperwork. Second, there is very little chance the money I could gain from that pool and the changes in markup and dispensing fee will come anywhere close to the money I will lose from generic companies in the form of rebates. The beauty of that money—and I admit, it's my own opinion—is that it's money I can earn without spending any time away from my patients. There is no other way I could spend so much time doing work for free and still run a viable business.

As I mentioned earlier, I have no problems with absorbing a hit to my bottom line. Cutting the generics to 50% of that of the brand will hurt me substantially because of those rebates, as will the drop in the markup, but I can survive that and I can continue to staff my pharmacy adequately. Besides that, at least from my point of view, it makes sense from a taxpayer point of view. However, eliminating the generic rebates or capping them does put my pharmacy at risk, since I bought mine just a little over two years ago, in April 2004, under the old system, at what I would say is fair market value. It also puts many of my neighbouring pharmacists whom I've talked to at risk as well. They have told me the generic rebates are the difference for many of them between operating in the red versus the black.

I also do not see what this accomplishes for the taxpayer. If the price that the government pays is fixed, how does it aid the taxpayer to constrain my ability to access this money that comes out of the manufacturer's profits?

As an aside, I actually had a conversation a little while ago with a member of the government's health bureaucracy. During our discussion regarding the rebates, amongst other points, he made the point that the system was never intended to have all these extra payments to

pharmacy. He said what they intended to pay for was a fair price for the drug, with a reasonable markup and a reasonable fee. My response to him was that the price of a drug, at least in my opinion, has always included the raw material cost, the research that goes into discovering it and bringing it to market, a reasonable profit for the company itself and, like it or not, the cost to advertise and market it. This is the same for both brand name and generic companies.

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These rebates are the main marketing tool that generic companies have. Eliminating or capping these takes away the ability of some of these smaller companies to generate market share and may in fact act as a disincentive to international generic manufacturers considering entering the Canadian market, which can only lessen future competition.

As well, I don't think there's any way you can justify a \$7 dispensing fee as being reasonable in this day and age. The average fee in Ontario right now is \$10.99, even taking into consideration those chains that use pharmacy as a loss leader. The Ontario Pharmacists' Association estimates the true cost of dispensing at \$10. You can probably quibble with those numbers and dissect them, but no matter what you do, the break-even point is well clear of \$7. We've been able to survive this because the generic industry has subsidized what the government probably should have been paying all these years. From a government perspective, I've always thought this would have been ideal.

The bottom line for me is this: If this bill goes through as is, it will be difficult for me to make my loan repayments to my financial institution. It will absolutely force me to reduce staff and will change the way I do business so that more of what I do actually generates direct revenue. Even with those changes, the future of my store is fragile. If I'm forced to close or go into fill-and-bill mode, I don't think you'll accomplish what you actually set out to do, no matter what you save on the drug file.

The Chair: Thank you, Mr. Chapleau. We'll have about 20 seconds each. To the government side. Mr. Wilkinson.

Mr. John Wilkinson (Perth–Middlesex): Thanks for coming in, Ron. As a rural member, I appreciate your input and the input I've been receiving. So, your position is that we should have rebates, which you say are being used to provide cognitive assistance to patients—which are not provided by all pharmacists—rather than actually paying pharmacists for the cognitive fee and actually—

The Chair: With apologies, Mr. Wilkinson, the question will have to remain rhetorical. Mrs. Witmer.

Mrs. Witmer: Thank you very much, Ron. I hope that the government and all people in the province of Ontario appreciate the outstanding role that individuals such as yourself play in our communities. The compassion and commitment that you have demonstrated and the services you provide are absolutely outstanding. Thank you very much.

The Chair: Thank you, Mrs. Witmer. The third party. Ms. Martel.

Ms. Martel: Thanks for coming. Let me be clear, then, that \$50 million spread across all these pharmacies is about \$17,000 per pharmacy. That's not going to make up the difference you're going to lose in promotional rebates; is that correct?

Mr. Chapleau: It's not even 10%.

Ms. Martel: So it's a significant loss for you.

Mr. Chapleau: Yes.

Ms. Martel: Can you put it in dollar terms for us?

Mr. Chapleau: There's an over \$200,000 difference.

The Chair: Thank you, Ms. Martel, and thanks to you as well, Mr. Chapleau, for your presentation and deputiation to the committee.

CANADIAN HEART RESEARCH CENTRE

The Chair: I would now invite our next presenter, and that is Dr. Anatoly Langer, heart specialist and chair at the Canadian Heart Research Centre.

Dr. Langer, as you've seen the protocol, you'll have 10 minutes in which to make your combined presentation. I invite you to begin now.

Dr. Anatoly Langer: Thanks very much, Mr. Chairman. It's a pleasure to be here. My name is Dr. Anatoly Langer. I am a cardiologist at St. Michael's Hospital. I'm a professor of medicine at the University of Toronto. I'm also chair of the Canadian Heart Research Centre, which is a non-profit academic organization dedicated to research and education in the treatment and prevention of cardiovascular disease. Therefore, as you can tell, I am naturally concerned about what this legislation may mean for the future of research right here in Ontario. Before I go into that, I would like to first discuss the impact of Bill 102 from the physician's and patient's point of view.

As a physician, my primary interest in the proposed legislation is its potential impact on the ability of doctors like me to provide optimal care to our patients. Appropriate drug utilization and the ability to support optimal, affordable care for our patients is a principal concern of all physicians.

"Appropriate utilization" means evidence-based. By that, I mean treatment according to guidelines which are based first on efficacy shown in clinical trials; second, safety demonstrated through experience; and third, cost, as an important but not the deciding factor.

Based on the available evidence, I would suggest that therapeutic substitution based on cost alone would not be in the best interests of Ontarians, nor would it lead to any long-term cost savings. Instead, drug-pricing strategies that result in limiting access to certain pharmaceuticals may well have the opposite effect: increased risk to patients and higher overall health costs.

Models of using drug interchangeability, such as the one that I think may be contemplated in Bill 102, rest on a very important assumption: that all drugs in the same class perform similarly. This appears to be an increasingly common assumption among politicians but is rejected

by the scientific and medical community since there is absolutely no data to support this assumption.

While all members of a drug class may have similar effects, substitutions may be harmful to patients for a wide variety of reasons, including individual response by the patient, safety and tolerability, drug interaction, other co-morbidities, and appropriate dose selection. Safety and efficacy of class members vary significantly and, therefore, evidence for improving patient outcomes cannot be extended to all members without scientific proof. In God we trust; the rest must show data.

The New Zealand experience with substitution of medications within a cholesterol-lowering class of agents highlights the potential hazards of therapeutic substitution. As reported in *The Lancet*, a prestigious medical journal, substitution of a proven drug, Simvastatin, with the less vigorously tested, less effective, but cheaper drug Fluvastatin resulted in an increase in average cholesterol levels and a statistically significant increase in arterial thrombotic events, meaning heart attacks and stroke. Thus, therapeutic substitution driven by cost and without consideration of efficacy and safety is not in the best interests of the patient and may result in patient non-compliance, additional physician visits, prescriptions and laboratory testing.

In general, health care costs have not declined in countries where drug interchangeability based on pricing has been in existence. The United States provides an interesting example, and an important example, at that. When we compare the US Medicaid database in 20 states with restrictive formularies to the 30 states without formulary restrictions, we see a 13.4% lower drug cost, but at the same time there is a 39.1% increase in cost for in-patient services and a 28.7% increase in cost for physician services. Thus, far from saving money, the evidence that we have suggests that cost-cutting approaches to drug spending result in much higher costs elsewhere in the health care system, such as hospital visits, additional tests and physician visits.

In summary, drug interchangeability cannot be recommended in light of published evidence, and important concerns for potential harm exist for people in Ontario. This policy will jeopardize physicians' ability to choose proven, evidence-based, patient-specific therapy, and denies patients the access to optimal treatment and future advances.

Bill 102 appears to provide the government with a framework that could permit a variety of approaches to cost containment and could limit therapeutic options. If that is not the government's intent, then the language in the bill needs to be clarified to ensure that this cannot and will not occur.

In the field of cardiovascular medicine, I am an expert on drug utilization, and I cannot tell at all what kind of strategy for drug interchangeability is planned in Bill 102. That's a problem.

Before I close, I would like to make a few comments about the potential impact of Bill 102 on the research environment in Ontario. The Canadian Heart Research

Centre is proud to be an Ontario-based organization serving research needs throughout North America. We work regularly with some of the best and brightest researchers who can be found anywhere in the world. Their work is truly cutting-edge, not only generating new discoveries that will be able to sustain health and fight disease into the future, but also providing for jobs and investment.

As someone acting in the research community, I'm concerned about the messages that are being sent by this bill—the message that new pharmaceutical products and life-saving medications are only appropriate if they are cheap.

The Canadian Heart Research Centre monitors the utilization of evidence-based therapies in Ontario and across Canada, and I can tell you without any shadow of a doubt that appropriate life-saving medications are underutilized in Ontario and Canada, resulting in a care gap that is costing thousands of Canadians their lives, and we do have the data.

As a clinician researcher, I'm not alone in being concerned about the implications for research and access to patients; many of my colleagues also have serious questions about this bill. The process in which this bill is being rushed through the Legislature—and, for that matter, through this committee—without adequate time for physicians and for the public to understand and to comment is remarkable for something as important as this bill.

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I contend that the Ontario government should not proceed with inappropriate cost-cutting exercises in health care without appropriate consultation with Ontario patients, physicians and other health care stakeholders. As citizens of Ontario, we recognize the importance of fiscal responsibility and offer our assistance in identifying appropriate strategies that do not risk the safety of our patients.

My concerns and our concerns are not new and have been previously formulated in a petition to Premier Dalton McGuinty last year in the letter that I have provided for your review.

Thanks very much for the opportunity to be here and discuss it with you.

The Chair: Thank you very much, Dr. Langer. We'll begin with the opposition side—about 45 seconds or so.

Mrs. Witmer: I very much appreciate an expert such as yourself being here. You have certainly indicated and emphasized many of the concerns that we have talked about: the impact on patients and the fact that some of these measures threaten lives and the quality of health care of Ontarians when we take a look at cost alone.

This government is ramming it through. Tomorrow, we're going to submit all of the recommendations and amendments, and we have absolutely no time for discussion or debate. It's all going to happen tomorrow, so it does lead one to the conclusion that perhaps the government does have something to hide.

I appreciate that you are here today and have put forward your expert opinion. I hope that, at end of the day, the government will listen to your concerns and the concerns of your colleagues. Thank you very, very much.

The Chair: Thank you, Ms. Witmer.

We'll move to the third party, Ms. Martel.

Ms. Martel: Thank you for being here today. You've said to the committee that you've looked at provisions around interchangeability and you're as confused as ever before. I think some of us are confused about that as well.

Can you respond more fully to what you see or what you don't see, and why you're worried about that?

Dr. Langer: In fact, I'm not confused; I'm in the dark. One must have some details to read about in order to be confused. There are no details provided. This is the most open-ended, most dangerous and most completely undefined bill I've ever seen. I cannot put my finger on any detail in any fact. I understand it's political legislation. I understand that it has to be rounded and water-proofed but, my God, there is absolutely no detail here as to how the drugs are going to be prescribed. This is how patients need to be treated. This is far too important to be left without detail.

The Chair: Thank you, Ms. Martel.

The government members. Ms. Wynne.

Ms. Wynne: Thanks for being here, Dr. Langer. A couple of things: I know you're aware of the extensive consultation that was done before this legislation was drafted. There were hundreds of meetings and many people from the profession were talked to.

It's interesting to me that, given we are not recommending therapeutic substitution, we are not recommending reference-based pricing, the citizens' groups that have come before us, the activists in the community, although they have some concerns about some of the details in the bill, are generally in agreement with us that there needs to be a move towards more sustainability in the drug system. So your concern about citizens doesn't seem to be borne out by the hearings we've had.

Can you comment on sustainability of the system?

Dr. Langer: Sure. I don't think you've had any experts dealing with this bill because there are no details, so I think—

Ms. Wynne: You talked about citizens having comment.

Dr. Langer: I know about the citizens.

The example is there—I've provided it—in New Zealand. If you simply do not have a definition of how the drugs can be counted on to be interchangeable, then you basically will be killing off more people than you're going to be managing successfully. You cannot simply substitute one drug with another. I, and only I as a physician and an expert and a specialist, can provide that.

Ms. Wynne: You have the authority to put “no substitution.” That's not being taken away from physicians. That remains.

Dr. Langer: Can you tell that by reading this bill? I cannot.

The Chair: Thank you, Ms. Wynne, and thank you, Dr. Langer, for your presence. On behalf of the committee, we'd like to thank you for your written deputation and submission on behalf of the Canadian Heart Research Centre.

Mr. O'Toole: Point of order, Mr. Chair: Just to put on the record that Dr. Langer's expert opinion is something very lacking in this. I'd like it to be recorded. This is being rammed through without any regard for the input.

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

DURHAM REGION HEALTH COALITION

The Chair: I will now invite our next presenter on behalf of the committee, Mr. Jim Freeman, the co-chair of Durham health coalition. Mr. Freeman, as you've seen, you have 10 minutes in which to make your full presentation. I invite you to begin now.

Mr. Jim Freeman: First, I'd like to thank you all for inviting me here today. My name is Jim Freeman. I'm the co-chair of the Durham health coalition. I'm also president of the Durham Region Labour Council.

Let me start. The Durham health coalition is a non-partisan citizens' group dedicated to preserving and extending a quality, universal, one-tier public health system. Our members include health professionals such as nurses and technologists, concerned citizens, seniors, unions and local business people. We are affiliated with the Ontario Health Coalition and work to honour and strengthen the principles of the Canada Health Act.

Our overview, when we looked at the bill: Drug costs in Canada are the fastest rising component in health care spending, rising at about 8% per year in real dollars. We believe that it is necessary, for the long-term sustainability of the health system, that governments act to control prescription prices and the cost of drugs. To that extent, we support several of the provisions that are included in this bill:

(1) We support widening generic substitution for more expensive brand name drugs. All the credible studies that we've seen and all our medical experts agree that this will cost less and will not harm patients. Brand name companies frequently seek to limit the impact of generic substitution by making slight alterations in the format of their drugs just before the patent expires so they can extend their market monopoly for another patent period and keep the prices high. The government's proposal to deal with this is a good one, and we support it.

(2) Stopping payoffs to drugstore companies by generic companies, called rebates: These rebates are given to pharmacies by drug companies as a payoff for stocking drugs, product placement etc. Most Ontarians have never heard of this; I think if they had, they would, as I was, be shocked when they heard about it. We're not talking about product placement for candy or magazines here.

Moreover, the government pays the drugstores the full cost of the drugs, and the drugstores pocket the difference between the amount they charge the government and the amount they pay for the drugs. So the Ontario drug program is effectively subsidizing for-profit pharmacies, especially the big chain pharmacies. We support the government's intent to use its bulk-buying power to

get lower costs from the drug companies for the people of Ontario and to eliminate these so-called rebates.

(3) Controls on pricing and markups for drugs: The bill has been accompanied by several announced initiatives that are not actually in the legislation, including the introduction of patient representatives in the drug review process and a Citizens' Council. We support these initiatives, and note that it is important for these patient and citizen representatives to be totally independent from drug industry influences.

In our view, the legislation is an important step. We believe that the initiatives contained in this bill will not harm the health of patients and will work to control the cost of drugs. I might add that if these provisions aren't included in the bill, then there is really nothing for the Durham health coalition to support. If we can't control the cost of drugs, then there is really nothing in this bill for our health coalition to support.

What is the opposition saying? We're aware that some of the pharmacies are opposing the ban on rebates and the reduction of their markups. However, these two initiatives they oppose will save money for the Ontario drug program, and we are supporting them. Regarding the rebate issue specifically, the pharmacies most affected are the big chains that are using their buying power to get rebates from drug companies in return for stocking their products.

We're also aware that brand name drug companies argue that generic substitution will threaten research and development jobs and harm patients. We do not believe either claim. There have been several published studies done on British Columbia's reference-based pricing system, involving a much wider generic substitution than that proposed by Ontario, which have found that patients are not harmed by the substitution. Despite the R&D claims of the drug companies, the evidence is that the non-profit sector and in fact government spend on and perform more R&D than the extremely wealthy drug companies. Moreover, the vast majority of the new drugs pushed onto the formulary by the drug companies offer few therapeutic advances and suck up many health resources. It is more accurate to say that the big drug companies, which are among the top wealthiest companies in the world, are simply trying to protect their monopoly in order to protect their profits, and this is all coming at the expense of the public health system.

In conclusion, we believe that the government, through this proposed legislation, attempts to balance the need for drug cost control with the protection of patient access to needed drugs and safety issues. Based on the available information and evidence, we've concluded that the legislation will likely work to contain costs and will not harm patients. This legislation will provide benefit to Ontario's health system and will protect access for Ontarians using the Ontario drug benefit program. We believe this is an important first step.

But Ontarians need more. Canada and the United States stand out among industrialized countries as two of the wealthiest nations without national drug plans. Yet

pharmacare has long been envisioned as an essential step in the evolution of medicare. Going back as far as 1964, it was recommended by Justice Emmett Hall.

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While we support this legislation, we also strongly support the Ontario government advocating at the national level. All Ontarians, and indeed all Canadians, need a safe and affordable national pharmacare program that would provide equal access to prescription drugs, be publicly funded and controlled, and cover essential drug costs.

While provincial governments pay the costs of provincial drug plans and have some regulatory powers, many regulatory powers still rest with the federal government. We hope the Ontario government will play a leadership role in advocating for a national formulary, an independent agency with more rigorous practices for drug approval, patent reform, post-marketing safety monitoring, enhanced controls on drug company advertising, and other measures that would improve our drug regulation regime. And we support a national pharmacare program.

The Chair: Thank you, Mr. Freeman. We have a minute or so, beginning with the third party.

Ms. Martel: Thank you for being here today. At the bottom of your page 2, I believe, you talk about announcements that are not actually in the bill: the patient representatives in the drug evaluation process and the Citizens' Council. Of course, you're right, they're not in the bill, so one does question the government's priority on this or attachment to this. If those don't appear in the bill, what would be your concerns with respect to the legislation and citizen participation?

Mr. Freeman: If those don't actually appear in the bill, especially the patient and citizen representatives, then we don't see why you would have a citizens' committee. They obviously have to be far removed from the drug industry, period. We don't need any influence from the drug companies on that committee. But I believe if that committee and the patient and citizen representatives aren't there, then we have a problem with—

The Chair: Thank you. To the government side.

Mr. Peterson: Thank you very much for the presentation. You argue for a national pharmacare system. In Ontario right now, our plan costs about \$3.2 billion a year. We would have to spend about \$6.4 billion if we wanted to put that across the board. We put in the health care tax, a levy that caused a huge cry amongst everyone about people having to pay and be more accountable for their health care costs. If we increased our taxes to pay for this and tried not to run a deficit, this would force us to tax everyone again almost more than the equivalent of what we've already taxed them. Do you see this as being at all workable for a government to even attempt, to be able to afford a national plan and put it on the backs of current taxpayers?

Mr. Freeman: I believe it is. You mentioned the Ontario health tax, but now we're talking about spreading those costs out over—

The Chair: With apologies, Mr. Peterson, I will have to offer it now to the opposition side.

Mr. O'Toole: Thank you very much for your presentation, Jim, and the work you've done. It's good to see you.

You were here for the presenter prior to you, Dr. Anatoly Langer. Clearly, in summation, he said that it puts patients at risk. In here, he says that Bill 102 is not good for patients. He's a cardiologist specialist; he teaches medicine. He says that Bill 102 is not good for research and innovation, that Bill 102 is not transparent, and therefore cannot proceed in its current form without appropriate and full consultations with medical and research experts.

We've heard this for the last week or two on this, and you're grudgingly—I think perhaps someone's urged you to support this; I'm not sure who it would be. Ms. Martel hasn't urged you to; she's against it, as far as I can gather. Why would you support this bill when the experts are telling us that there may be some good intentions here, but there's not much you can see? Why would you support it when it's—

Mr. Freeman: Well, sir, all the studies—

The Chair: Mr. O'Toole, with apologies, I will have to call this presenter's time.

Mr. O'Toole: See, that's the travesty of this.

The Chair: Mr. Freeman, thank you for your presence and deputation on behalf of the Durham health coalition.

MULTIPLE MYELOMA SUPPORT GROUPS OF HAMILTON, TORONTO AND LONDON

The Chair: I would now invite on behalf of the committee Mr. Rob Darwen, a member of the London and Hamilton multiple myeloma support groups, and your colleagues. As you may have seen, you have 10 minutes in which to make your combined presentation. I'd also ask that members of your deputation identify themselves for the purposes of the permanent record recording here. I invite you to begin now.

Mr. Rob Darwen: Thank you for the opportunity to address your committee. My name is Rob Darwen and with me, on my right, is Mr. Michael Kacsor and, on my left, Ms. Carolyn Henry. Together, we represent the Multiple Myeloma Support Groups of Hamilton, Toronto and London. Mike and myself will be sharing the time allotted for our presentation.

I am a 52-year-old resident of Ancaster, Ontario, and a survivor of multiple myeloma, a cancer of the bone marrow. I've been the beneficiary of various forms of effective treatment that have allowed me to survive and, to varying degrees, live a fairly normal life. This has been possible, in part, through the loving support of my wife and family.

As I sit before you, I may appear to be in relatively good health. The truth is somewhat different and, although I am in remission, the deadly myeloma cells still reside within me. So while I'm pleased to be healthy

enough to come here and be with you today, many other myeloma patients within the province are not so lucky. One of them is Laura McCallum from Dundas, a young wife and mother with two children, who has recently relapsed and is currently under treatment. We're here on behalf of Laura and other patients like her who are in the battle of their lives.

Like many people, when I was first diagnosed with cancer in 2003, I thought it was an immediate death sentence. My oncologist at Hamilton's Juravinski Cancer Centre helped me to regain my optimism by explaining to me the numerous treatment options that were available. Sadly, much of my optimism has been extinguished because of the position of the current provincial government that life-extending cancer drugs deserve significantly less support than those that provide a cure. I believe that this distinction between life-extending and curative treatments is unfair. Fighting cancer is based on gradual, progressive incremental improvements in treatment.

With the introduction of Bill 102, cancer patients have a glimmer of hope in the good words that the government has used in reference to improved access to life-extending drugs. However, we remain wary that these intentions will wither under the economic and bureaucratic pressures during the implementation process. We're here to urge you, as members of this committee, to ensure that the following features are clearly defined in the final legislation for the benefit of all cancer patients in Ontario: First, a conditional listing that allows access to new drugs during their evaluation prior to their formal listing; secondly, rapid funding decisions for breakthrough drugs to treat life-threatening conditions; and thirdly, a quick-response, exceptional-access mechanism that patients can utilize when they have no other method of obtaining life-saving or life-extending drugs.

These provisions are a good start, but only if they work. Cancer patients have consistently expressed to the government that time is critical. When we need drug treatment, we cannot afford to wait. Oncologists who work to take care of us must have the latitude to select the appropriate treatment program for each patient. It might be cheaper to have one drug therapy per disease, but that's simply not how cancer should be treated in the 21st century.

I'll now turn it over to Mike Kacsor for the second part of the presentation.

Mr. Mike Kacsor: Good afternoon. My name is Mike Kacsor, and I'm a self-employed environmental engineer. I represent the 350 members of the Toronto and District Multiple Myeloma Support Group.

According to the Canadian Cancer Society, over 1,800 Canadians will be diagnosed with this disease this year. Former Ontario Health Minister Tom Wells suffered from myeloma. In 1969, during Mr. Wells's tenure as health minister, medicare was introduced in our province. He was a very active member of our Toronto support group after his diagnosis until his death in the year 2000.

I was diagnosed with multiple myeloma in April 1997 at the age of 45. At diagnosis, it was suggested that I

should get my affairs in order as it was unlikely that I would live more than two years. I immediately sought a referral to Canada's only myeloma clinic at Princess Margaret Hospital. I have been very fortunate to be treated by a dedicated team of doctors and nurses who have not been afraid to push the envelope. I have participated in six clinical trials and received access to innovative treatments and medications before they were readily available. I am convinced that I am alive today, working full-time and paying my taxes solely as a result of access to these treatments and drugs.

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It is extremely disappointing for all Ontario myeloma patients that Velcade, the first in a new generation of drugs for the treatment of this disease, has not been approved for provincial funding. It is tragic that the ministry chose to ignore the advice of the world's leading hematologists who treat myeloma every day and its own medical experts who developed the provincial evidence-based guidelines for the use of this drug. Why are Ontario myeloma patients different from patients in other parts of Canada? They have access to Velcade.

All cancer patients in the province of Ontario have concerns about Bill 102. There are a number of issues in the ministry's drug reform announcement which require more clarity, detail and transparency.

Ontario's cancer patients are looking for assurances that we will have access to necessary medications precisely when we need them. Unfortunately, the recent proposal coming from Cancer Care Ontario, to have all patients who require cancer drugs not currently funded by the province pay for these drugs out of pocket, is a profound step in the wrong direction. This runs contrary to the stated intention of the legislation.

The bill must address the needs of cancer patients who do not have the means to pay for effective life-extending drugs. Private insurance is simply not available for many cancer patients. Believe me, a diagnosis of cancer is devastating. The burden on patients and their families who have to mortgage their homes or cash in their children's college savings plans in order to pay for essential cancer drugs is wrong. This is not better access to better care for all Ontarians, rich and poor. Thank you very much.

The Chair: Thank you for your deputation. We'll now have about a minute or so per side, beginning with the government side, Mr. Ramal.

Mr. Ramal: Thank you very much for your presentations. I had the chance to speak to Carolyn Henry in my office in London. We talked about the intent of the bill. I guess you've been listening to a lot of deputations. A lot of people from different stakeholders and backgrounds spoke about this stuff. I strongly believe that the intent of the bill is just to save some money and also to elicit more drugs which directly and indirectly affect patients on cancer drugs, especially those who cannot wait because time is not on their side. I believe in general that the intent of the bill is just to strengthen the ability of the ministry and

the government to list more drugs and enhance service across the whole spectrum.

Basically, thank you very much for your presentation. I have no questions.

The Chair: Thank you, Mr. Ramal. We'll move to the opposition side, Mr. Jackson.

Mr. Jackson: I appreciate very much your being here. You all remember George Petrunas. I was with his wife and children yesterday at a soccer event and it brought back some memories about the fight we've been having to get Velcade.

As you know, I share with you the concern that the new cancer drug program was taken away from Cancer Care Ontario, ceded to the minister, and now it would appear that it's going to shift over to this new unelected, unaccountable person who will determine what drugs are eligible. Given that the minister has historically and consistently said we just can't afford this drug, how are we supposed to expect that this is going to be available in Ontario if they're going to cut half a billion dollars out of the program and no elected person is accountable to speak to cancer patients?

Mr. Darwen: I suppose that is a very difficult question, but members of the public can only be guided by the government's stated intention. When I corresponded with Dalton McGuinty on this subject, he responded by saying, "We firmly believe that all Ontarians, regardless of their ability to pay, deserve timely access to the best possible health care." While it's difficult for me—

The Chair: Thank you, Mr. Jackson. With apologies, I will have to intervene; the floor to Ms. Martel of the third party.

Ms. Martel: Thank you for being here today. Cancer Care Ontario, which was before us last week, made it very clear that section 16 in this bill, that provides exceptional access, will only apply to oral medication for cancer patients, not for intravenous medications that are provided in a hospital on an outpatient basis. I believe that section 16 needs to be amended so that it will allow oncologists to apply to the executive director and have the executive director or executive officer have the new drug funding program at CCO pay for some of these drugs on an exceptional basis. What would you think of that proposal, so you'll actually be covered under this bill?

Mr. Kacsor: I think it's absolutely essential—absolutely that that mechanism be available.

Ms. Martel: Because otherwise there's no exceptional program for you to apply to for intravenous cancer drugs.

Mr. Darwen: Yes. The issue has been the absence of coverage for IV cancer drugs, which tend to be extremely expensive, in the tens of thousands of dollars.

The Chair: Thank you, Ms. Martel.

On behalf of the committee, thank you to you, Mr. Darwen, Mr. Kacsor and Ms. Henry, for your deputation on behalf of the multiple myeloma support groups.

WESTMOUNT PHARMACY

The Chair: I now invite our next presenter, and that's Ms. Carla Heinrichs Bradshaw, the owner of Westmount Pharmacy. Ms. Heinrichs Bradshaw, as you've seen, the protocol is that you have 10 minutes in which to make your combined presentation. I invite you to begin now.

Ms. Carla Heinrichs Bradshaw: Thank you, Mr. Chair, members of the committee and guests. My name is Carla Heinrichs Bradshaw, and I'm a pharmacist-owner of a small medical pharmacy in Guelph. There has been an independent pharmacy at this location since the facility was built in 1965 and I have been affiliated with the store since I graduated from University of Toronto in 1981. My staff includes one of the previous owners, two dispensary technicians who have worked here for 27 and 13 years, and a few more recent additions to the group.

Some of my patients have been dealing with me for over 20 years. They trust me to provide them with the professional advice required to deal with their medication needs. They look to me for reassurance after they've been to their doctor that the therapy prescribed is reasonable and will not interact with their current meds. They will not choose an over-the-counter remedy without my involvement.

Then there are those people who come into the pharmacy, their loved one just discharged from hospital after a serious illness, and the caregiver now has to muddle their way through a raft of new prescriptions. We help it all make sense to them, perhaps distribute the drugs into a weekly dosette, so they no longer have to be anxious about that aspect of the care their beloved requires; or perhaps someone is returning home for palliative care, and we work together with the other health professionals to make the last weeks and days as comfortable as possible for the patient and less stressful for their families, locating and delivering medications as quickly as possible. I have a wonderful, professional and personal relationship with my patients, one that impacts positively on the health of them and their families.

If Bill 102 goes through in its current form, there will certainly be changes in my practice, the most drastic of which would be the closure of the pharmacy. Over the last 10 years, profits have slowly been bleeding away from the pharmacy business. Although it is accepted that it costs more than \$10 to provide a prescription to a patient, the ODB fee has remained stagnant for 15 years. The brand name drug companies have either quit selling pharmaceuticals to stores directly, which enabled us to save the wholesale upcharge, or they have increased their minimum orders required from a few hundred dollars to as much as \$3,000. This can mean four months' worth of product on my shelf—a heavy investment. Even if it is possible to buy drugs directly from a drug manufacturer, this does not necessarily mean that ODB pays any more than the actual cost of the drug, plus the \$6.54 fee, as many companies have increased their prices way above the cost of the drug, plus 10%, as listed in the ODB formulary. Naturally, all overhead costs such as rent, sal-

aries and delivery charges have increased as well, while we struggle to stay in business, having little or no say in our level of reimbursement.

Our business is unlike any other. We cannot promote our products to the public or put a slow-moving item on sale. Often, expensive drugs are brought into the store to fill a single prescription for a person in need, never to be used again, and instead of making any money filling that prescription we end up losing a lot more. To think that we are somehow making money hand over fist is simply erroneous.

If we had not been receiving rebates from the generic drug companies, pharmacies as they exist today would not have survived. The rebates are not some underhanded payola, but a necessary component of income required to keep pharmacies financially viable. There is provision in this bill for an increase in professional fee, and hopefully the price of brand name drugs is being addressed, but this does not compensate for the loss to our pharmacies due to the reduced markup from 10% to 8%, the upcharge loss due to generic price reduction, rebate loss due to generic drug price reduction and the elimination of generic rebates.

I have done a financial analysis of my business and the loss of the generic rebates, coupled with the other losses of income as described, will devastate my business. In the last fiscal year, my prescription sales were \$1,320,000 and my profit was \$105,000. I will gain \$4,600 due to the increase in professional fee from \$6.54 to \$7.00; however, I will lose \$2,400 due to the reduction in markup, \$6,700 due to the upcharge loss from generic drug price reduction, plus \$70,000 if the generic rebates are eliminated. This adds up to a grand loss of \$75,000—72% of my profit.

As you can well imagine, that loss will make my business unsustainable. Right now, I have a great relationship with the physicians who practise in the building where I am located. If there is a problem with the patient's therapy, I can go to the doctor's office, discuss the problem and solve it without making a sick person wait while phone calls are made and returned.

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However, if profit is reduced to \$30,000 on over \$1 million in sales, it makes little sense to keep the doors of the pharmacy open. I have little room to cut back on staff or hours of operation without compromising patient care, and the risks involved in running a business are too high for that kind of return on investment.

The closure of pharmacies such of mine will be a great loss to the care of patients. Do we want to send all patients, no matter how poorly they are feeling, across town to the stores selling milk and bread—as that will be the product mix required to sustain a business? There will be no neighbourhood pharmacy where we know you, your family, your medical history and your doctor.

I depend on the Ontario Pharmacists' Association to work with the government to resolve the issues relevant to Bill 102 and the business of pharmacy. OPA should be entrenched in Bill 102 as the exclusive representative of

pharmacists, and should be able to negotiate professional fees on our behalf. I urge you, the committee members, to focus on OPA's proposed amendments to the bill, because they solve problems pharmacies have identified.

Although all of these amendments proposed by OPA are important to pharmacy, dealing with rebates and professional allowances is critical to supporting our business. There should be a robust code of conduct to govern these practices. However, there should be no limit placed on the level of investment permitted. The regulatory process should be defined, and OPA fully engaged as a partner with the government in developing the regulations associated with Bill 102.

To date, the draft regulations, timeline and consultation plan are unknown. These regulations cover the dispensing fee and the reduction in the markup. As a result, OPA and its members have yet to establish a full sustainability evaluation of the impact of the regulations.

You have the power to make Bill 102 workable. Hopefully, you are beginning to understand that passing the bill as it stands now will be ruinous to pharmacies. The total revenue lost is not gravy to the owner, but meat and potatoes.

Allowing the generic companies to invest only in educational programs does not address the financial loss. If the goal of this government is improve health care, this is not the answer, as pharmacies will have to cut back on staff and business hours or simply close the doors.

We want to work with you to improve health care.

I, along with the Ontario Pharmacists' Association, remain committed to that goal, but it can only happen if pharmacies like mine remain sustainable businesses.

I ask that this committee move forward to accept and implement what OPA has presented as carefully considered and workable solutions that will fix this bill.

The Chair: Thank you, Ms. Bradshaw. We'll have about minute per side, beginning with the opposition.

Mr. Jackson: Carla, first of all, thank you. We've heard this story many times. I noticed that you're almost trembling when your business is about to be devastated.

As a long-time supporter of pharmacy, I want to apologize for this legislation even though we didn't construct it. It almost has made you out to be dishonest by taking rebates, when in fact government has been dishonest about your proper, fair professional fee and has allowed the rebates to allow you to operate. There's no hope of replacement here with the current legislation.

If no one has ever apologized to a pharmacist—I know I'm not the government but I feel badly for the attack on your profession. Thank you for being here.

The Chair: To the third party.

Ms. Martel: Thank you for being here today. We heard a presentation as a group this morning where everybody was going to make money off this whole little scenario: the generics, the community pharmacists, brand names, the whole nine yards.

You provided numbers to us, and they were pretty concrete, about the impact the bill will have on your pharmacy. Do you feel very confident about those num-

bers? You've had a look at what you can look at, because admittedly some of this is not very clear. But do you feel quite confident about the numbers you've put to the committee today in terms of how this bill will impact you? Is there anything else you'd like to add in terms of those particular numbers?

Ms. Heinrichs Bradshaw: I think they speak fairly well for themselves.

Ms. Martel: Thank you for being here.

The Chair: To the government side.

Mr. Peterson: Thank you very much for coming and taking your time away from your business. Contrary to what some other people in the room might say, we are trying to give the pharmacists the essential role they provide in health care, recognize that and move them forward as an essential part of the health care in Ontario. That's why we're trying to restore the rebate and stop the pricing increases from branded pharmacies. That's why we're looking at cognitive services as a way of rewarding you for all the extras you've been doing in the past. It's why we're asking for an increase in the dispensing fee, which no other government has done.

Our problem is that we've found a system that's broken and we're trying to fix it. That's also why we're talking now about—and we've ended the cap on the rebate at \$25 so you can handle the more expensive drugs, and we're looking at a professional or an educational allowance.

You mentioned the educational allowance. You thought that could make you a bit nervous because you have to actually expend the money. So you'd probably prefer that this be more of a professional rebate to keep this whole thing intact. But you are not the only person who has made this presentation. I do very much appreciate the numbers, because we have been accumulating numbers from pharmacies.

The Chair: Thank you, Ms. Bradshaw, for your presence and deputation on behalf of Westmount Pharmacy.

CANADIAN GENERIC PHARMACEUTICAL ASSOCIATION

The Chair: Now, on behalf of the committee, I invite our next presenter, Mr. Jim Keon, president of the Canadian Generic Pharmaceutical Association. Mr. Keon, as you've seen, you have 10 minutes in which to make your deputation, beginning now.

Mr. Jim Keon: Thank you, Mr. Chair. With me today is my colleague Jeff Connell, from the Canadian Generic Pharmaceutical Association. I am Jim Keon. I'm the president of the Canadian Generic Pharmaceutical Association. We are the association that represents on a national basis Canada's generic pharmaceutical industry.

Before commenting directly on Bill 102, I'd like to highlight three pieces of information that I think are important for you in your consideration of this bill:

First point: Generic drugs are equivalent, in terms of quality, safety and efficacy, to brand name drugs. Generic drugs are low-cost versions of brand name drugs that

are produced by several manufacturers once the patents expire on the brand name versions. Brand name drugs have 20 years of patent protection. During that time, only the patent holder can produce the drug. After that, other manufacturers can apply to Health Canada to produce the generics. There are no differences as far as quality, purity, effectiveness and safety between generic drugs and higher-priced brand name drugs.

All drugs sold in Canada must be approved by Health Canada. Each product must meet the strict regulations established by the Food and Drugs Act. Both generic and brand name drugs are subjected to the same rigorous standards. When applying to sell a generic equivalent of a brand name drug, the manufacturer must prove that the product is as safe and effective as the brand version. Generic manufacturers must also prove that the active ingredients in the medicine are as pure, dissolve at the same rate, and are absorbed in the same manner as the original product. Generics are used 57 million times a year in prescriptions in Ontario. They are safe drugs.

The second point I'd like to make: a few words about Ontario's generic pharmaceutical industry. Ontario is the proud recipient of one of the largest and most impressive clusters of generic drug companies in any jurisdiction in the world. The generic pharmaceutical industry employs some 7,500 Ontarians in well-paid, highly skilled jobs in its research, development and manufacturing facilities. Thirteen of our member companies are located in Ontario, many of them in the GTA.

The generic industry spends approximately \$300 million a year on research and development. One of our member companies, Apotex, is the largest R&D spender of any pharmaceutical company, brand or generic, in Canada each and every year. On average, our generic companies are spending close to 15% of their revenues on research and development. This is nearly twice the amount spent by the brand name companies, as reported by the Patented Medicine Prices Review Board. The reason for this is because unlike most brand name drugs which are shipped into Canada and Ontario, virtually all generic drugs sold in Canada are made in Canada, and the majority of those are made right here in Ontario.

The third point: health care savings from generic pharmaceuticals. Generics fill 45% of all prescriptions in Ontario yet represent only 17% of the costs. For the public sector, generics fill more than 50% of all prescriptions paid for by the Ontario government, yet account for only 20% of the \$3.5 billion spent by the province. Generics, on average, cost \$23 per prescription; brand name products, \$62 per prescription. These figures clearly demonstrate that generic drugs offer excellent value for money and play a key role in the affordability and ongoing sustainability of the system.

By increasing the use of lower-cost generic equivalents, there will be more money available for other priorities for our health care system, such as investing in pharmacy, hiring nurses, reducing waiting times and investing in new life-saving technologies, including new brand name pharmaceutical products. Saving money by

using generics is also a far better solution to reducing costs than cutting benefits or asking seniors and social assistance recipients to pay more for their prescription drugs. I'd ask you to keep all of those three points in mind as you consider changes to this bill.

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There are two broad issues we're going to address on Bill 102. The first is the interchangeability of generic pharmaceutical products. We believe that the generic industry, despite the benefits it brings to the system, can do more. Bill 102 takes a number of important steps in ensuring that the generic pharmaceutical industry can increase its contribution to health care in both the public and private sectors in this province and its significant investments in the Ontario economy.

We support Bill 102 and the government's efforts to bring greater transparency and cost savings to the operation of its drug benefit program. In particular, CGPA supports the announced initiatives to provide greater access to lower-cost generic drugs for those Ontarians not covered by the Ontario government's drug plan. It's called OFI.

Before I speak about OFI, we also support the changes made in the bill on the "same" and "similar" issue. The intent of these is to allow the government to designate products as interchangeable where there have been minor changes in the brand name product for the purposes of reducing competition from generics. A typical example is where a product has been changed from a capsule to a tablet: There is no difference in the product. This will allow the government to have its expert committee look at these drugs, and if they're determined to be the same or similar, then they can be determined to be interchangeable.

Off-formulary interchangeability: The second aspect of interchangeability in the package, more than \$30 million a year, will be brought in savings. This is bringing the Ontario jurisdiction in line with almost every other jurisdiction in North America. Currently, these rules penalize Ontario seniors and social assistance recipients who need these medicines that are not covered by the drug plan.

At the stakeholder briefing on April 13, when the government's proposals were announced, representatives of the Drug System Secretariat noted that every major employer group that provided comment during the consultations on the government's proposed changes asked for the government to implement off-formulary interchangeability.

I'd also like to reiterate that all the brand name drugs that would face competition in the Ontario private sector under OFI have already enjoyed the benefit of their 20-year patents. The patents have expired. It's time for Ontario employers and consumers to benefit from lower-priced competition from the generics.

This is an important point. There's absolutely nothing in Bill 102 that in any way erodes intellectual property protection for brand name drugs. Intellectual property protection is set by federal law and is based on inter-

national trade agreements. When brand name drug companies ask you to oppose the government's interchangeability proposals, they are asking that you force Ontario employers and consumers to pay for higher-priced brand name drugs even after patents have expired. They're asking you to do that rather than face the equivalent lower-cost generic competition.

The second main area, and the last area I will cover, relates to changes in generic pharmaceutical pricing and reimbursement. We support the government's desire for greater transparency in the drug reimbursement system. The Ontario government and, frankly, other governments in Canada and around the world believe that the reimbursement system for generic pharmaceutical products must be more transparent for taxpayers and patients.

There has been concern raised in the pharmacy sector, and we have listened to it, as you have, about the government's proposed ban on rebates and professional allowances in Bill 102. CGPA member companies understand the concerns of pharmacy with the proposed changes. Our companies also recognize the key role that pharmacists and the pharmacy sector play in the health care system. We are pleased to see that in Bill 102, pharmacists will be better recognized for more of the important services they provide to patients.

On the question of rebates and allowances, our industry needs clear rules. We also need to put in perspective our industry's ability to fund these payments. The generic pharmaceutical industry has only 17%, as measured by revenues, of the market share in Ontario. If the government proceeds with the major price decrease of approximately 20% for generic medicines that it has announced, then our revenue base will fall even more.

On the issue of pricing, I would note that several of our member companies came before you last week and argued that the committee should ask the government to maintain at least fair prices for generic medicines. I won't repeat those arguments, other than to say that there must be fair prices and some flexibility in reimbursement prices, particularly for some new, expensive products such as biopharmaceuticals. If prices are too low, generic companies will not be able to produce these medicines and provide savings to the health care system. However, it's clear, if generic prices are cut, that then it will not be financially possible for the Ontario generic industry to support pharmacy at the same level it does today. It would not make financial sense.

Clearly, the pharmacy sector is our partner. It is our goal to work with the government and pharmacy and wholesaler representatives to develop rules for generic reimbursement, including a new code of conduct for marketing practices, that will achieve the government's goal of transparency while also ensuring the long-term viability and sustainability of all players in the generic pharmaceutical value chain, including pharmacy and Ontario's generic pharmaceutical industry. Thank you.

The Chair: Thank you, Mr. Keon. I must commend you on the precision timing of your remarks and your

deputation on behalf of the Canadian Generic Pharmaceutical Association.

GLENDAMPBELL

The Chair: I would now, on behalf of the committee, invite our next presenter, Ms. Glenda Campbell, to come forward. As you've seen, Ms. Campbell, you have 10 minutes in which to make your combined presentation. I'd invite you to begin now.

Ms. Glenda Campbell: Mr. Chairman and committee members, thank you very much for allowing me the time to speak with you today. I'm Glenda Campbell and I'm a clinical consultant pharmacist working in the Hamilton area. I'm not sure you've heard from a consultant pharmacist yet in your presentations. I work for Medical Pharmacies, which is a pharmacy that has specialized in service to long-term-care facilities. I don't work in the pharmacy; I spend my full time in the long-term-care facilities, working with the nurses and with the physicians.

When I first started to work in long-term care—and I hate to admit it, it was back in the 1970s—our role was very limited. We audited their documentation, we checked their treatment cards, we did in-service teaching sessions to the nursing staff, and we attended their pharmacy and therapeutics committee.

Back then, physicians were not used to consultant pharmacists. I'm not sure that they trusted us. When we made recommendations it was very rare that they would even listen to us or follow through on recommendations for medication therapy change. I'm proud to say that consultant pharmacists today have earned the respect of the administrators, the nurses and, most importantly, the physicians we work with.

We're expected to work 24 hours a day, seven days a week. We're always on call. I'm always at the end of my cellphone. The company doesn't know it, but it's on even on vacations and holidays. Even in times of crisis, such as an influenza outbreak—and I think we've all heard of influenza—we're the first ones to get the call. We're the ones who go in and keeps them on track. We've already pre-calculated their kidney function, we've already ordered the doses and suggested to the physician what's appropriate.

Today, while we continue to support the facilities with a formalized auditing program, it's really the change in our clinical support that's made a difference. Most of our time, we're in the facilities checking on medication for the residents and making recommendations. We've truly become an integral part of the health care system. Physicians now accept and expect us to review their charts and make recommendations. When I first started, at the end of a meeting with one physician, he said, "I thought as a pharmacist that you would ask me to add all these different medications," and that's not what we do. Most of the time, they're pleasantly surprised; we ask for medication to be discontinued, the dose to be reduced.

We're not trying to play doctors, but we can often recommend another medication that's more appropriate.

This is obviously a benefit to the residents, a benefit to the nurses who are giving out a lot of medications these days—it's a large part of their time—and a benefit for the government, which pays for them. Outside of our very specialized field, I don't think citizens or representatives of the government actually know we exist. Even our pharmacist colleagues don't know we exist. But we do provide a very unique service.

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While others have talked about improving care to seniors, we've made it happen with some innovative programs, and I'd like to mention a couple of them to you. When residents in facilities first started to receive a medication called Amantadine for influenza—I'm glad there are some physicians on the team here—the rate of discontinuing due to adverse effects, literature would tell you, was 20%; in practice, I actually found it to be a little bit more than that. Everyone received the same dose. Consultant pharmacists got involved. We calculated their kidney function and made recommendations to the physicians and recommended an appropriate dose. Personally, in my care facilities, if one or two people had to discontinue it because of adverse effects, that was unusual. We did a great job.

Residents in long-term-care facilities are also known to have poorer kidney function due to their age and their clinical conditions. Medications for many of these should be adjusted according to their dose. I work as part of a research team on my own time out of McMaster, and we've been kind of creative with some of the things we've done. We collected data from fellow consultants that represented over 14,000 patients in long-term care, and we showed how poor their kidney function was: over 40%, or under 40 mls per minute. Previous published studies, when we checked, were done with 50 people or less in this study. When this was published in November 2001, it had quite an impact on the level of knowledge. We received calls from across North America—Canada and the United States—especially from the colleges of pharmacy. We followed this up with a review of the top 100 medications that were dispensed in long-term care. We then narrowed it down through looking at literature to find the clinically evidence-based support. We now have 25 medications where we have an automatic computer review. This strongly supports our consultant pharmacists.

So what does this mean? It means that if you were in one of my care facilities as a resident and your doctor wrote a prescription order, that would go to the pharmacy and be keyed into the program. The computer would identify that you were taking one of these 25 medications. It would then go look in its memory bank and find out what we had already told it was your level of kidney function. If your kidney function was low, the computer automatically spits out an alert for the physician. If your kidney function is fine, it's just going to carry on.

If the medication happened to be an antibiotic, the pharmacist in that store would contact the physician that day before dispensing it. If it was another medication that wasn't quite as time-sensitive, that would come to my attention. I would take that into the care facility, check the chart, speak to the nursing staff and hopefully make an appropriate recommendation to the physician.

Also, we did a survey of long-term-care physicians, and they identified Warfarin as one of the drugs that's most challenging for them to prescribe. Warfarin, for you non-physicians, is a medication which is used to prevent blood clots from forming, which can go on to strokes. If you take too much of it, it can cause bleeding.

A recent review that we just finished in the fall: We went into five care facilities and we looked at all the residents who were receiving Warfarin. What we found was that they were in therapeutic range only 54% of the time. That really is not good enough. If that was my mother or father in there and that was their percentage, I'd be really upset.

So what we're doing about this right now: As a tool, there's a new meter that's out. We're trialling that this month in a care facility. And we should have the INR results within 60 seconds, or the blood results, rather than sending that out to a lab and waiting for the time for it to come back. We're going to follow this up with implementation of a web-based resource. This way, the nursing staff in the care facilities can go into the computer and find out what the appropriate recommendations are and pass those on to the physician, or the physician will be able to access this program from their office. Using an algorithm, we can help the physicians with what the appropriate dose is. Studies have shown that by using an algorithm, we can get this up into 80%. Eighty per cent of the time, those patients will be in therapeutic range.

With additional government support—which is probably not going to happen right now—we can do a lot more and be more creative. Because of my concern that funding changes with Bill 102 might result in long-term-care pharmacies such as the one I work for having to cut back on consultant time in the facility, I asked one of the directors of care whom I work with, Jim Millington, in Beamsville, how he would feel about this. He answered, “You as a consultant pharmacist are the radar that identifies and teaches us how to keep current with best practices of care. We simply do not have the staff or the expertise to do that. We have to depend on you.” I can add to that that with the current physician shortage, it's very, very difficult to get physicians to look at long-term care. Then, when they consider some of the extra paperwork they have to do and the workload, these gentlemen and ladies are so stressed that they don't have time to do the extras for the clinical review of charts like we can do to help back them up.

I ask you to ensure that if you or your family members happen to be in long-term care, I, along with my fellow consultants, will be there for you, so we can continue to be a member of the health care team and provide the best of best practice care. This will require that pharmacies

we work for receive at least the same funding to dispense a prescription as a regular retail pharmacy would for their client. We provide so much more for this dispensing fee.

I'd like to thank the team who worked to put Bill 102 together. I recognize the time that you've given to the review of section 8 and limited-use drugs, and as a previous speaker said, they have really been very difficult for physicians to handle.

Thank you for understanding these issues, and hopefully, I've given you some insight as to what a clinical consultant pharmacist is.

The Chair: On behalf of the committee, thank you, Ms. Campbell, for your deputation and your written submission.

Interjections.

The Chair: From what we can determine, Parliament has adjourned for the day, probably in view of the lovely weather; we're not entirely sure. If there is a vote, the committee will adjourn for that vote, and I would respectfully ask you to return immediately. But apparently, it's adjourned. Fine. No vote.

SOBEYS PHARMACY GROUP

The Chair: Let's move to the next presenter, Ms. Sandra Aylward, division vice-president of Sobeys Pharmacy Group, and colleague. As you've seen, you have 10 minutes in which to make your deputation. Welcome. Please do introduce yourselves for the purposes of recording. Please begin.

Ms. Sandra Aylward: Thank you. Good afternoon. My name is Sandra Aylward. I'm division vice-president of professional and regulatory affairs with Sobeys Pharmacy Group. With me today is Kevin Comeau, director of operations for Sobeys Pharmacy Group in Ontario. I am a pharmacist, currently licensed in the province of Nova Scotia. I'm a member of the Ontario Pharmacists' Association and the Canadian Pharmacists Association.

Sobeys Pharmacy Group is a national operating division of Sobeys, a grocery retailer with hundreds of locations across Canada. In Ontario, Sobeys Pharmacy Group owns and operates 29 pharmacies as of today, with over 100 people employed, including pharmacists, technicians and other support staff. These pharmacies are part of a growing network of approximately 170 pharmacies across the country in both grocery store and traditional drugstore formats.

Sobeys pharmacy has been operating in Ontario since 2001, so we are relative newcomers to this province. Although we are part of a larger corporation, our pharmacies operate as separate business units within the grocery store.

On that note, let me say that I was very surprised by the comments of Mr. D'Cruz this morning. I've never met Mr. D'Cruz, although I've been working in community pharmacy for over 20 years. I'm not aware that he is a pharmacist, I'm not aware that he's ever operated a pharmacy, and I can tell you that his rosy picture of

community pharmacy does not match our operational reality. I simply don't know where he got his numbers.

We see that the need for pharmacy services in Ontario and elsewhere is growing, as drug treatment, as you've heard, offers improved health outcomes and quality of life for many, especially as the population ages and deals with health issues that often result. Our pharmacists and pharmacies contribute to the overall capacity in the health care system to respond to primary health care issues on an everyday basis. Our pharmacists and pharmacies build on a long history of public service by our profession in delivering front-line health care in Ontario. We have found that people in Ontario trust their pharmacists and value the very real and practical help they provide on a daily basis all over this province.

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Based on the experiences of our pharmacists, I agree with the Minister of Health that there are opportunities to improve the drug system in Ontario. I appreciate that one of the goals of Bill 102 is to address the fact that the system within which pharmacists operate in order to deliver medications and services to the citizens of Ontario is at times very convoluted, with various elements from times long past and the resulting necessity for workarounds—complicated processes that pharmacists, physicians, patients and government administrators must employ to fulfill our goal of getting people the medications they need.

Let me give you an example of what I mean. I'm sure that this week you've heard about a phenomenon known as cost-to-operator claims. Simply put—if it's possible—the price that the Ontario government will reimburse to pharmacies for many drugs is lower than what the pharmacy can buy the drug for. If a pharmacy wishes to be reimbursed for the full and actual cost they incur to purchase the drug, the pharmacy must submit a cost-to-operator claim, a separate administrative process on top of the basic claim to the drug plan. Their reward for this? The difference in price between the government's outdated price list and the real cost of the medication can be paid to the pharmacy, but then it is subtracted from the pharmacy's markup, an element of the reimbursement model which is intended to cover other costs associated with providing the drug to the patient. Because the pharmacist must perform this extra step—this workaround—to be paid the actual cost of the drug and because the pharmacy loses that amount anyway in a bizarre example of giving with one hand and taking away with the other, I can understand why some pharmacies don't bother submitting cost-to-operator claims. We estimate that these situations cost our pharmacies hundreds of dollars per day in inadequate reimbursement, lost productivity or both.

Sobeys Pharmacy Group is committed to growing our network of pharmacies in Ontario. We have plans to expand by at least six pharmacies in this fiscal year. Our business model includes large investments in human resources and other infrastructure in order to deliver much more than basic prescription services. Our pharmacists

and their front-line teams are building on a solid foundation of pharmacist training, tools and programs with the operational support to deliver what patients need and want to a very high professional standard. For example, in the last 18 months, our Ontario pharmacists have reviewed and updated our privacy standards as part of a national Sobeys pharmacy program that the Privacy Commissioner of Canada has called "exemplary" and "a model for best practice." Our pharmacists have undergone training and implemented new operational standards to improve medication safety. I'm proud to have been part of that. They've been trained to provide emergency contraception as a primary health care service. In the next six months, we have plans for the launch of our Diabetes Care in Action initiative in Ontario, including pharmacist training and certification and the launch of practical tools for people affected by diabetes to better manage their health.

Bill 102, as it has been presented, means that we will need to re-evaluate our business model in Ontario. As corporate employees, our pharmacists' focus is on providing care to their patients. They trust Sobeys Pharmacy Group to make sure that our business is financially viable so they can continue and improve upon the services they provide to their patients every day. They know that allowances from manufacturers are part of our business model. They know that these allowances are legal, ethical and, like everything else in our supplier relationships, subject to the Sobeys code of business conduct. They're concerned about Bill 102. They are naturally excited, as am I, about the minister's stated intention to recognize their role as medication advisers by funding activities such as individualized medication consultations. However, our pharmacists know first-hand how much time, effort and cost is involved in delivering our current level of pharmacy service, and they realize that reimbursement from the Ontario government and other payers has never been sufficient to cover these costs. They wonder how we'll find the resources to offer the certification program and the full-day training that we plan for them on diabetes care. They hope that we will be able to continue to offer wellness clinics in our stores. If the changes in Bill 102 are enacted without amendments, our company will need to assess the sustainability of continuing activities for which there is cost but no funding.

We will do everything we can to maintain and, if possible, improve what we offer the citizens of Ontario. However, we are responsible business operators and, as such, we will need to make changes if Bill 102 means that our business model no longer works.

What's needed? We need amendments to Bill 102, followed by careful crafting of appropriate regulations and policies to effect what I believe this government intended when it introduced the bill—a more transparent, more efficient drug distribution system as part of a regulatory and commercial environment that allows pharmacists and pharmacies to continue to meet the needs and, yes, even raise the bar in terms of what we offer.

We support amendments to Bill 102 that create a transparent process through which pharmacies can access professional allowances that support the development of patient services, including the operational support needed to deliver those services.

We support amendments to Bill 102 that clarify the government's intentions with regard to interchangeability of drugs. If the government's position on this is not clear to us as pharmacists, the medication experts, it's sure going to be difficult for us to implement the changes and explain them to the public.

We support amendments to Bill 102 to establish the proposed Pharmacy Council in law. It's critical that the government have, in its infrastructure, access to expertise from pharmacy operators when developing policy in this area. One simple example is that the minister has expressed an intention to negotiate prices with drug manufacturers so that pharmacies will not pay more than the government-established price. We need to discuss what happens if and when the minister is unable to deliver on this guarantee, with the potential result that pharmacists and patients are once again left with the financial consequences. The Pharmacy Council is the place where these discussions can take place so that the system works for the people of Ontario.

I am happy to see indications that the minister and this government are prepared to listen and respond to the feedback that pharmacists are providing on this bill. In that respect, the work of this committee is incredibly important. We thank you for the opportunity to speak with you today.

The Chair: Thank you, Ms. Aylward and to your colleague, for your deputation on behalf of Sobeys Pharmacy Group.

ONTARIO AIDS NETWORK

The Chair: I would now call on behalf of the committee our next presenter, Mr. Ron Lirette of the Ontario AIDS Network, joined by his colleague Ms. Patti Bregman, legal counsel. As you've seen the protocol, you have 10 minutes in which to make your deputation, and I would invite you to begin now.

Mr. Ron Lirette: We appreciate the opportunity to appear before the committee on an issue very important to people living with HIV/AIDS.

The Ontario AIDS Network is a province-wide organization. It has more than 30 members, including AIDS service organizations and provincial organizations working with various constituencies. We have attached a brochure describing our organization for your perusal.

Last week marked the 25th anniversary of the pronouncement by the Centres for Disease Control that five gay men were infected with an unusual cancer, which turned out to be AIDS. At meetings held around the world last week, including the United Nations, there were two areas of focus: prevention and medication.

In 1984, people diagnosed with HIV/AIDS had little chance of survival. The advent of AZT, followed by the

HAART or HIV/AIDS antiretroviral treatment, has dramatically changed the outlook for many people with HIV/AIDS, although it remains a fatal disease.

Unfortunately, however, the disease is once again on the increase in Ontario. Recent statistics show that the number of women and heterosexuals considered to be at high risk are growing quickly. This means that the number of people in Ontario relying on access to the most effective drugs will continue to grow. A summary of recent statistics produced by Dr. Robert Remis and his colleagues, along with an executive summary of his report, will be forwarded to you tomorrow to your clerk. Unfortunately, we don't have it available with us today.

This legislation is timely. Drugs remain the link between life and death for people with HIV/AIDS. We know that drugs that work today may lose their effectiveness, requiring the development of newer and more effective drugs. This, in turn, will result in an increased cost for government and private health insurance plans. The government's goals with respect to this legislation are consistent with our priorities: ensuring that affordable drugs are available and that they are covered under the Ontario drug benefit plan. Although not covered by this legislation, we hope that this legislation will also help manage the rate of increase for drug costs overall. Many people with HIV are working and depend on private insurance to cover the cost of drugs. We are concerned that, with the rapid increase in the cost of drugs in Canada, employers will stop providing coverage or increase the amount of employee contribution.

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In this submission, we want to focus on three areas: the restructuring and accountability of the executive officer; the process for designating drugs for the formulary as interchangeable and for special use; and the involvement of people who rely on medications on the Drug Quality and Therapeutics Committee and on a new Citizens' Council.

In announcing the legislation, the rationale for restructuring the drug programs branch was to improve the efficiency of the program, particularly following concerns raised by the Provincial Auditor. In principle, we support the changes that will improve the effectiveness of the program in a cost-effective way. Changes that will reduce the length of time in which a drug is added to the formulary, designated as interchangeable or approved for special use is positive.

We are concerned, however, that the legislation gives the executive officer sweeping authority over billions of dollars and the lives of millions of Ontarians without any clear accountability or transparency beyond the obligation to explain decisions not to approve a drug for the formulary. Under the existing legislation, various stakeholders could challenge decisions. Under the new legislation, only the manufacturers have that right.

There is nothing in legislation that describes the relationship between the executive officer, the minister and cabinet. In response to questions, the ministry officials have compared the executive officer to the general man-

ager of OHIP, who also manages a multi-billion dollar budget. The difference is that the general manager does not have the authority to enter into contracts with health practitioners nor determine which services are covered. The only reference to terms and conditions under which the executive officer will act is with respect to regulations that may be passed.

It is our position that a balance can be struck between a more streamlined process while retaining accountability if the legislation were amended as follows:

(1) that the regulations setting out the qualifications, process for hiring, and dismissing the executive officer and the lines of accountability be mandated rather than discretionary;

(2) that the regulations require cabinet approval of contracts over a specific amount so that the government retains accountability for these expenditures;

(3) that the regulations be subject to public consultation prior to enactment or change. This gives the public an opportunity to have real input into the process.

There are three important decisions that are assigned to the sole discretion of the executive officer: designating drugs as interchangeable; deciding which drugs are on the formulary; and deciding on processes for conditional and special-use drugs. All three of these areas are of particular importance to people with HIV/AIDS. In the early years of the epidemic, we were forced to lobby hard to get coverage for drugs which allowed people to extend their lives. As HIV evolves and becomes resistant to current drugs, we anticipate that there will be new drugs, some of which may be experimental in nature, all of which will likely be expensive.

Having citizen representatives on the DQTC is useful, but with only two representatives, they are unlikely to be familiar with the wide range of health conditions for which drugs are approved. As we said above, we are concerned with transparency. The legislation requires the executive officer to provide reasons for his or her decisions, but that requirement is limited.

We understand the government's decision to move authority from the minister to a senior bureaucrat to make the process more efficient. However, without changes to the legislation, we are concerned that the process will in fact become even more closed, with only limited information available. In order to address these concerns, we recommend:

—That the executive officer be limited in the criteria that can be used to withhold information on decisions. In order to be consistent, we suggest using the criteria under the Freedom of Information and Protection of Privacy Act, which would apply in any event. Allowing the withholding of information beyond that permitted by FIPPA would be a step backward in terms of transparency.

—That there should be a period for public consultation on decisions about drug interchangeability and whether or not a drug should be on the formulary. This approach would be less time-consuming than the regulation-making process but would still allow for public comment. This could occur by placing notices in specific publica-

tions or on the Internet giving people an opportunity to make comment. It would not only make the process more open, but would ensure that the executive officer had access to the full range of information.

—Where a request for a special-use or conditional drug is denied, that there be an appeal process to review the decision. One possibility would be to use the existing health service appeal tribunal. Given the impact that a refusal has on the potential life and health of the person applying, it is reasonable to provide some opportunity to have the matter reviewed. This recommendation would allow the review to occur without the cost of setting up an entirely new process.

In terms of interchangeability, we agree with the concerns raised by the AIDS Canadian Treatment Action Council and other HIV/AIDS organizations.

We are pleased that the government has acknowledged the important role that citizens and those who rely on medications can play. Since the early days, HIV/AIDS organizations have been strong supporters of full participation of people with HIV and AIDS in all aspects of decision-making about treatment. That is reflected in the successful Canadian AIDS Treatment Information Exchange, which recently celebrated its 10th anniversary. CATIE represents the benefit that comes from collaboration between professionals and those who use the services.

We are, however, concerned that none of the citizen participation proposals are included in the legislation itself. Without a statutory mandate, an advisory council can be easily eliminated or disregarded. It also makes the council itself less accountable.

The Chair: With apologies, Mr. Lirette, I will have to intervene. On behalf of the committee, I would like to thank you for your deputation and written submission on behalf of the Ontario AIDS Network.

McKESSON CANADA

The Chair: I would now like to efficiently call before the committee our very last presenter of these hearings—I believe our 100th or so presenter, after having received several hundred written submissions as well—Mr. Joe Varkul, vice-president for Ontario of McKesson Canada, and colleague. I remind you, gentlemen, you have 10 minutes in which to make your combined deputation. Please identify yourselves for the purposes of the permanent record here at Hansard. Please begin.

Mr. Joe Varkul: Thank you, Mr. Chair and members of the committee. My name is Joe Varkul. I'm the vice-president and general manager for Ontario of McKesson Canada. With me is Anthony Leong, our director of new business development.

McKesson Canada is the leading provider of logistics within the Canadian health care marketplace. In Ontario we operate five distribution centres which provide employment for 900 local residents. McKesson Canada's Ontario operations offer same-day and next-day deliveries of 35,000 products from 800 manufacturers to 2,400

pharmacies and 250 hospitals and institutions. Our geographical coverage includes 403 pharmacies in the most remote areas of the province, ensuring that patients receive their prescribed therapy in a timely manner no matter where they live. In Ontario last year, our company provided logistics for over \$2 billion worth of pharmaceutical products.

We are the gears in the machine. We are the wholesaler and the transporter. We add no cost to government. While patients don't see us or even know about us, we play a vital role in making drug access and distribution possible.

Like everyone, we have watched the costs of the Ontario drug benefit program grow rapidly over the last number of years. We have watched the work of the drug secretariat and have tried to have input wherever possible into the process.

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Unfortunately, our company and indeed our industry would suffer great collateral damage, however unintentionally, by the contents of this bill if it is passed and tabled without amendments. In this regard, I would like to draw your attention to four specific issues.

Number one, in the government's effort to curtail the rebates paid by generic drug manufacturers to pharmacists, we may be caught in the definition of what constitutes a rebate. We purchase generic drugs from the manufacturers and sell them to retail pharmacies at the same price. We are compensated by the manufacturers with a distribution allowance that is based on a small percentage of the value of their goods that we handle. The distribution allowance paid to us is for a service rendered. It is not an incentive for us to alter our commercial practices. It does not result in higher drug prices. It allows the pharmacist to make the full allowable markup, currently at 10%. Therefore, we are asking the committee to amend the bill to exempt distribution fees paid to wholesalers from the definition of a rebate.

Our second issue is the proposed price reductions in the bill and their timing. Our own analysis is that a 20% price reduction in generic drugs will have an immediate negative impact of \$6 million on us. The proposed roll-back on brand name pharmaceuticals would have a \$1-million negative impact. In total, this \$7 million represents a significant impact on our approximately 1% operating margin, the loss of which would require us to reduce our workforce, initiate layoffs and begin service reductions soon after the bill's implementation.

Therefore, we propose that a phased-in, transitional approach be taken, commencing only with new generic drugs that are added to the formulary. Similarly, the current prices of branded pharmaceuticals listed in the ODB formulary could be accepted as the new book price and unauthorized price increases could be restricted on a go-forward basis. This approach would give all businesses impacted by Bill 102 time to adapt and reduce the need for widespread inventory cost adjustments throughout the entire pharmaceutical supply chain.

Thirdly, though the financial transactions between manufacturers and pharmacists have little bearing on our company, it has a number of indirect impacts, particularly with respect to the economic sustainability of retail pharmacy. We certainly endorse a transparent system regarding professional allowances. However, we believe that imposing a cap on these allowances would not result in any savings to the government and would only serve to foster an underground economy similar to what a neighbouring province experienced when it implemented a similar measure. Furthermore, the combination of limitations on professional allowances and the multiplying effect of generic price reductions would have a dramatic impact on the economic viability of retail pharmacy, particularly the smaller independents. As of this moment, we have \$90 million in credit extended to independent pharmacies in Ontario. Their financial health is important to us.

We suggest that the bill or the forthcoming regulations be amended to establish a transparent system for professional allowances with no limits on the amounts paid. If the government finds that these allowances become excessive in the future, they could exercise their power in establishing new ceilings for generic prices.

Our final issue deals with our role in the system. For many years now, Ontario has been the only province in which traditional and accredited wholesalers, such as McKesson Canada, are not recognized for the value they bring in terms of consolidated supply, cost savings and timely access to pharmaceuticals. Other provinces utilize a pharmacist reimbursement model based on actual acquisition cost, or AAC, which ensures that pharmacists are reimbursed 100% for the cost of the drugs they acquire, including the wholesaler markup. This system greatly simplifies the ordering and inventory management process for pharmacists. We would like to see an earnest and ongoing effort that would investigate and make recommendations on the feasibility of an AAC-based reimbursement model, which would recognize the value that traditional and accredited wholesalers provide without negatively impacting the reimbursement that the pharmacists receive. As Ontario's largest pharmaceutical wholesaler, we would appreciate the opportunity to be consulted as part of this process.

In conclusion, we recognize and support what the government is trying to accomplish, and we think we can help. However, if our recommendations are not taken into account, we would suffer large collateral damage and would have to reduce our operations and services to customers and, ultimately, to patients. We have been in this business in this province and this country for 100 years, and would like to be here for another 100.

The Chair: Thank you very much, Mr. Varkul. We'll have about a minute per side, beginning with the government.

Mr. Peterson: Thank you for making the submission. I was a businessman in the distribution business in several areas—clothing, electronics and hardware products—and I've never seen a system as efficient as yours

that operates on such low margins. We take to heart what you're talking about.

One of the biggest problems we had in reforming the drug act was how to figure out where the rebates were coming and these price increases were going through you. This must be a dog's breakfast in terms of keeping your computer pricing in check and on track, and making sure that you're not leaving money on the table when you operate on such margins. Is there a better way for us to work through the pricing, the price increases and the fixing of the prices?

Mr. Varkul: Our recommendation, as I've said here, would be that prices as they are today should be left in place and should be recognized; that the reduction in prices should apply to future listed generic drugs; and that the current brand drug pricing should be frozen and only allowed to increase with your permission.

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

Mr. Jackson: We've heard from some who've complained that wholesaling upcharges take away a significant portion of the pharmacists' allowable markup. That could be 5.6% versus 8%. Could you help me understand that a little bit better?

Mr. Varkul: Sure. Essentially, the business is divided into two. As you've heard today, generic prescriptions make up about 50% of the total number of prescriptions, in addition to which we get a fee for service from the generic manufacturers. So on the generic side, there is no markup from the wholesaler, and the pharmacist is not impacted in any way. They get their current 10% in full.

The issue arises on the brand side. On the brand side, McKesson generally upcharges and invoices at 5.5%. However, by the time the pharmacy pays us and has received their cash discounts and allowances, our selling margin, as it were, would be somewhere in the twos.

Mr. Jackson: You're formerly Drug Trading or like Drug Trading?

Mr. Varkul: We're formerly National Drug. Some years ago, we actually purchased the distribution assets of Drug Trading as well.

Mr. Jackson: That's what I thought. Thank you.

The Chair: Thank you, Mr. Jackson. To the third party.

Ms. Martel: Thank you very much for your contribution here late in the day.

Just let me go back. The effect, then, in terms of the markup is that if a very significant portion of a pharmacy's drugs are brand name versus generic or ODB, then they could be really impacted by that change in markup from 10% to 8%.

Mr. Varkul: It's not my position to comment on that—

Ms. Martel: I understand that, but you work with them.

Mr. Varkul: —except that the price increases which were not recognized before were being deducted from the 10%. My understanding would be that today these price increases or current prices would be recognized, so there would be no loss from the price difference between the formulary and the manufacturer's selling price.

Ms. Martel: It's going to depend on if that's clarified in the bill—because I don't think it's as clear in the bill as you've outlined at all—whether the markup is off the wholesale price or not.

Mr. Varkul: Absolutely.

The Chair: Thank you, Ms. Martel. On behalf of the committee, I would like to thank you, Mr. Varkul and Mr. Leong, for your deputation on behalf of McKesson Canada, which is, as I've mentioned, the final external hearing we'll be having on this particular bill.

If there is no further business before the committee, I declare that we are adjourned in this room until after question period, at approximately 3:30 p.m., for clause-by-clause consideration.

The committee adjourned at 1818.

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Also taking part / Autres participants et participantes

Mr. Cameron Jackson (Burlington PC)

Clerk / Greffier

Mr. Trevor Day

Staff / Personnel

Ms. Lorraine Luski, research officer,
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